MENTAL HEALTH PROBLEMS AMONG THE STUDENTS OF DHAKA UNIVERSITY AND OUTCOME OF PSYCHOLOGICAL TREATMENT ON THEM

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To my mother and in memory of my father

Supervisors' Certificate

This is to certify that we have read the dissertation entitled **"Mental Health Problems among the Students of Dhaka University and Outcome of Psychological Treatment on Them"**, submitted by Ms. Nusrat Sharmin, in partial fulfillment of the requirements for the Degree of M.Phil in Clinical Psychology, University of Dhaka, and that this is an original research work carried out by her under our supervision and guidance.

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Abstract

The present study was conducted to see mental health problems among 402 students of Dhaka University and outcome of psychological treatments on 7 students seeking help for their psychological problems at the Guidance and Counselling Centre of Dhaka University.

There were two parts of the study. In part I, to find the mental health problems among the students of Dhaka University, General Health Questionnaire (GHQ-12) was applied on 402 students of Dhaka University. By analyzing GHQ-12 scores it was found that a high percentage (55%) of the students were identified as having clinical level of psychiatric distress. Chi- Squire Test was done between mental health status (based on GHQ-12 score) and variables such as gender, marital status, religion, origin, living status, faculty, educational stage, income of family, income of student, number of siblings and family size of the subjects of this study, where the cut-off point was 3. No significant association was found between male and female Ss. Interestingly, significant association was found between GHQ-12 scores and variables like marital status (married and unmarried), religion (Muslim and others), origin (urban and rural), educational level (1st year, 2nd year, 3rd year, 4th year, masters and above), and family income (0-5000TK, 5001-10000TK, 10001-20000TK and 20000TK+). On the other hand, no significant association was found between GHQ-12 scores and variables such as living status

(residential and non-residential), faculty (science, humanities and commerce), individual income of the student (yes or no), number of sibling (0-2 or 2+), and family size (small or large). Significant correlation coefficients were found between GHQ-12 scores and age, level of education, family income and students' income. On the other hand, no significant correlation coefficient was found of birth order, number of sibling and family size with GHQ-12 scores.

In part II, 7 cases seeking psychological help were selected randomly at the Students Guidance and Counseling Centre of Dhaka University for giving them psychotherapeutic intervention to see its outcome on them. The major problems of the cases were as follows: relationship problem- 3 cases, conflict about career choice- 2 cases, depressive illness-2 cases. The major causes of their clinical conditions were personality pattern, academic problems, developmental problems, communication difficulties, negative automatic thoughts (NATs), family problems, emotional problems and physical ailments. To see the outcome of psychological treatment GHQ-12, 10-point self-rating scale, anxiety scale, depression scale and goal assessment sheet were applied and pre-intervention scores were compared with post-intervention scores. Marked improvements were noticed at the post intervention phase in all cases.

Mainly, cognitive behavior therapy was used to see the outcome of psychological treatment of the 7 cases. But depending on the need of the clients Person Centered Counselling along with Cognitive Behavior Therapy was also used. The specific therapeutic techniques used in this study were psycho education, ventilation, graded task

assignment, distraction, contract, exposure, role play, anger management, assertiveness training, behavioural experiment, breathing retraining, muscular relaxation, imaginary relaxation, exercise, recreational activities, cognitive restructuring, downward arrow technique, empowering self, making hope and see dream, self reward and worry postpone. The lowest number of session was 5 and the highest number of session was 18 were required by the clients.

The results of the present study evinced that the majority students of Dhaka University are in clinical level of psychiatric morbidity. Many of them are suffering from mental health problems. The results also demonstrated clearly that psychological treatment is effective in dealing with students' clinical conditions. It is suggested that adequate psychological services be made available to the students in the greater interest of the nation.

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INTRODUCTION

1.0 What is Health:

According to World Health Organization (WHO), 'Health is a positive state of physical mental and social well-being and not merely the absence of disease and infirmity, so that each citizen can lead a socially and economically productive life.' Health is not only the absence of infirmity and disease but also a state of physical, mental and social well-being (WHO, 1992).

1.1 What is Mental Health:

It is highly problematic to define mental health. Mental health can be defined variously, for example: as the absence of disease; as an ideal state of mind; as the average level of functioning of an individual within the context of a total group; as a capacity to function autonomously and completely; as a subjective sense of contentment and satisfaction; and as an ability to adjust to one's social environment effectively. Cox (1974) said that mental health is a mental maturity, the ability to understand real life problem, values, self concept, the ability to serve people, creative work and to cope with stress. Mental health refers to the capacity to live in a resourceful and fulfilling manner, having the resilience to deal with the challenges and obstacles that life presents, (University of Western

Sydney, 2004). One way to think about mental health is by looking at how effectively and successfully a person functions. Feeling capable and competent; being able to handle normal levels of stress, maintain satisfying relationships, and lead an independent life; and being able to "bounce back," or recover from difficult situations, are all signs of mental health , (Wikipedia, 2007). Emotional, physical and social, all these aspects must function together to achieve overall health.

Mental health is generally conceptualized as some thing wider than the absence of mental illness. According to Kakar (1982) "mental health is a label which covers different perspectives and concerns, such as the absence of incapacitating symptoms, integration of psychological functioning and feeling of ethical and spiritual well being." Mental health is a concept that refers to a human individual's emotional and psychological well-being. Merriam-Webster defines mental health as "A state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life, (Wikipedia, 2007).

1.2 Mental Illness and Mental Health Problems:

Mental health is not the converse of mental illness. The term mental illness generally refers to patterns of maladaptive behavior and states of distress, which interferes with some aspects of adaptation. American Psychiatric Association's (1994) Diagnostic and Statistical Manual (DSM-IV) conceptualize mental disorder as the mental condition that causes significant distress or disability (impairment in one or more important areas of

functioning); and that which is not merely an expected and culturally sanctioned response to a particular event.

According to DSM-III-R (V-code) and DSM-IV (some problems of "other conditions that may be a focus of clinical attention" and some problems in Axis-IV) there are few problems, which we cannot call, disorders but which need clinical attention to prevent the growth of potential mental illness. These kinds of conditions can be better characterized as mental health problems. For example, adjustment problem, relationship problem, bereavement, academic problem, occupational problem, identity problem, religious or spiritual problem, acculturation problem, phase of life problem, which we cannot consider illness or disease but mental health problems. There is an understanding among common people that 'mental health' is related with mental illness. But mental health is the range which extends from good mental health to mental illness.

Many attempts have been made to define mental disorders (Clare, 1979; Fulford, 1989). In general medicine there are three types of definition: 1) absence of health, 2) presence of suffering and 3) pathological process whether physical or psychological. First, illness of any kind can be defined as the absence of health. A second approach is to define illness in terms of the presence of suffering. A third approach is to define mental disorders in terms of pathological process. Such a view was expressed by Lewis (1953b), who suggested that illness could be characterized by evident disturbance of part functions as well as general efficiency. In psychiatry part function refer to perception, memory, learning, emotion, and other such psychological function.

"The Diagnostic and Statistical Manual of Mental Disorder" DSM-IV, conceptualizes each of the mental disorders as a clinically significant behavioral and psychological syndrome, or pattern that occurs in an individual and that is associated with present distress (e.g., painful symptom) or disability (i.e., impairment in or more important areas of functioning) or with a significantly increased risk of suffering, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an acceptable and culturally sanctioned response to a particular event, for example, the death of a loved one.

Whatever its original causes, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above (APA,1994). Mental health problems exist across a spectrum of states of mind and behaviors, from temporary responses to painful events through more debilitating and persistent conditions. At some time in our life we will all experience adverse life events. At such times it is not unusual for a person to experience symptoms such as: lack of energy; loss of interest in everyday life activities; changes in sleep or appetite patterns; inability to make decisions; irritability or moodiness; confusion; sexual problems; or feelings of helplessness and hopelessness.

Problems arise when the above symptoms become severe or long-lasting or if they start to negatively affect every facet of our life, e.g., relationships, personal health, job and academic performance. For some people the stress they experience at these times may lead to the start of a mental health disorder. 'Mental illness' is not the same as poor mental health. Mental illness is a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. Mental illness is a broad range of disorders with psychological or behavioral symptoms and/or impairment in functioning due to a social, psychological, genetic, physical/chemical or biological disturbance (APA, 1994). The term covers a broad range and severity of disorders, and the experience of a particular illness will vary between individuals. Mental illness is a psychological or behavioral pattern that occurs in an individual and is thought to cause distress or disability that is not expected as part of normal development or culture (Wikipedia, 2007). Broadly speaking, mental illnesses can be divided into two types – psychotic and non-psychotic illnesses.

Over decades, from ancient time to twentieth century the concept of mental health is changing. Mental illness and mental disorders are considered and treated in different ways. Today psychologists, psychiatrists, social workers, and other mental health professionals practice many different forms of psychotherapy. Moreover, currently different types of mental disorders are classified under internationally recognized classification system.

1.3 DSM Classification of Mental Disorders:

Diagnostic and statistical Manual of Mental Disorder (DSM-IV and DSM-IV-TR) specifies what subtypes of mental disorder are currently officially recognized and provides for each a set of defining criteria. A multiaxial system is an assessment on several axes, each of which refers to different information that helps the clinician treatment plan and predict outcome.

Five axes are included in the DSM-IV-TR multiaxial classification (APA, 2000). The multiaxial system is a systematic and convenient format for organizing and communicating clinical information, capturing the complexity of clinical situations and for describing the heterogeneity of individuals with a particular diagnosis. It promotes application of the biopsychosocial model in clinical, educational and research settings. All axes are given below.

Axis	Mental Disorders
Axis I	**Clinical Disorders** **Other Conditions That May Be a Focus of Clinical Attention** # Disorders Usually First Diagnosed in infancy, Childhood, or Adolescence (excluding Mental Retardation, which is diagnosed on Axis II) # Delirium, Dementia, and Amnestic and Other Cognitive Disorders # Mental Disorders Due to a General Medical Condition # Substance Related Disorders

	# Schizophrenia and Other Psychiatric Disorders # Mood Disorder # Anxiety Disorder # Somatoform Disorders # Factitious Disorders # Dissociative Disorders # Sexual and Gender Identity Disorder # Eating Disorder # Sleep Disorder # Impulse Control Disorders not elsewhere classified # Adjustment Disorder # Other Conditions That May Be a Focus of Clinical Attention
Axis II	**Personality Disorders** **Mental Retardation** # Paranoid Personality Disorder # Schizoid Personality Disorder # Schizotypal Personality Disorder # Antisocial Personality Disorder # Histrionic Personality Disorder # Narcissistic Personality Disorder # Avoidant Personality Disorder # Dependant Personality Disorder # Obsessive-Compulsive Personality Disorder

	# Personality Disorder Not Otherwise Specified # Mental Retardation
Axis III	**General Medical Conditions** # Infectious and Parasitic Diseases # Neoplasm's # Diseases of Blood and Blood-Forming Organs # Diseases of the Nervous System and Sense Organs # Diseases of the Circulatory System # Diseases of the Respiratory System # Diseases of the Digestive System # Diseases of the Genitourinary System # Complication of Pregnancy, Childbirth, and Puerperium # Diseases of the Skin and Subcutaneous Tissue # Disease of the Masculoskeletal System and connective Tissue # Congenital Anomalies # Certain Conditions Originating in the Perinatal Period # Symptoms, Signs, and III defined conditions # Injury and Poisoning
Axis IV	**Psychosocial and Environmental Problems** # Problems with primary support group # Problems related to the social environment # Educational problems # Occupational problems

	# Housing problems # Economic problems # Problems with access to health care services # Problems related to interaction with legal system/crime # Other psychosocial and environmental problems
Axis V	**Global assessment of Functioning** Axis V is reporting the clinician's judgment of the individual's overall level of functioning. It is necessary in planning treatment and measuring its impact, and in predicting outcome.

According to V-code of DSM 3R and axis-I of DSM-IV-TR there are some problems, which are under the classification of "other conditions that may be a focus of clinical attention", and some problems of axis-IV, which cannot be called disorders but need clinical attention to prevent the development of potential mental illness. These kinds of conditions can be better characterized as mental health problems, rather than diseases or disorders. For example, relationship problems, problems related to abuse or neglect, bereavement, academic problem, occupational problem, identity problem, religious or spiritual problem, phase of life problem, economic problems, and problems with primary support group problems related to the social environment, educational problems, occupational problems, housing problems etc. These kinds of problems are very common among university students.

1.4 Causal Factors of Mental Health Problems:

It is very important to know about what causes people to behave in a maladaptive way. We might be able to prevent conditions that lead to them and perhaps reverse those that maintain them. We could also classify and diagnose disorders better if we clearly understood their causes rather than relying on cluster of symptoms. Some of the major contributory causal factors are biological, psychological, psychosocial, and sociocultural (Carson, Butcher & Mineka, 1996). These causal factors are discussed below:

Biological Causal Factor: Biochemical imbalances in the brain can result in abnormal behavior. There may be excessive production and release into the synapses, causing a functional excess in levels of that neurotransmitter. Many recent studies suggesting that heredity is an important predisposing causal factor in several disorders-particularly depression, schizophrenia, and alcoholism support the biological viewpoint (Cloninger, Reich, Sigvardsson, von Knorring & Bohman,1986; Gottesman, 1991; Plomin, 1991; Torgersen,1993). Due to Constitutional liabilities the mental retardation, hyperactivity and emotional disturbances may occur. And significant damage of brain tissue places a person at risk for psychopathology, but brain damage is rarely a cause of psychiatric disorder (Eisenberg, 1990). Physical deprivation can also cause mental illness or stress. For example when a person is ill physically he may suffer from depression due to his limits to control over his life. Due to physical deprivation the person may become irritated, unsocial, may face concentration problem. Though it is very difficult to show a clear cut biological causal factor for mental illness but there are some behavioral traits

like introversion, extroversion, high or low sensation seeking are characterized by distinctive biological characteristics.

The Psychological Viewpoints: From psychodynamic perspective the role of unconscious is very much important for normal and abnormal behavior. From this point of view a person's behavior results from the interaction of three key components of the personality: id, ego and superego. This perspective also emphasis on ego defense mechanism for some behavior. On the other hand, according to behavioral perspective most behaviors are learned. For example, a boy who has nearly drowned in a swimming pool may develop a fear of water and consistently avoids all large bodies of water, when he sees a pond, lake or a swimming pool, he gets anxious. According to Beck(1967,1976), different forms of psychopathology are characterized by different maladaptive schemas that have developed as a function of adverse early learning experiences and that lead to the distortions in thinking characteristic of certain disorders such as anxiety, depression and personality disorders. But, the humanistic perspective focuses on feeling people from disabling assumptions and attitudes so that they can live fuller lives. According to interpersonal perspective psychopathology is rooted in the unfortunate tendencies we have developed while dealing with our interpersonal environments. Abnormal behavior has a great deal of impact on our relationships with other people.

Psychosocial Causal Factors: A schema is an organized representation of prior knowledge about a concept or about some stimulus that helps guide our processing of

current information. Schemas about the world and self schemas are vital to effective and organized behavior, but they are also source of psychological vulnerabilities. The onset of many cases of depression has been linked repeatedly with the prior occurrence of negative life events, such as illness, divorce, or a serious financial setback. Some evidence suggests that traumatic experiences, such as the death of a parent in childhood may encourage the acquisition of such maladaptive self-schemas (Bowlby, 1980). Due to parental deprivation in yearly years psychological problems may occur in later life. Even in the absence of severe depression-neglect or trauma, many kinds of deviations in parenting can have profound effects on a child's subsequent ability to cope with life's challenges and thus create vulnerability to various forms of psychopathology. The children of seriously depressed parents are at enhanced risk for disorder themselves (Downey and Coyne, 1990; Gotlib and Avison, 1993), at least partly notably including inattentiveness to a child's needs (Gelfond and Teti, 1990). Pathogenic family structure is an overarching risk factor that increases an individual's vulnerability to particular stressors (Carson, Butcher, & Mineka, (1996). Parents' dissatisfactory marital relationship, divorce are sometimes the causes of mental problems. Sometimes gap between verbal and non-verbal communication of the parents and disturbed family structure initiate mental health problems of the children. Another important set of relationships outside the family usually begins in the preschool years, those involving age mates, or peers. Rejected by the peers or maladaptive peer relationship is another cause of mental health problem Kupersmidt Coie (1990) reported that boys who were rejected by their peers in the fifth grade were more likely to have nonspecific negative outcomes seven years later than were average, popular or neglected boys.

The Sociocultural Viewpoint: Physical and mental disorders in a given society could change over time as sociocultural condition change. The relationship between maladaptive behavior and sociocultural factors such as poverty, discrimination, or illiteracy are complex. Behavior considered abnormal in one society was sometimes considered normal in another. When people become so mentally disordered that they can no longer control their behavior, perform their expected roles or even survive without special care, their behavior is considered abnormal in any society.

Sociocultural Causal Factors: Particular factors in the social environment may increase vulnerability, for example low socioeconomic class, disorder-engendering social roles, prejudice and discrimination, economic and employment problems and social change and uncertainty. An inverse correlation exists between socioeconomic status and the prevalence of abnormal behavior-the lower the socioeconomic class, the higher the the incidence of abnormal behavior (e.g., Eron & Peterson, 1982). On the other hand, vast number people in different society have been subjected to demoralizing stereotypes and overt discrimination in areas such as employment, education, housing, which causes abnormality. Economic difficulties and unemployment have repeatedly been linked to enhanced vulnerability and thus to elevated rates of abnormal behavior (Dew, Penkower & Bromet, 1991; Dooley & Catalano, 1980).

In case of students' abnormal or maladaptive behavior the occurrence is the joint product of a person's vulnerability to disorder and of certain stressors that challenge his or her coping resources. So, it is necessary to understand all the causal factors to understand

students' mental health problems. Moreover, it is essential to know about the prevalence rate of mental health problems, which is discussed in the next section.

1.5 Prevalence Rate of Mental Health Problems:

Epidemiological study can identify the prevalence rate of mental health problems. WHO made a global assessment that at least 1% of the population of any society suffers from severe mental disorders and at least 10% of the population will suffer from mild mental disorders during lifetime (NIMH, 2002). From a recent study of WHO in Bangladesh it is found that the prevalence rate of mental disorders for adult age population is 16.1% and the prevalence of psychotic disorders is 1.1% (NIMH, 2007).

From a study on depression (Coyne, Fecner-Bates & Schwenk, 1994) found an estimated prevalence of 13.5% for major depression and 22.6% for all depressive disorders. Community surveys indicate that anxiety disorders are the single most prevalent class of mental disorders in the population at large. Estimates of point prevalence of anxiety disorder range from 13% to 17% (Kessler, Gonagle, Shanyang, Nelson, Hughes, Eshleman, Wittchen & Kendler, 1994; Regier , Myers, Kramer, Robins, Blazer, Hough, Eaton & Locke, 1984). Although only 32.2% of patients with anxiety disorder seek treatment, approximately half of these patients seek treatment in primary care settings. After reviewing the above studies it can be concluded that the prevalence of mental disorders are very high in community. But in many cases they are not recognized or diagnosed by primary care physicians (Broadhead, 1994; Fifer, Mathias, Patrick,

Majonson, Lubeck & Buesching, 1994; Shear & Schulberg, 1995). It is estimated that in case of university students mental health problems are similar to normal population.

1.6 Mental Health Problem among University Students:

University students are generally at their youth or early adulthood, who has passed their secondary and higher secondary schooling, who have to study hard to achieve in their higher education. If they suffer from any mental health problems it affects their study and achievement. Failing exams or classes, getting nervous during conversation, experiencing severe test anxiety, having trouble studying, studying but having trouble with tests, thinking about quitting university or changing major are very common problems for the students. There are some common reasons of academic problems what they experience:

Motivation: Some students don't have a clear vision regarding their reason for being in college. Perhaps they are here at their parent's insistence while not feeling that they are doing what they really want to do with their life. Sometimes courses and majors are chosen to please others, but have little or no relationship to the student's true interests. Many students just aren't sure about what they really want to do in their future career. It takes a fairly clear purpose to motivate a student to successfully engage in the lengthy and difficult process of higher education.

Inadequate Time Management: Some student work at part-time jobs and/or are engaged in time consuming extra-curricular activities at the University. The demands of academic

assignments almost require students to have the time management skills and formal training in this area.

Study Skills: Apart from time management skills, it is known that a large proportion of students entering university have not had much in the way of useful instruction or assistance with specific study methods.

Social Distractions: Love and friendship are the most important things in the lives of most people. It is often difficult to find the needed balance between socializing and studying. Due to the demand for maintaining social relationship, sometimes students are more prone to pass time in variety of social circumstances with their beloved one rather than studies, as a result they fail to study properly, which ultimately brings poor academic results and frustration.

Substance Abuse: While some students bring with them serious problems of substance abuse or addiction from their pre-university years, it is known that the university years are those where alcoholism and other forms of substance abuse begin and become serious (sometimes life-long) problems. While not all addicted or substance-abusing students flunk out of college, none do as well as they could. Some of these students are actually "treating" themselves chemically for a psychological problem that they may or may not be aware of.

Psychological Issues: A large number of students are struggling with the many demands of university life while also dealing unassisted with major emotional issues such as loss,

depression, and anxiety. Undiagnosed and untreated, many of these kinds of problems lead to academic difficulties or failure.

Separation from family: Separation from family is another important factor for students' mental health problem. There are many students whose families are settled in outside Dhaka city. As a result for higher education the students get admitted at Dhaka University and live in residential hostel. Due to separation from the family many of them may suffer from psychological problems.

Any of the above issues and problems may cause students to feel inadequate or result in serious academic difficulties and failure. It is important to avoid waiting until it is too late to ask for assistance.

Many studies have been done on university students around the world. Among different studies, the number of studies on drug addiction is not less. Psychoactive substance use can reduce scientific progress and academic achievement of college students; therefore, authorities of the university must be able to assess the extent of the problem, understand the contributing factors, recognize signs and symptoms, and use educational interventions in identifying and preventing substance dependency (Coleman, Honeycutt, Ogden, McMillan, O`Sullivan, Light & Wingfield, 1997). The rate of substance use has been found to be high among males than females (Merchant, Pournadeali, Zimmer, and Ronaghy, 1976). In a study assessing substance dependency among nursing students,

10% of nurses were chemically dependent, and for many, substance use began while attending nursing college (Coleman, et al., 1997).

To assess anxiety and depression levels among medical students of a private university of Karachi it was found that 113 (60%) students had anxiety and depression. Prevalence of anxiety and depression in students of 4th year, 3rd year, 2nd year and 1st year was 49%, 47%, 73%, and 66% respectively. It was significantly higher in 1st year and 2nd year, as compared to 3rd and 4th year (Inam, Sakib & Alam, 2003). It was seen that birth order, monthly income, number of siblings, and monthly expenditure on education did not affect the prevalence of anxiety and depression (Inam et.al., 2003).The study finding highlights the need of psychiatric counseling and support services available to vulnerable students.

In South Africa black university students in psychology reported significantly less depression than non psychology students, and younger students reported significantly lower scores on depression than older students on the Beck Depression Inventory (Pillay, Edwards, Gambu & Dhlomo, 2002).

To assess psychological changes in medical students in Antalya, Turkey during their undergraduate education all first year undergraduate students were given a detailed, self-report questionnaire and another in the second year. They were asked to complete General Health Questionnaire (GHQ), the Spielberger State-Trait Anxiety Inventory (STAI) and the Beck Depression Inventory (BDI). The findings showed that psychological test scores on the GHQ, the STAI and the BDI rose significantly in

medical students between the first and second years. Using the GHQ, with different cut-off scores, the percentage of students scoring above the thresholds was higher in medical students in year 2, compared with economics and PE students. In addition, the scores for some stressful life events of medical students showed a significant rise from year1 to year 2. Multiple regression analyses indicated that some stressful life events related to social activities were associated with the psychological test scores for medical students. The results indicated that there was a decrease in the psychological health of first-year medical students. Some inadequacies in the social activities of the students might play a role in this type of disturbance (Aktekin, Karaman, Senol, Erdem, Erengin & Akaydin, 2001).

To find out the relation of depression and anxiety to personal and academic problems among Iranian college students the study investigated the role of anxiety and depression in students' adjustment to family and campus life. The cognition Checklist and a problem questionnaire were given to 1452 college students (998 men, 454 women). Analysis showed that off-campus students were significantly less depressed and anxious. These on campus college students were worried about jobs and marriage. Feelings of anxiousness and worry were reported; sex differences on depression scores were not significant (Makaremi, 2000).

A number of recent studies suggest that the mental health of students is significantly worse than that of general population. Crawford, Henry, Crombie & Taylor (2001) found that in the student population there was a significantly high rates of anxiety compared

with general population. In one study it was found that 12.1% of male students and 14.8% of female students had measurable level of depression, ranging from mild to severe, a figure slightly higher than the 11.4% found in the general population (Singleton, Bumpstead, O'Brien, Lee & Meltzer,2003). A survey of 482 students in London found that their General Health Questionnaire GHQ-12 score was twice as severe as for the general population Robert-Brown, 2000). In a large-scale study in the North-west of England students were found to be 1.64 times more likely to be prone to anxiety and/or depression (GHQ-12) than the general population (Harrison, Barrow, Gask & Creed, 1999). A survey of 1620 second year students at Leicester University identified 23% who reported anxiety, phobias and panic attacks, and 40% who experienced sadness, depression or mood changes (Grant, 2002).

Currently suicides at Dhaka University residential halls are on the increase. According to a report of The Daily Star, increasing cases of suicide among the Dhaka University students, especially girl students, have prompted the authorities to go for appointing psychologists in the dormitories and nine psychologists will be appointed for five residential halls (The Daily Star, 2008, June 9). "Considering the gravity of the situation that needs immediate attention, we have decided to appoint psychologists in dormitories," said Prof SMA Faiz, vice-chancellor, DU (The Daily Star, 2008, June 9). Statistics show suicidal tendency has increased notably among the female students of Dhaka University during the last few years. A total of 11 students, including nine girls, of the university committed suicide during the past five years (The Daily Star, 2008, June 9).

Above discussion indicates that there is a high demand on mental health study with university students to understand the mental health condition of Dhaka University, so that the authority can take steps to develop appropriate strategies for promoting psychological services at this university.

1.7 Mental Health Services:

The word mental health problem is a taboo in our community. Many people suffer from mental health problems, but don't seek help from the professionals. In fact many people don't know where they should go to get help. In Bangladesh the people can not have all the mental health facilities. There are few hospitals and private sectors where the services are provided partially. But the educational institutes don't provide this service although a big part of population is student. We can have a look at the picture of mental health services, which is needed in a community.

Psychiatric Treatment: Psychiatric treatment plays an important role to deal with mental disorders. The psychiatrists diagnose the cases as well as do pharmacological treatment. The psychiatrists deal the severe mental disorders, and without psychiatric drug it is very hard to handle those cases. There are many cases that are suffering from psychological problems, but with psychological treatment they need medication. For example to deal Obsessive Compulsive Disorder (OCD), psychiatric medicine also plays a very important role. In the treatment of OCD anti depressant drugs are often prescribed, and varying degrees of success have been reported (Cobb, 1992; Goodman, McDougle, & Price, 1992).

Psychological Treatments: The term psychological service refers to any psychological intervention that is applied for bringing a desired positive change in person's life. The goal of providing psychological service is to bring a shift from undesirable condition to a desirable condition that is related to mental health. There are varieties of psychological treatments, psychoanalytic therapy, cognitive behavior therapy, behavior therapy, humanistic therapy and therapeutic group, all these therapy have their own perspectives and strategies, and unique in their own field. Psychological service includes, Clinical psychology service, Psychotherapy and Counseling. Clinical psychologists deal with comparatively difficult clients. Through psychotherapy different types of mental health problems are dealt with different psychotherapeutic techniques. Counseling is a two-way process, where mild mental problems are dealt. Counseling is a process, which helps the person to explore issues of concern and also deals with emotional state, as well as thoughts.

Psychiatric Social Work: For rehabilitation of psychiatric patients the role of psychiatric social worker is very important. They look after the patients and also help to solve daily life and family problem. Moreover, they helps the patients how to cope in the community. In psychiatric social work the psychiatric patients are assisted by psychiatric social worker for rehabilitation or other program.

Psychiatric Nursing: In psychiatric nursing the nurses have specialized in care and treatment of psychiatric clients. The roles of psychiatric nurses are different than the

other professionals. Their involvements with the patients are more direct and continue for long time. Without their contribution the psychiatric teamwork is impossible.

The right to health includes the right to mental health, which in turn requires mental health services and needs integration of all the professionals. Mental health service is a teamwork approach, where the professionals can work together or sometimes independently, according to the needs of the clients. In case of university students mild to moderate mental health problem cases are available. So, many students having psychological problems do not need pharmacological treatment, but they need psychological and social support. For few mental health disorders the cases can be referred to psychiatrist to the hospitals. In this context, the clinical psychologists, counselors and psychiatric social worker can play an important role. But, there should be a link within the whole team. In case of university students, they need psychological support during their study period. So, it is essential to know how effective psychological services are.

1.8 The Effectiveness of Psychological Services for Mental Health Problems:

There are varieties of psychological services, including psychoanalytic therapy, cognitive behavior therapy, behavior therapy, humanistic therapy and therapeutic group. Psychological services are aimed at amelioration of both psychological distress and disorders. The ability to provide psychological services does not depend on a diagnosis of

psychopathology or psychiatric disorder. The scopes of the terms psychological and psychiatric are not equivalent (Salmon, 1984). In one study of suicidal case it was found that the primary problems of the case were seemed to involve interpersonal problems inadequate coping skills, situational adjustment issues, chronic internal conflicts or one of a variety other primary psychological problems, where a clear preference was for psychologists (Antonuccio, Danton & Denelsky, 1995). In one survey Judith Hartley found that psychology departments for some GPs were the preffered service for patients with a more complex presentation in the absence of more serious psychiatric disorder. The provition of psychological services results in the reduction of overall health care costs (Cummings & Follette, 1968; Pallak, Cummings, Dorken & Henke, 1995). A large and growing body of literature indicates that both the presence of psychologists as members of the primary care team and a variety of specific psychological interventions reduce unnecessary medical visits, reduce overall health care costs, and enhance patient care (Friedman, Sobel, Myers, Caudill & Benson, 1995; Kenkel, 1995). Psychological interventions can reduce the inappropriate medical care utilization (Cummings, 1991; Gold man & Fedman, 1993).

Providing effective psychological intervention can save time, expense, and frustration for the students. So, for proper delivery of care to the community, proper recognition of psychological problems in general practice is crucial (Goldberg & Huxley, 1992). So psychological services must be available at University for the promotion of mental health of the students.

1.9 Methodological issues:

According to the research questions, appropriate research method was used. To see the mental health problem among the students of Dhaka University, questionnaire method was used. Beside quantitative methods, qualitative methods was also a good choice for conducting research in this area, as it serves some advantages that quantitative methods can not. Also no research has been conducted on Dhaka university students on psychological intervention, so as a pioneer research it was thought that it would not be possible to conduct the study in large context and by using quantitative method, and was thought that using case study method would be an appropriate choice.

Qualitative Research

Qualitative Research involving detailed, verbal descriptions of characteristics, cases, and settings. Qualitative research typically uses observation, interviewing, and document review to collect data (BJA Bureau of Justice Assistance, Centre for Program Evaluation, 2008). Qualitative research is a field of inquiry that crosscuts disciplines and subject matters (Denzin, Norman & Lincoln, Yvonna. (2005). It involves an in-depth understanding of human behavior and the reasons that govern human behavior. Unlike quantitative research, qualitative research relies on reasons behind various aspects of behavior. Simply put, it investigates the why and how of decision making, as compared to what, where, and when of quantitative research. Hence, the need is for smaller but focused samples rather than large random samples, which qualitative research categorizes data into patterns as the primary basis for organizing and reporting results. Qualitative

researchers typically rely on four methods for gathering information: (1) participation in the setting, (2) direct observation, (3) in depth interviews, and (4) analysis of documents and materials (Marshall, Catherine & Rossman, Gretchen. (1998). Research that derives data from observation, interviews, or verbal interactions and focuses on the meanings and interpretations of the participants is qualitative research (Holloway and Wheeler, 1995).

Information that is difficult to measure, count, or express in numerical terms. For example, how safe a resident feels in his or her apartment is qualitative data (BJA Bureau of Justice Assistance, Centre for Program Evaluation, 2008). Qualitative data is extremely varied in nature. It includes virtually any information that can be captured that is not numerical in nature. Here are some of the major categories or types of qualitative research methods:

- In-Depth Interview

In-Depth Interviews include both individual interviews (e.g., one-on-one) as well as "group" interviews (including focus groups). The data can be recorded in a wide variety of ways including stenography, audio recording, video recording or written notes. In depth interviews differ from direct observation primarily in the nature of the interaction. In interviews it is assumed that there is a questioner and one or more interviewees. The purpose of the interview is to probe the ideas of the interviewees about the phenomenon of interest.

- Direct Observation

Direct observation is meant very broadly here. It differs from interviewing in that the observer does not actively query the respondent. It can include everything from field

research where one lives in another context or culture for a period of time to photographs that illustrate some aspect of the phenomenon. The data can be recorded in many of the same ways as interviews (stenography, audio, video) and through pictures, photos or drawings (e.g., those courtroom drawings of witnesses are a form of direct observation).

- Case Study

A case study is an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and context are not clearly evident. The case study inquiry copes with the technically distinctive situation in which there will be many variables of interest than data points...In this sense, the case study is not either a data collection tactic or merely a design feature alone but a comprehensive research strategy" (Yin, 1994, p. 13).

Case study generally involves collecting in-depth observations in a limited number of cases. It focuses on fewer "subjects," but on more "variables" within each in-depth interview with those cases. The goal is to obtain detailed textual data describing the cases. An important strength of the case study is its ability to answer "how" and "why" questions within real-world context, which is one of the noted interest of the practicing psychologists (Trickett, 1994). Case studies can follow one of two major designs: a single case study, where a single case is examined in-depth, or a multiple case study, where several cases or events are studied. A multiple case study design has all the advantages that a single case study has in capturing real-world contexts. One added advantage that a multiple case study has is its enhanced validity and generalizability of the findings, which

is achieved through repeating the same procedure on multiple cases (Galloway & Sheridan, 1993).

Though case study design can be an appropriate choice for many studies in clinical and community psychology, but many psychologists are reluctant to choose this strategy due to misconceptions and some criticisms about it. Previously reported case studies have been criticized for not employing methodological rigor in describing procedures, and failing to address reliability and validity (Kazdin, 1981; Kennedy, 1979).

To address the potential criticisms of case study methods, qualitative methodology literature contains many suggestions:

Reliability refers to the extent to which consistent results would be obtained if the same procedures were followed by different researchers. To enhance the reliability of multiple case study designs, multiple coders can be used to review and analyze textual data. This will help to ensure a level of objectivity and will allow for the computation of inter-rater reliability, (Larsson, 1993; Sackmann, 1991; Yin & Heald, 1975).

There are two types of validity, external and internal validity. External validity is a central concern of multiple case studies. The term external validity refers to the extent to which the findings from a small number of cases can be generalized. To ensure these researchers emphasized the importance of supplying detailed information to the reader about the process of conducting the research and the decisions made by the research team, so that the readers can evaluate the utility of their work from their own perspective. To ensure the internal validity the use of multiple measures and/or assessment point is

very important. This evaluates the credibility of the findings (Huberman & Miles, 1994; Sackman, 1991; Yin, 1981). Interview data can be supplemented with observations (Sackman, 1991), or documentary information (Maton & Salem, 1995), or questionnaires (Banyard, 1995).

The case study, as a comprehensive research strategy offers several benefits. With attention to the reliability and validity of data analysis and interpretation, researchers can have greater confidence in the applicability of their findings.

Quantitative Research

Quantitative research is the systematic scientific analysis of quantitative properties and phenomena and their relationships. Quantitative research is broadly used in both the natural and social sciences, from physics and biology to sociology and journalism. It is also used as a way to research various aspects of education. The objective of quantitative research is to develop and use mathematical models, theories and hypotheses pertaining to natural phenomena. The process of measurement is central to quantitative research because it provides the fundamental connection between empirical observation and mathematical expression of quantitative relationships (Wikipedia, 2008).

Quantitative methods are research methods dealing with numbers and anything that is measurable. They are therefore to be distinguished from qualitative methods. Counting and measuring are common forms of quantitative methods. The result of the research is a number, or a series of numbers. These are often presented in tables, graphs or other forms of statistics (Wikipedia, 2008).

- Questionnaire

Among quantitative methods questionnaire method is very common. Questionnaire is a form containing questions to which a subject or subjects respond. The information gained from the questionnaire is often subjected to statistical analysis. Questionnaires can be used to examine the general characteristics of a population, to compare attitudes of different groups, and to test theories. Questionnaires appear simple, but they are very difficult to compile in a manner which establishes reliability and validity. A question worded in one way, for example, may elicit a different response from the same question worded slightly differently (Sports Science and Medicine, 2008).

1.10 The Present Study:

The present study was conducted to see mental health problems among the students of Dhaka University and outcome of psychological treatments on them. At first to fulfill the purpose of the study the non-psychotic psychiatric cases among Dhaka University students was detected to see mental health problems among them. Secondly, the outcome of psychological treatment was studied on the students who already had psychological problems and came at the Counselling and Guidance Centre of Dhaka University for psychological support. So far no research has been conducted from the psychological point of view, so there is wide scope for conducting research on Dhaka University students from several viewpoints. This study was conducted to see the mental health problems of the students and exact nature of psychological problems, which was also done to see the outcome of psychological services on university students.

The mental health professionals (Trainee Clinical Psychologists) at the Dhaka University Counseling and Guidance Centre are trained to help students cope with most of their psychological problems. The professionals help them to find out strategies that would help them to solve their problems, reduce their anxiety and other mental health problem and get back on track. They also provide vocational and career counseling to assist students in making good decisions and choices about their future. In addition, experiencing academic difficulties is nothing to be ashamed of and to avoid the problem, rather it is necessary to seek help to overcome difficulties. In the present study the age range of the students was 18 to 35 years which is an appropriate age range for career choice. The students start their university life with a new educational system, new peer groups, teachers, accommodation, and political situation. Due to their studies, some of them are separated from their families and live in a residential accommodation. Many of them can cope with this new situation very well but some cannot. Who cannot cope well, they face various difficulties and lead a stressful life. Because of these stressful situations they are slowly affected and suffer from mental health problems, many of them even suffer from mental disorders. Since June 1998 the trainee clinical psychologists of Dhaka University are providing psychological support to the students of Dhaka University. Among them mental illness and mental health problems were found like: anxiety, panic disorder, Obsessive Compulsive Disorder (OCD), sleep disorder, relationship problem, headache, adjustment problem, difficulty in study, memory problem, depression, psychosexual dysfunction, stuttering problem, phobia (exam, social), anger, post traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), eating disorder, assertion problem, performance anxiety, health anxiety, antisocial personality disorder,

marital problem. Due to these problems drug addiction drop out, failure in exam were found, even few of them attempted suicide or committed suicide. In view of the context discussed above the present study was conducted to find out the percentage of mental health problems among the students of Dhaka University and also to see the outcome of psychological intervention on them. Another purpose of the study was to find out the causal factors of mental health problems among them, so that appropriate strategies can be taken for psychological services for the students of Dhaka University. To fulfill the purposes the present study was conducted.

1.11 Objectives of the Study:

1) To find out the percentage of mental health problems among the students of Dhaka University.
2) To find out the causal factors of mental health problems among the students of Dhaka University.
3) To find out the outcome of psychological intervention offered by trainee clinical psychologist at the Counseling and Guidance Centre of Dhaka University.

1.12 Specific Objectives of the Study:

1) To assess pre and post intervention mental health condition of students.
2) To suggest developing appropriate psychological services at Dhaka University.

1.13 Rationale of the Study:

From a report of The Daily Star, more than 30 thousand students are currently studying at Dhaka University and there is only one psychologist working at the Students Counselling and Guidance Centre of the university (The Daily Star, 09-06-2008). According to World Health Organization (WHO) at least 10% of population suffers from mild mental disorders in the world (NIMH, 2002). From a recent study of WHO in Bangladesh it is found that 16.1% population suffers from mental disorders (NIMH, 2007). In a one year of US study it was found that, the rate of all psychiatric disorders was 20% (Robins and Regier, 1991). So, the number of people who need psychological services at Dhaka University would be about 3 to 5 thousand. But unfortunately there is no study on them regarding this issue. There is no clear idea about mental health problems and services, and only very few people know about it. So the cases are not appropriately referred by the authority. Although the students are suffering but do not know where to go for help. As a result severity of the problems may increase day by day. Statistics shows that the suicidal tendency has increased notably among the female students of Dhaka University during the last few years. A total of 11 students, including nine girls, of the university committed suicide during the past five years (The Daily Star, 2008, June 9). If the cases come with minor problem, they do not have to suffer in the long run. They can prevent themselves from major problems and sufferings. According to scientist Lorin (1990), 'prevention can be in the long run far less costly than the treatment of mental disorders and their effects.' Keeping this in mind it can be said that mental health services are needed among students. From 1998, the trainee clinical psychologists of the Department of Clinical Psychology of Dhaka University are providing services at the Students

Counseling and Guidance Centre for the university students. But there is no study on mental health problem on them. So it is assumed that after conducting research on this area, appropriate referral should be established by the student advisors or by the university authority. To fulfill the greater need of service planning for the university students, research on mental health problems of the university is essential.

The study is important:

1. to know about the mental health condition among the students of Dhaka University
2. to find the causes of these problems, so that appropriate prevention strategies can be taken
3. to give necessary psychological support to the students who need it
4. to suggest developing appropriate psychological services for the promotion of mental health of Dhaka University family members.

Chapter-2

METHODS AND PROCEDURE

2.0 The Sample:

The sample of the present study was selected from the students of Dhaka University. It was conducted in two parts:

In part I, to see the mental health problems among the students of Dhaka University, 402 students were selected from all the departments of Dhaka University. Purposive sampling technique was used to collect data. From all departments and institutes (50 departments and 9 institutes) a minimum of 6 students were taken from each year of 1st year, 2nd year, 3rd year, 4th year honours, Masters and above (Masters, M. Phil. and Ph. D.) courses. From all the institutes and departments any student from any year was included in this study purposively. The institutes or departments, which have only, post graduation or diploma course were also included. The age range was from 18 to 35 years. Among them 198 was male and 204 was female. The number of 1st year students was 78, 2nd year 95, 3rd year 67, 4th year 74, Masters and above 88.

In part II, 20 students were listed who came first within first 2 weeks of January 2003 at the Student Guidance and Counselling Centre of Dhaka University for psychological help. A lottery was done among 1 and 2 then 2 was selected. After that every second number was selected randomly. As a result even number subjects were selected. Those

selected 10 cases were given appointment by the researcher. Among them 3 cases were dropped out after few sessions (after 2/3 sessions). Finally 7 cases were included in this study to see the effectiveness of psychological intervention on them.

2.1 Design of the Study:

For part - I quantitative design was used. A questionnaire (GHQ-12, Appendix-3) was chosen to see the mental health problems among the students. To see the demographic information they also filled up an information sheet (Appendix-2). Before that a written instruction was given to the students (Appendix-1). And for part - II qualitative case study design was selected mostly. In part - II, quantitative research method was also followed. A structured interview schedule (Appendix-4) was used. Few scales (Depression, Anxiety and GHQ-12, Appendix 6, 7 and 3) were also used to see the changes from session to session which was taken in quantitative form. A goal assessment sheet (Appendix-5) was used as an indicator of success to what extent the treatment goal was achieved.

2.2 Measures used in the Study:

The General Health Questionnaire (GHQ) - 12 was used to identify the cases of mental health problems in the part - I of the study. An information sheet was also used along with GHQ-12 to find out the factors related to mental health problem. In part - II of the research, in the assessment and intervention phase the data was mostly qualitative. For

exploring the causes of various mental health problems in-depth interview was done among 7 cases. Rating scale, goal assessment sheet, Depression Scale of Zahiruddin and Rahman (2005), Anxiety Scale of Deeba and Begum (2004), GHQ-12 of Goldberg (1992) were used during intervention. Instruments, which were used in the current study, were the following:

I. Questionnaire/ Scale:

Some questionnaires were used in the present study. They are:

A. General Health Questionnaire (GHG)-12: The GHQ-12 (Appendix-3) is a self-administered screening test. It was constructed for detecting non-psychotic psychiatric disorder. It was designed by Goldberg (1978) to detect non-psychotic psychiatric disorder in people in community setting, such as primary care or among general medical outpatients. The General Health Questionnaire has different version i.e., GHQ-60, GHQ-28, GHQ-12 etc. The GHQ-12 (Goldberg, 1992) is a shortened version of the well-validated full version, the GHQ-60, but is equally valid and reliable. In the present research GHQ-12 was used.

Scoring: There are two scoring systems, in GHQ scoring, where responses score 0, 0, 1 and 1 respectively; and in Likert scoring where responses score 0, 1, 2 and 3 respectively. The first method gives scores ranging from 0 to 12 and is appropriate for detecting clinical level of psychiatric distress (cases). The first method was used in the present research.

Interpretation: Higher scores indicate a greater probability of clinical disorder. Based on five validation studies, the recommended cut off threshold for psychiatric disorder is 2/3 using the first method of scoring. But higher cut-offs may be necessary for respondents with somatic symptoms which can inflate scores. The GHQ uses cut off points to determine whether the respondents are in psychiatric distress. The cut off points is set to minimize the risk of incorrect decisions- wrongly identifying a respondent as in distress.

Psychometric properties: Internal consistency as assessed by Cronbach's alpha ranged from 0.82 to 0.90 in a series of studies. The split- half reliability was 0.83 and 0.73 respectively. Validity has been evaluated by assessing its sensitivity in detecting cases of psychiatric disorder. In the original validation study the sensitivity was 93.5 percent and the specificity in detecting cases of disorder was only 78.5 percent.

The validity of the GHQ-12 was also compared with the GHQ-28 in a World Health Organization study of psychological disorders in general health care (Goldberg et al, 1997). It was found that, minor variations in the criteria used for defining a case made little difference to the validity of GHQ and complex scoring methods offered no advantage over simpler ones. For the purpose of the same study the GHQ was translated into 10 other language and validity co-efficient was almost high as in the original language. There was no tendency for the GHQ to work less efficiently in developing countries. Finally, gender, age and educational level are shown to have no significant effect on the validity of the GHQ. It was concluded that if investigators wish to use a

screening instrument as a case detector, the shorter version of the GHQ is remarkably robust and works as well as longer instrument.

In the present study the translated version of the GHQ- 12 was used. The reliability of the Bengali version of the GHQ-12 was measured parallel form method (Sarker & Rahman,1989) and was found to be quite satisfactory (r=0.69). The GHQ-12 was also used in four published studies (Banu & Akhter, 1996; Banu & Chowdhury, 1999; Huq , Sorkar & Uddin, 2000; Jahan & Akter, 2000; Zaman & Rahman, 2003) conducted in Bangladesh.

B. Anxiety Scale: Anxiety scale of Deeba and Begum (2004), (Appendix-7) was used to determine the base line anxiety and to monitor it during the intervention phase. It is a 36-item scale that measures the severity of anxiety of adults and adolescents. The Split-half reliability was assessed and the correlation between two halves of the scale was found 0.916 (significant at □ = 0.01) and the Cronbach-aplha reliability was 0.9468. The test-retest correlation (r = 0.688) was also found to be significant at □ = 0.01. The content validity of the scale was ensured through strictly following the sequential system model of scale development and by experts' input in different stages of item construction. Three external criterions were selected to assess the criterion related validity. All the three criterions were found to be significantly (□ = 0.01) and positively correlated with the present scale score (Psychiatrists' rating, r = 0.317; Patients' self-rating, r = 0.591; HADS, r = 0.628). Construct validity was assessed by a) discriminability of the scale among clinical and non-clinical samples (F = 60.275 at □ = 0.01), and b) item-total

correlation which was found to be ranging from r = 0.399 to r = 0.748, and were all significance □ = 0.01. Both severity and screening norm were developed for the current Anxiety Scale. Score ranges for mild, moderate, severe and profound severity were 27-54, 55-66, 67-77, and 78-147 respectively. Cot-off score for screening an individual as anxious or non-anxious was 47.5.

C. Depression Scale-DS: Depression Scale of Zahiruddin and Rahman (Appendix-6) was used to find out base-line level of depression among the clients and to monitor their progress during the intervention phase. It is a 30-item self-report instrument for measuring the severity of depression in adults and adolescents developed by Zahiruddin and Rahman, (2005). The split-half reliability of the scale is 0.7608 and test-retest reliability is 0.599 at 0.01 level of significance. Reasonably high concurrent validity of the scale was found. For the estimation of concurrent validity, three external criteria were used: rating of depression by the psychiatrists, patient's self-rating of depression and diagnosis of depression by the psychiatrist. The estimated correlation between the obtained total scores on the current Depression Scale and the rating of Depression by psychiatrists is 0.377 and correlation between the obtained total scores on the Depression Scale and the patients' self rating of depression is 0.558 at 0.01 level of significance.

II. Information Sheet, Semi Structured Interview Schedule and In-depth Interview:

In the first part of the study an information sheet was provided to the students to fill up (Appendix-2). In the second part of the study, In-depth Interview was the main tool of

this study. To collect necessary information for assessing the participants' mental health state thoroughly, in-depth interview was conducted with the help of semi-structured interview schedule. This semi-structured interview schedule (Appendix-4) sheet was focused to obtain data in the following areas:

a. Demographic information (name, age, sex etc);
b. Personal and family history;
c. Presenting problems

Questions which was asked during the in-depth interview was open and general rather than formed by a particular hypothesis, which could be leading. Some of the Questions that were asked are:

How was your life as a child?

How was your feeling after being admitted at Dhaka University?

Was there any adjustment problem after admitted at Dhaka University?

Can you tell me about any other major life event?

In-depth interview was initiated by asking questions (open-ended and close ended) about each case's personal life and then gradually information about university and associated mental health conditions. The clients were allowed to talk more and more. Downward arrow technique was also used to understand the problem. From such information formulation of the cases were done and causes of the problems were found which helped for treatment plan. The questions were also problem oriented.

III. Rating Scale:

The severity of the problem was measured through rating scale. In the present study the distress of the total presenting problem was measured. A self-report rating scale was used to determine the base-line level of distress, whether any change was occurred during the intervention phase. This was an 11-point rating scale, ranged from 0 to 10, in which 0 is described as "no problem", then subsequent score indicated cumulative level of distress, such as, 5 would indicate "moderate level of problem", while10 would indicate "highest level of problem".

IV. Goal Assessment Sheet:

A goal assessment sheet was used as an indicator of success to what extent the treatment goal was achieved. It was used for pre and post treatment monitoring on five-point scale where 1 indicates 'the goal not achieved at all' and 5 indicates 'completely achieved'(Appendix-5).

2.3 Procedure:

The subject matter of this study was very sensitive and in this case the researcher should consciously try to remember this in every steps of the study. Korchin and Cowan (1982) identified some central principles for all psychological research to be ethically sound. These are taking informed consent, ensuring confidentiality and minimizing potential harm. The researcher of the current study followed these principles. Researcher took

informed consent from every participant before initiating the study, by disclosing what would happen during the study and other information that might influence his or her decision to participate. The participants were also told that they had the freedom to leave the study anytime they want. Protecting the confidentiality was a big issue there. So the researcher did not disclose any information to third party without informed consent of the clients. On the other hand, to minimize potential harm and considering ethical matter the researcher organized appointments to the all 20 clients who came first to seek help for psychological services at the Students Guidance and Counselling Centre of Dhaka University. Among 20 students even number 10 students were selected for the present research. And the other 10 odd number students who were excluded from the research were given appointment by the other trainee clinical psychologists. So, in the present study all the students were ensured psychological services whether or not they were included or excluded in the study.

At first in part I the selected students were demonstrated verbally and then they were given a written instruction (Appendix-1). Then they administered GHQ-12 (Appendix-3) and filled up an information sheet (Appendix-2). Some research assistants were appointed to do this. Research assistants were instructed verbally by the researcher how to administer the questionnaires and how to fill up the information sheet and also how to talk with the students.

In part - II, 20 students were listed who came first within first 2 weeks of January 2003 at the Students Guidance and Counselling Centre of Dhaka University for psychological help. A lottery was conducted between odd number and even number to figure out the

cases which will be selected for the research. Then even number was selected from the lottery and 10 even numbered students from the list of 20 students were finally selected randomly for this particular research. As a result, even number subjects were given appointment by the researcher where the total number of cases was10. They filled up a semi structured interview schedule before starting the sessions (Appendix-4). Among them 3 cases were dropped out. Finally 7 cases were included in this study to see the outcome of psychological intervention on them. To find out the efficacy of psychological intervention, mainly cognitive behavior therapy was given among 7 students who came and sought mental health support to the Students Guidance and Counselling Centre of Dhaka University. Behavior therapy, person centered counseling and ventilation were also used according to the needs of the clients. They were given minimum 5 to maximum12 sessions, once in a week (exception due to strike, Hartal or vacation). A brief note was taken during each session and detail note of that session was written immediately after each session on the basis of notes, memory and observation. The cases were supervised by a Clinical Psychologist, who is an Assistant Professor of Clinical Psychology, Department of Psychotherapy, Clinical Psychology and Psychiatric Social Work, National Institute of Mental Health (NIMH) and he has a long experience of supervision of clients in the Department of Clinical psychology of Dhaka University. The therapist of the present study (researcher) got the supervision on weekly basis over two hours. During supervision the cases were discussed on the basis of importance and needs of the clients' problem. In every 5th session depression scale, anxiety scale, GHQ-12, self rating scale were given to the clients. Those were administered by them at the $1^{st,}$ 5^{th} and end of the sessions. In the 1st or 2nd session a goal assessment sheet was completed by

the clients. They set some goals for intervention. At the end of the sessions those goals were assessed by them to what extend those were achieved. The therapist wrote the transcripts of all the sessions carefully. After terminating the cases, case reports of them were written by the therapist.

RESULTS

Chapter 3

RESULTS

The data of part-I of the present study was analyzed by using computer software 'SPSS for Windows. The frequency and percentage of clinical level of psychiatric distress (cases) among the students of Dhaka University was found by using cut off point 3 and 9 of GHQ-12 score. Cut off point 3 was used based on different published studies (Banu & Akhter, 1996; Banu & Chowdhury, 1999; Huq , Sorkar & Uddin, 2000; Jahan & Akter, 2000; Zaman & Rahman, 2003) conducted in Bangladesh. Cut off point 9 was also used from the average score of GHQ-12, of the 20 students who came first within first 2 weeks of January 2003 and sought psychological services at the Counseling and Guidance Centre of Dhaka University. $\chi 2$- test of GHQ-12 score was done with other variables such as gender, origin, faculty, educational stage, living status, marital status, religion, income of family, income of the student, and family size. The correlation coefficients within GHQ-12 score and variables like age, level of education, birth order, number of siblings, number of family members, family income, and student's own income were analyzed.

In part - II of the study, to see the outcome of psychological interventions data were analyzed through qualitative and quantitative way. In this part, qualitative data were mainly collected through in-depth interview. It was aimed at assess pre-intervention and post- intervention mental health condition of the students. In-depth interview helped to formulate the cases and find out the causes of mental health problems. Case study method

was followed here. The transcripts of the cases were taken then the cases were presented in a descriptive way. The information was assembled according to the sequence to prepare the transcripts. All the sessions those were offered to each case was written down in detail in transcripts. Finally, case studies were written for all 7 cases. GHQ-12, Anxiety Scale, Depression Scale, goal assessment sheet and rating scale were also administered on the clients for measuring distress level of their problem to supplement the data collected through in-depth interview and to monitor whether any changes were happening due to psychological interventions, which were quantitative. So, in part II, 7 cases were analyzed by both qualitative and quantitative way to see the outcome of psychological treatment and causes of their problems.

The findings of the study have been presented in two Parts:

Part I

Mental Health Problems among the Students of Dhaka University:

3.0 In this part the frequency and percentage of mental health problems among the students of Dhaka University have been presented.

3.1 $\chi 2$ test between GHQ-12 score and different variables among the students of Dhaka University have been presented.

3.2 Correlation-coefficient between GHQ-12 score and other variables among the students of Dhaka University have been presented.

Part II

3.3 Presentation of the Case Reports: 7 case studies have been presented in this part which is detailed and narrative. Names of the cases used in this part are fictitious, not the real name of the cases. The fictitious names were used to keep confidentiality and code of ethics.

3.4 Causes of mental health problems of 7 cases have been also presented.

3.5 Presentation of findings of the 7 case reports: In this part the demographic information of the cases have been presented. Outcomes of the case reports have been presented in quantitative form through assessing pre-intervention and post-intervention mental health condition of the students.

Part I

Mental Health Problems among the Students of Dhaka University

3.0 Frequency and Percentage of Mental Health Problems among the Students of Dhaka University

Table 1. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases) among the students of Dhaka University, where the cut-off point is 3*.

	Cases (Cut-off point=3)	Non-cases	Total Number of Students
N	221	181	402
%	55%	45%	100%

Table 1 shows that 55% students are under clinical level of psychiatric distress and 45 % students are non-cases, where the cut-off point of GHQ-12 was 3.

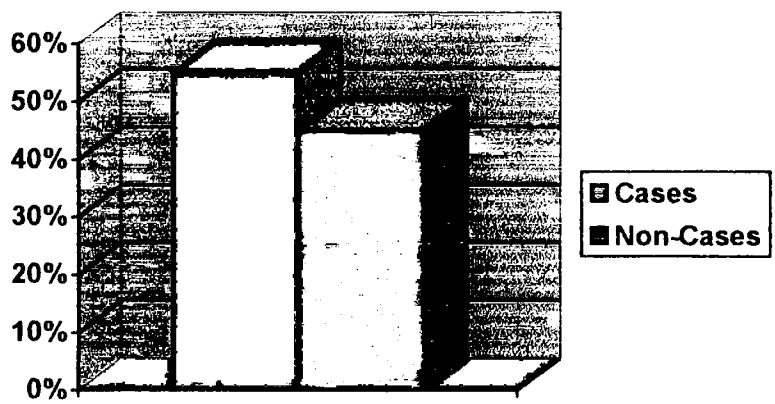


Figure 1. Percentage of case and non-case, where the cut-off point is 3.

*Cut-off point 3 was used based on different published studies (Banu & Akhter,1996; Banu & Chowdhury,1999; Huq, Sarker & Uddin,2000; Jahan & Akhter,2000 and Zaman & Rahman,2003).

Table 2. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases) among the students of Dhaka University, where the cut-off point is 9*.

	Cases (Cut-off point=9)	Non-cases	Total Number of Students
N	38	364	402
%	9.5%	90.5%	100%

Table 2 shows that 9.5% students (cases) are under clinical level of psychiatric distress and 90.5% students are non-cases, where the cut-off point of GHQ-12 was 9.

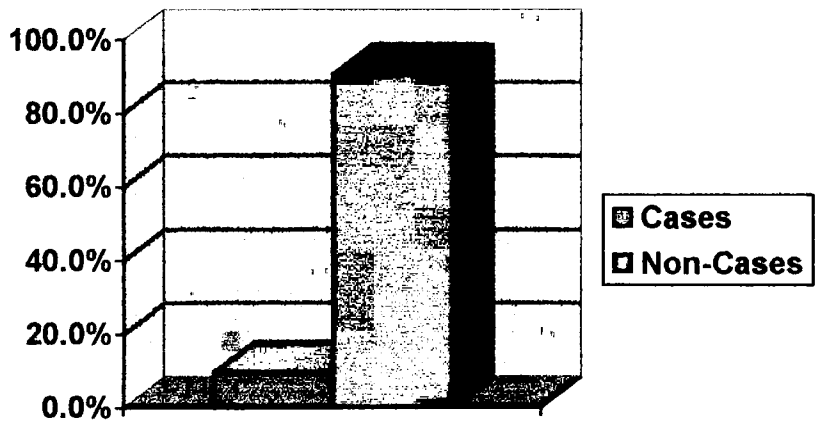


Figure 2. Percentage of case and non-case, where the cut-off point is 9.

*Cut-off point 9 was used from the average score of GHQ-12 of 20 students who came first within first 2 weeks of January 2003 and sought psychological services at the Counseling and Guidance Centre of Dhaka University to know the percentage who has greater probability of psychological distress, as higher score of cut off point indicate the greater possibility of psychological disorder.

Table 3. Mean, Median and Standard Deviation of GHQ-12 score among the Students of Dhaka University.

Type	Value
Mean	3.71
Median	3.00
Standard Deviation	3.20

Table shows that mean median and standard deviation of GHQ-12 within 402 students of Dhaka University is 3.71, 3.00 and 3.20 subsequently; all of them are very close to cut-off point 3.

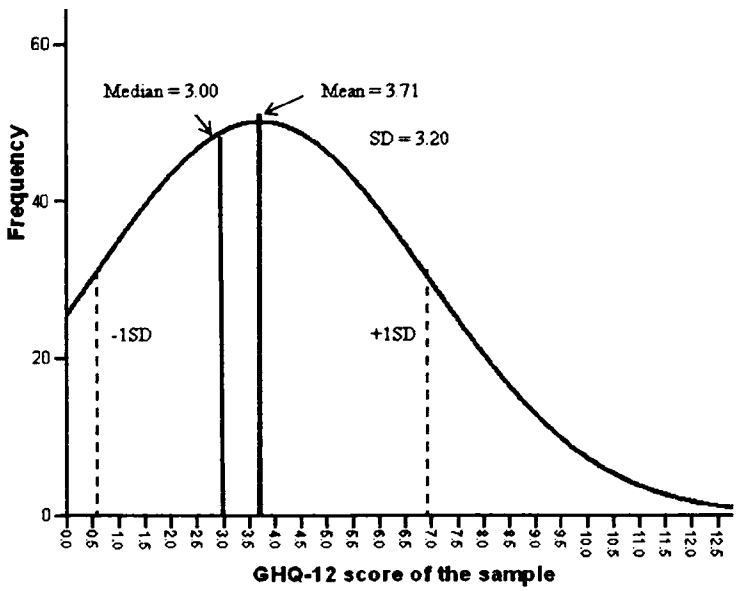


Figure 3. Mean, Median and Standard Deviation of GHQ-12 scores of 402 students.

Table 4. Percentile of GHQ-12 scores among the Students of Dhaka University.

GHQ-12 Score	Frequency	Percent	Cumulative Percent
0	76	18.9	18.9
1	59	14.7	33.6
2	46	11.4	45.0
3	38	9.5	54.5
4	33	8.2	62.7
5	32	8.0	70.6
6	28	7.0	77.6
7	26	6.5	84.1
8	26	6.5	90.5
9	16	4.0	94.5
10	10	2.5	97.0
11	10	2.5	99.5
12	2	0.5	100.0
Total	402	100.0	

Table 4 indicates the frequency, percent and cumulative percent of GHQ-12 scores among the 402 students of Dhaka University.

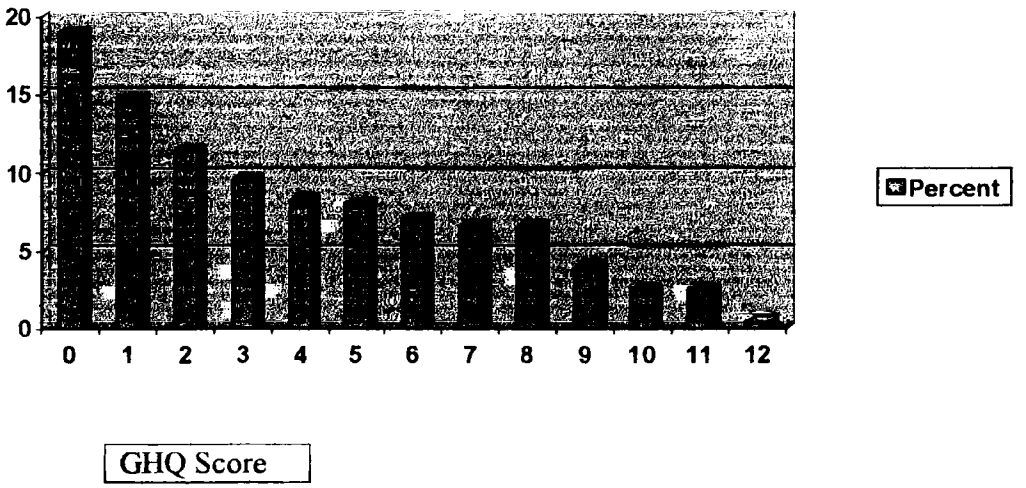


Figure 4. Percentage of GHQ-12 score of all 402 students.

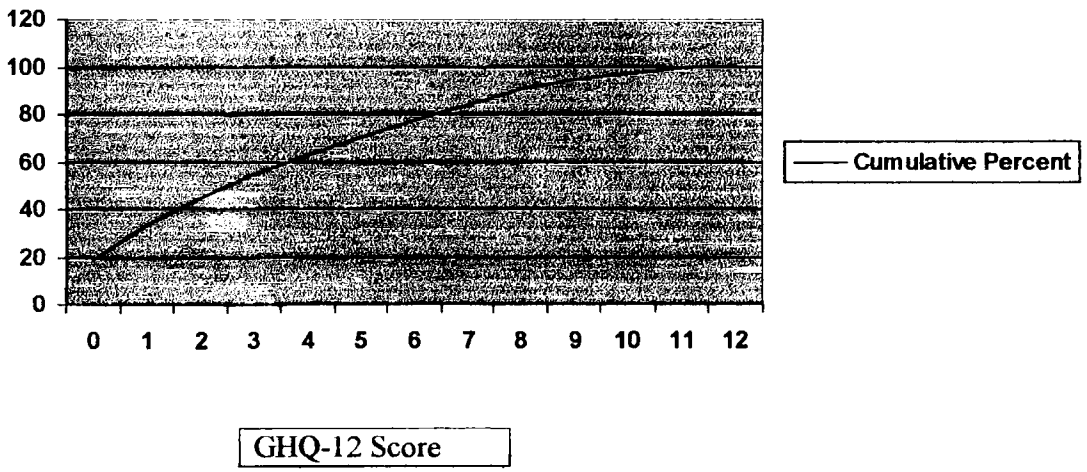


Figure 5. Cumulative Percentage of GHQ-12 score of all 402 students.

3.1 $\chi 2$ test between GHQ-12 score and different variables (gender, marital status, religion, origin, living status, faculty, educational stage, income of family, income of student, number of siblings and family size) among the students of Dhaka University where the cut-off point is 3.

*Cut-off point 3 is used based on different published studies (Banu & Akhter,1996; Banu & Chowdhury,1999; Huq, Sarker & Uddin,2000; Jahan & Akhter,2000 and Zaman & Rahman,2003).

Table 5. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases), in terms of Gender (Male and Female) among the students of Dhaka University.

Gender	Case Cut-off point=3	Non-case	Total
Male	112 (57%)	86 (43%)	198 (100%)
Female	109 (53%)	95 (47%)	204 (100%)
Total	221	181	402

$\chi 2$= 0.399, df =1 (P>.05, i.e. Not Significant)

Table 5 indicates that there is no significance association is found in terms of male and female for being case or non-case.

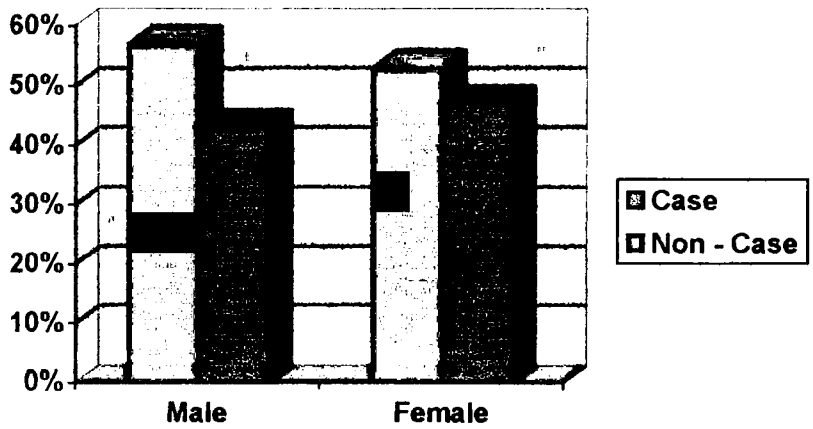


Figure 6. Clinical level of Psychiatric Distress, in terms of gender

Table 6. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases), in terms of Marital Status (Unmarried and Married) among the students of Dhaka University.

Marital Status	Case Cut-off point=3	Non-case	Total
Unmarried	208 56.5%	160 43.5%	368 (100%)
Married	13 (38.2%)	21 (61.8%)	34 (100%)
Total	221 (55%)	181 (45%)	402 (100%)

$\chi 2 = 4.21$, df =1 (P>0.05, i.e. Significant)

Table 6 shows that there is a significance association found in terms of unmarried and married for being case or non-case.

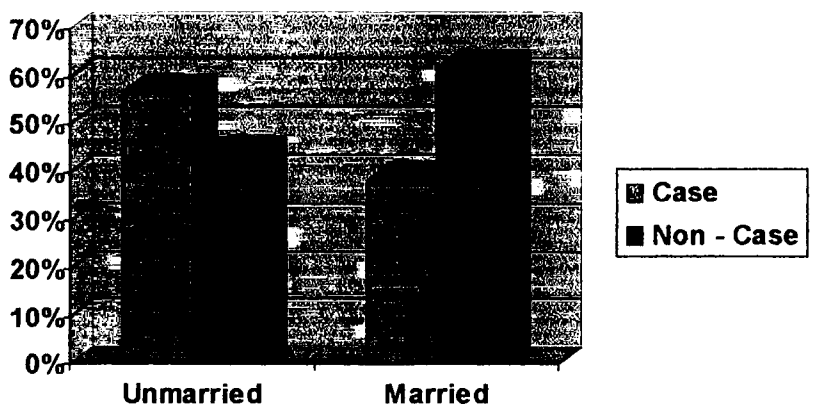


Figure 7. Percentage of clinical level of psychiatric distress of case and non-cases in terms of Marital Status (Unmarried and Married).

Table 7. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases), in terms of Religion (Muslim and Non-Muslim) among the students of Dhaka University.

Religion	**Case Cut-off point=3**	**Non-case**	**Total**
Muslim	193 (53%)	169 (47%)	362 (100%)
Non-Muslim	28 (70%)	12 (30%)	40 (100%)
Total	221	181	402

$\chi 2 = 4.051$, df =1 ($p>0.05$, i.e. Significant)

Table 7 indicates that there is a significant association is found in GHQ-12 score in terms of different religion for being case or non-case.

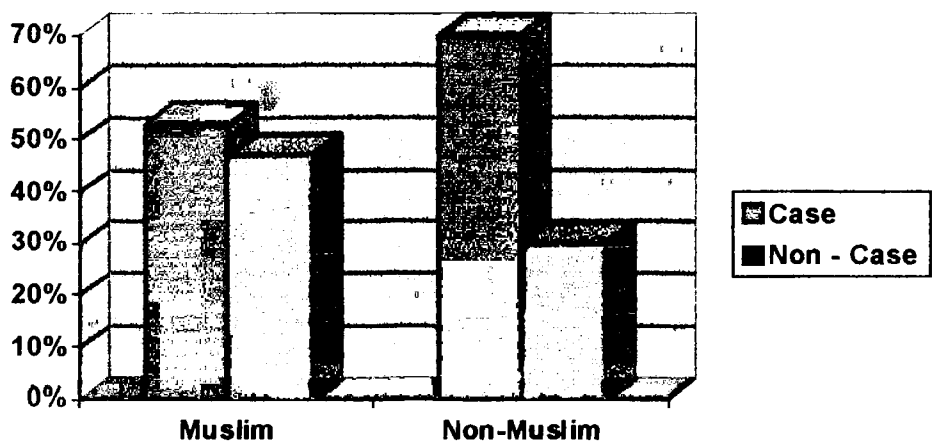


Figure 8. Percentage of clinical level of psychiatric distress of case and non-cases in terms of Religion (Muslim and Non-Muslim).

Table 8. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases), in terms of Origin (Urban and Rural) among the students of Dhaka University.

Origin	**Case Cut-off point=3**	**Non-case**	**Total**
Urban	101 (50%)	102 (50%)	203 (100%)
Rural	120 (60%)	79 (40%)	199 (100%)
Total	221	181	402

$\chi 2 = 4.517$, df =1 ($p<0.05$, i.e. Significant)

The above table shows that there is a significant association found in terms of urban and rural origin for being case and non-case. Where 60% of the rural students are case, and only 40% are non-cases, but among urban students, there are 50% chances of being cases and non-cases.

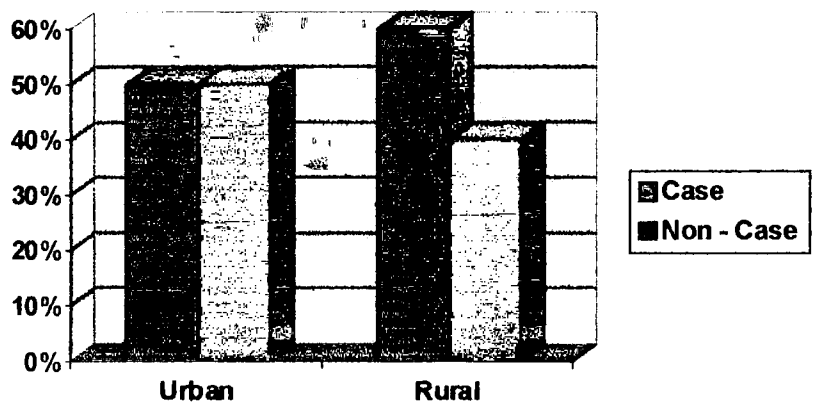


Figure 9. Percentage of clinical level of psychiatric distress of case and non-cases in terms of origin (Urban and Rural).

Table 9. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases), in terms of Living Status (Residential and Non-Residential) among the students of Dhaka University.

Living Status	Case Cut-off point=3	None case	Total
Residential	124 (59%)	87 (41%)	211 (100%)
Non-Residential	97 (51%)	94 (49%)	191 (100%)
Total	221	181	402

$\chi 2 = 2.581$, df =1 (P>0.05, i.e. Not Significant)

Table 9 indicates that there is no significant association is found in terms of residential and non-residential status for being case and non-case.

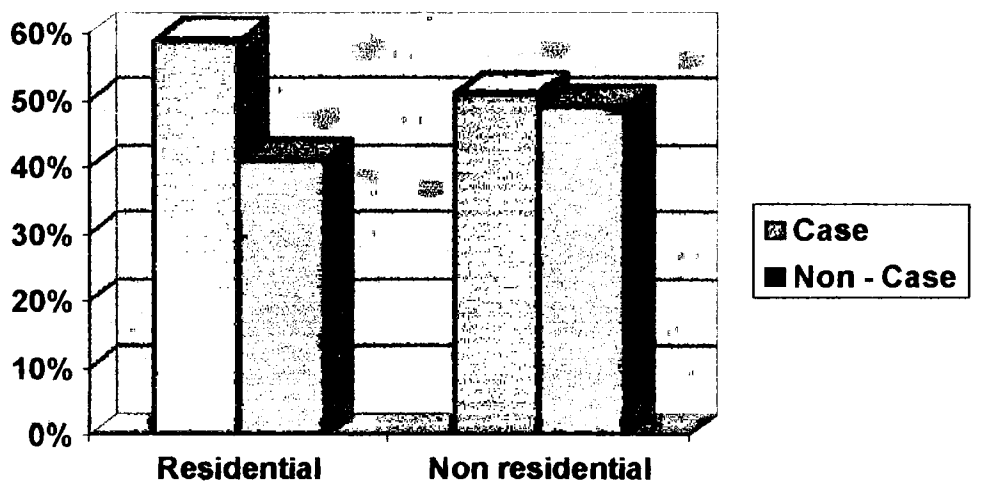


Figure 10. Percentage of clinical level of distress of case and non-cases in terms of living status (Residential and Non-residential).

Table 10. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases), in terms of Faculty (Science, Humanities and Commerce) among the students of Dhaka University.

Faculty	Case Cut-off point=3	None case	Total
Science	88 (57.5%)	65 (42.5%)	153 (100%)
Humanities	113 (54%)	98 (46%)	211 (100%)
Commerce	20 (53%)	18 (47%)	38 (100%)
Total	221	181	402

$\chi 2 = 0.656$, df =1 (P>0.05, i.e. Not Significant)

Table 10 indicates that there is no significant association is found in GHQ-12 score in terms of different faculties for being case and non-case.

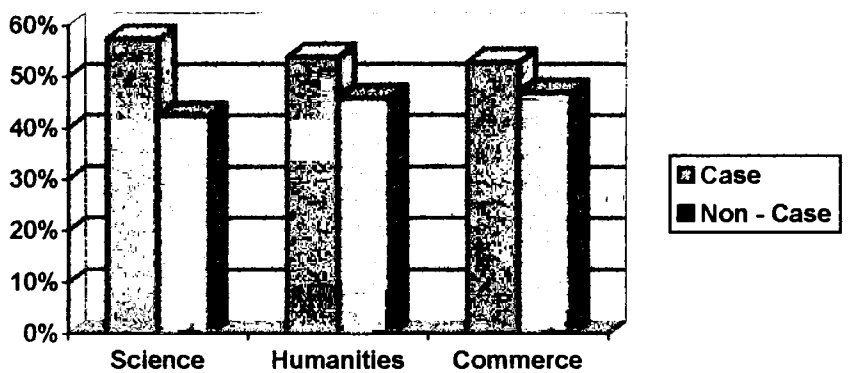


Figure 11. Percentage of clinical level of psychiatric distress of case and non-case students in terms of faculty (Science, Humanities and Commerce).

Table 11. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases), in terms of Educational Stage (1st year honours, 2nd year honours, 3rd year honours, 4th year honours, Masters, M. Phil and Ph. D) among the students of Dhaka University.

Educational Level	Case Cut-off point=3	None case	Total
1st Year	43 (55%)	35 (45%)	78 (100%)
2nd Year	57 (60%)	38 (40%)	95 (100%)
3rd Year	43 (64%)	24 (36%)	67 (100%)
4th Year	42 (57%)	32 (43%)	74 (100%)
Masters, M. Phil. And Ph. D.	36 (41%)	52 (59%)	88 (100%)
Total	221	181	402

$\chi 2 = 10.392$, df =4, ($p<0.05$, i.e. Significant)

Table 11 shows that there was a significant association is found in GHQ-12 score among the students of Dhaka University in terms of different educational level for being case and non-case.

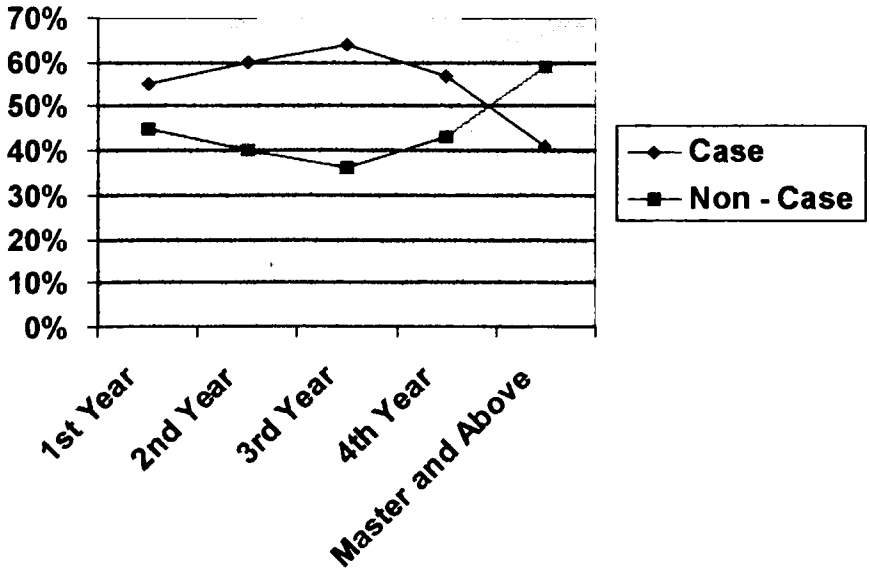


Figure 12. Percentage of clinical level of psychiatric distress of case and non-cases in terms of Educational Stage (1st year, 2nd year, 3 rd year 4th year, Master, M. Phil and Ph. D) shown by line chart.

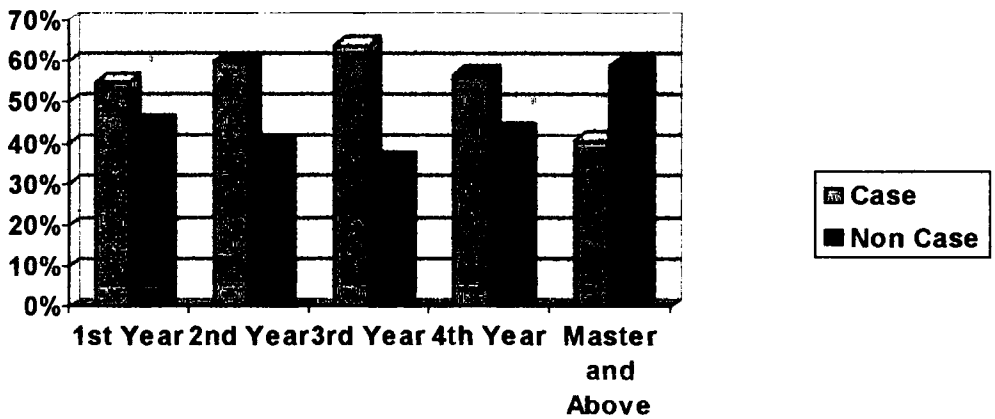


Figure 13. Percentage of clinical level of psychiatric distress of case and non-cases in terms of Educational Stage (1st year, 2nd year, 3 rd year 4th year, Master, M. Phil and Ph. D), shown by bar chart.

Table 12. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases), in terms of Family Income among the students of Dhaka University.

Family Income	**Case Cut-off point=3**	**Non-case**	**Total**
TK.0-TK. 5,000	32 (65%)	17 (35%)	49 (100%)
TK.5,001-TK.10,000	85 (62.5%)	51 (37.5%)	136 (100%)
TK.10,001-TK. 20,000	62 (47%)	71 (53%)	133 (100%)
TK.20,000+	42 (50%)	42 (50%)	84 (100%)
Total	221	181	402

$\chi 2 = 9.81$, df =3 ($p<0.05$, i.e. Significant)

Table 12 shows that there is a significant association is found by GHQ-12 scores in terms of differences in family income for being case and non-case.

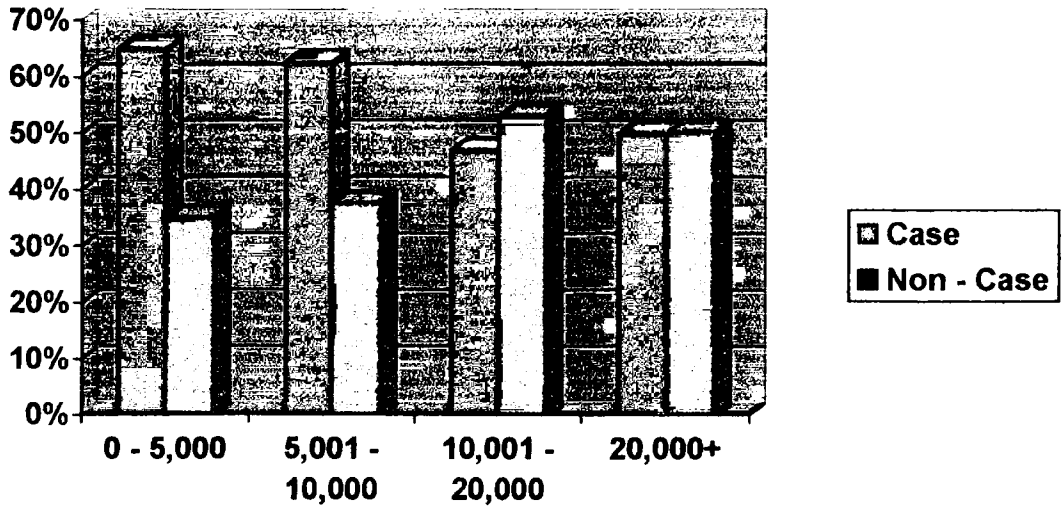


Figure 14. Percentage of clinical level of psychiatric distress of case and non-cases in terms of Family Income (Tk.0-5,000, Tk.5,000-10,000, Tk.10,000-20,000, Tk.20,000 or more).

Table 13. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases), in terms of Personal Income among the Students of Dhaka University.

Personal Income of the Students	**Case Cut-off point=3**	**Non-case**	**Total**
Yes	64 (49%)	67 (51%)	131 (100%)
No	157 (58%)	114 (42%)	271 (100%)
Total	221	181	402

$\chi 2 = 2.94$, df =1 (P>0.05, i.e. Not Significant)

Table 13 shows that there is no significant association is found in GHQ-12 score whether students have own income or not for being case or non-case.

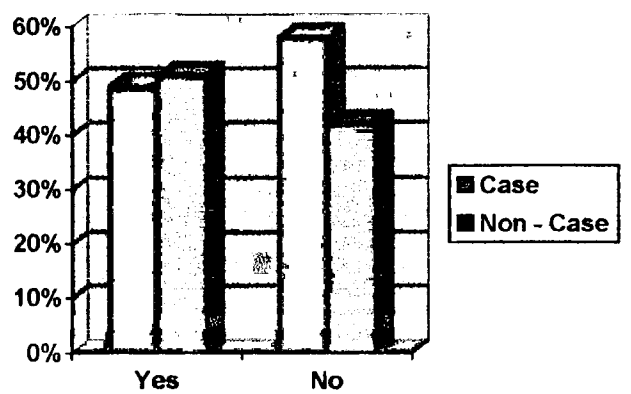


Figure 15. Percentage of clinical level of psychiatric distress of case and non-cases in terms of Personal Income (On the basis of **Yes** or **No**).

Table 14. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases), in terms of Number of Sibling among the students of Dhaka University.

Number of Sibling	Case Cut-off point=3	Non-case	Total
0-2	69 (57%)	53 (43%)	122 (100%)
2+	2 (54%)	128 (46%)	280 (100%)
Total	221	181	402

$\chi 2 = 0.177$, df =1 (P>0.05, i.e. Not Significant)

Table 14 shows that there is no significant association is found in GHQ-12 score in terms of number of siblings among the students of Dhaka University for being case and non-case.

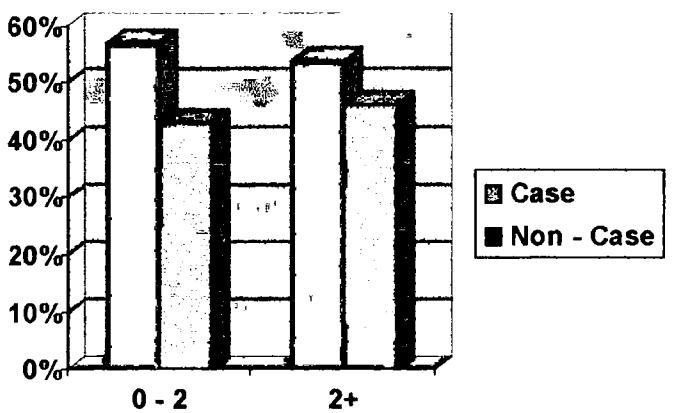


Figure 16. Percentage of clinical level of psychiatric distress of case and non-cases in terms of Number of Siblings (Number 0-2, Number 2 or more).

Table 15. Frequency and Percentage of Clinical Level of Psychiatric Distress (Cases), in terms of Family Size among the students of Dhaka University.

Type of Family	Case Cut-off point=3	Non-case	Total
Small Family (0-5 Member)	117 (54%)	99 (46%)	216 (100%)
Large Family (6-above Member)	104 (56%)	82 (44%)	186 (100%)
Total	221	181	402

$\chi 2 = 0.123$, df =1 (P>0.05, i.e. Not Significant)

Table 15 shows that there is no significant association is found in GHQ-12 score among the students of Dhaka University students whether they have a small family or large family for being case or non-case.

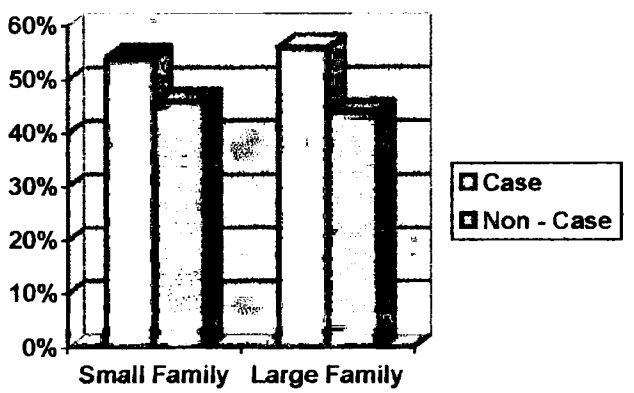


Figure 17. Percentage of clinical level of psychiatric distress of case and non-cases in terms of Family Size (Small family and Large family).

3.2 Correlation-coefficients between GHQ-12 and other variables among the students of Dhaka University is presented below.

Table 16. Correlation-coefficients between GHQ-12 and different variables.

Variables	Rho	Significance
Age	-0.164	0.01
Level of Education	-0.143	0.01
Birth Order	0.027	NS
Number of Sibling	0.015	NS
Number of Family Member	-0.105	NS
Family Income	-0.129	0.05
Student's Own Income	0.013	0.01

NS= Not Significant

The above table reveals that in terms of age, level of education, family income and the student's own income is significantly correlated with GHQ-12 score. On the other hand, no significant relation was found in terms of birth order, number of sibling and number of family member with GHQ-12 score.

PART II

3.3 Presentation of the Case Reports

In this part Seven (7) case studies have been presented which appeared as qualitative research. All the names used in these cases are fictitious.

Case Study-1

Reason for referral

Mr. Rahit, a 23-year old, 3rd year student of Dhaka University, first came at the department of Clinical Psychology as he knew before about the mental health service of the department. He was then referred to the Counseling and Guidance Centre of Dhaka University to get psychological service to manage his relationship and concentration problem.

Presenting problems

Rahit came with the complaints of relationship break up problem with his fiancé and concentration problem during his study. He also complained that his fiancé could not trust him. His problem started 10 months earlier he came to the session, when his relationship started with her. According to the client his problem started due to dissimilar

attitude and values between him and his fiancé. Rahit also thought that due to his fiancé's rigid personality the relationship broke up repeatedly. When he came first he was looking nervous, depressed, and restless. He complained palpitation, hot and cold responses, feeling weak, crying, loneliness, headache and poor study habit.

Relevant background information/ Causes of problems

Mr. Rahit came from a middle class family. He had only one sister and he was the eldest one. Both of his parents were educated and doing services. He had a very close attachment with his family. His academic result was always above average. But his H. S.C. result was unexpectedly bad, so he had to appear at the exam for the second time, at that moment he was feeling lonely. During his adolescence he was introvert in nature, did not have much social contacts and wanted to become saint (Shonnashi). When he was a 2nd year honors student he had a shocking experience when he found that his best friend was a homosexual. Again he became lonely and got involved with cultural activities, where he made many friends. In an occasion of their cultural activities he was introduced to a female student. Gradually their friends started teasing them about their supposed love relationship and after sometime they really became involved in romantic relationship. But after one month of their relationship his fiancé decided to break up the relationship. This break up happened 6 times within 10 months repeatedly. According to the client this happened because of his fiancé. But after every break up the client became disturbed and could not concentrate on his study. Then when he was a 3rd year honors student he started to have poor marks. So he decided to come for psychological help for solving

concentration problem during his study and to take a final decision about their relationship either to break up or to continue it forever. He also brought his fiancé in the therapy session once but she denied coming to the session for the next time.

Formulation

Mr. Rahit, a 23-year old student, came with the complaint of repeated relationship break up problem with his fiancé. Due to this problem he could not concentrate on his study. The predisposing, precipitating and maintaining factors of the case were:

Table 17. The predisposing, precipitating and maintaining factors (case number-1)

Predisposing factor	Precipitating factor	Maintaining factor
*Introvert personality *Poor H.S.C. result *High expectation for academic result *Loneliness during adolescence *Friend's homosexuality	*1st time relationship break up	*Repeated relationship break up * Personality pattern of his fiancé *Negative automatic thoughts ("she does not trust me, ultimately she will leave me, she can also break up relation after marriage, I am a failure person in affair relation") *Pent up emotion of the client

Goal setting for intervention

Mr. Rahit could focus all his problems in the first session. So, few goals of intervention were set at the end of that session. Anxiety and depression scales were administered in the first session and subsequent scores were 35 (below cut off point), and 96 (minimal depression). He rated the quantity of his total problem 8, in the 0-10 point rating scale. His General Health Questionnaire (GHQ)-12 score was 10. In this scale the score range was 0 to 12, where a high score indicated lower mental health.

In consultation with the client, the following goals were set for psychological intervention:

Goal 1) to reduce his anxiety about the unstable relationship and the pressure due to social stigma around the breaking of a relationship

Goal 2) to develop his concentration in study

Goal 3) to change the attitude of both partners to continue their relationship

Psychological interventions and therapeutic process

Rahit was given 5 sessions in 4 months. In the 1st session he was allowed to talk more about his anxiety around his relationship. As he had no one to share his pent up emotion after disclosing his emotion during sessions his level of distress decreased due to psychological support. There was no therapeutic technique named ventilation in cognitive therapy, but the therapist of this study felt that ventilation was essential for him, so she

used it as a technique with cognitive behavior therapy. Through which he started to feel relieved. After empathetic listening his pent up emotion was expressed and he got relief, which helped him to concentrate on his study, to take decision about their relationship and also to cope with the social situations.

In the second session psycho education on love and relationship was given to him which helped him to understand his problem. According to Sternberg, R.J. (1986) love can be conceptualized as consistency of three primary components: passion, intimacy and commitment. This is known as the triangular theory of love, which helped him to understand his affair relation. He felt that he got to understand about their relationship problem, which might help him for further improvement of the relationship. He decided that he would talk more with his fiancé so that their relationship goes towards a healthy direction. He got relief as he could talk about his problem and started to concentrate on his study. He could also able to manage social stigma around breaking of their relationship through cognitive therapy. In the 3rd session his girl friend came to the therapy session where she shared her emotion. As she did not want to continue session due to her personal problem so her attitude to keep the relationship could not be changed, otherwise the sessions could also be dealt as a couple therapies.

His negative automatic thoughts about relationship problem ("she does not trust me"; "ultimately she will leave me"; "she can also break up relation after marriage"; "I am a failure person in affair relation") were also changed through cognitive therapy. Those thoughts were identified by thought diary and challenged cognitively by downward arrow

technique. After that in the 4th session he reported that he was able to concentrate better than before. In the 5th session, which was the last session, he reported that he has been successful in conceptualizing his problem and due to the therapeutic interventions all his confusions and anxieties have been reduced.

As the problems were not much severe and the client was also very much motivated and cooperative, so only 5 sessions were needed to terminate the case. Rahit's level of anxiety and depression was at minimal level, so few sessions were needed to work with him. Mainly cognitive therapy was given to him. As the client was very much motivated to solve his problem and as his lifestyle was healthy, so he could tackle his problem comparatively well after receiving the therapeutic sessions. He used to do meditation previously so he was not given any relaxation training. He reported that he felt good after meditation. There have been six meta-analyses examining the relationship between exercise and anxiety reduction (Calfas & Taylor, 1994; Kugler, Seelback, & Krüskemper, 1994; Landers & Petruzzello, 1994; Long & van Stavel, 1995; McDonald & Hodgdon, 1991; Petruzzello, Landers, Hatfield, Kubitz, & Salazar, 1991). All six of these meta-analyses found that across all studies examined, exercise was significantly related to a reduction in anxiety. As he used to walk regularly, this is also an indicator of his healthy life style and anxiety reduction. He was also involved in various cultural activities. All those things were healthy coping strategy for the management of anxious and depressed mood.

Outcomes

Result of rating scale, GHQ-12 score, Anxiety and Depression scales which were reported and administered by the client.

Table 18. Result of rating scale, GHQ-12 score, Anxiety and Depression scales (case number-1)

Sessions	0-10 Point Rating Scale*	GHQ-12 Score**	Anxiety Score***	Depression Score****
1st	8	10	35 (mild)	96 (minimal)
5th (Last)	5.5	8	28(mild)	89 (minimal)

Level of depression and anxiety decreased from pre-intervention to post-intervention scores. The score of GHQ-12 was also decreased slightly. He also reported that the quantity of his problem decreased.

* 0-10 point rating scale, where 0= no problem at all, 10= highest quantity of problems
** GHQ-12 score, where 3= cut off point which detect clinical level of psychiatric distress (case), in this scale the score range was 0-12, where a high score indicates lower mental health
*** Anxiety score, where 47.5= cut off point, 54 and less= mild, 55-66=moderate, 67-77=severe, 78-135 and above= profound
**** Depression score, where cut off point=94, 30-100=minimal depression, 101-114=mild depression, 115-123=moderate depression, 124- 150 = severe depression

Table 19. Results on the degree of goal achievement (case number-1)

List of goals	Not at all (0)	Slightly (1)	Moderately (2)	Considerably (3)	Completely (4)
1. To reduce anxiety about the unstable relationship and social stigma around breaking-up of a relationship.			2		
2. to develop concentration in study		1			
3. to change both partners' attitude to keep relationship	0				

Table 19 reveals that goal 1 was achieved moderately, goal 2 was achieved slightly and goal 3 was not achieved at all, as it was dependent on both partners, which could be achieved with more sessions.

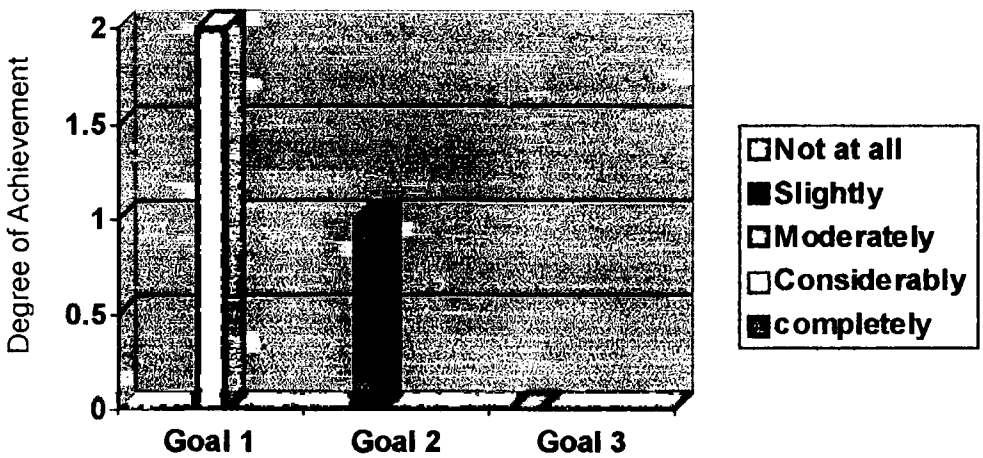


Figure 18. Degree of goal achievement of case number 1.

Therapist's observation

At the beginning of the sessions the client (Mr. Rahit) was looking very restless, anxious, and helpless. He could not contact eye with the therapist. He was taking long breath. But at the end of all sessions he was looking confident, stable. According to the therapist's observation he was very much motivated to solve his problem and applied possible opportunities to reduce his problems. During termination he appeared comparatively relaxed.

Prognosis

During termination he was hopeful that he would be able to deal with the repeated break up problem through conversation between him and his fiancé. It can be assumed that in future he would be able to manage his problems through the process of NATs challenge. It can be predicted that over time his residual problems will decrease gradually. As he used to walk regularly and do meditation, so these are also good indicators of his healthy life style and anxiety reduction. He was also involved in various cultural activities. All those things were healthy coping strategies for the management of his anxious and depressed mood. So, it was assumed that he would be able to manage himself well after termination.

Case Study-2

Reason for referral

Ms. Kanij, a 19-year old 1st year student of Dhaka University, came at the Counseling and Guidance Centre for psychological help. She was self-referred to manage her conflict regarding her career choice.

Presenting problems

The client came with the complaints of indecisiveness in choosing subject. She was also in conflict about her career choice. She had been depressed for long after having admitted in a subject at Dhaka University. Then she again appeared at the admission test there and got few subjects. She had also an opportunity to study in a private university on her preferable subject. Her dream was to create some thing exceptional. She thought that if she studied in a private university she would miss the Dhaka University campus and may not fulfill her dream at last. On the other hand, she was confused thinking that her dream of life may not be fulfilled wherever she studied. So, she could not decide on her career choice. Due to her conflict and indecisiveness she was severely depressed. She was restless and became irritated frequently and she cried at the beginning of the sessions.

Relevant background information/ Causes of problems

The client came from an upper middle class family. They were two siblings and she was the eldest one. Her father was an engineer and mother was a housewife. She was very close to her mother and loved her very much. According to the client as a mother she was wonderful. But she did not like her father at all as he was never respectful towards the women. According to her opinion her father had been suffering from mental problem, as she could not accept his values. Her academic result was always good and she was never worried about performance. As she was very calm and quiet in her childhood so her friends called her stupid and she used to draw pictures and read storybooks. She loved to travel very much. After being conscious about life she started dreaming to be some one powerful than man. She also wanted to be powerful than her husband. She wanted to make some thing worthy which would be appreciated by all. She loved to lead a relaxed and free life and do some creative work. So she was no more interested to study a subject which the other people would say feminine subject. For this reason she wanted to be an architect, which is a male work in Bangladeshi culture. As a protest to her father and society, she wanted to do masculine work. But she could not get chance at BUET (Bangladesh University of Engineering Technology). As a result she got admission at Dhaka University. She started loving the campus but was very much bored with her chosen subject. Then she became confused slowly about her career. On the next year she again appeared at the admission test at Dhaka University to study some different subject of her choice and at the same time she tried to get admission in a private university to study architecture. After her admission test, she did not get chance on her desired subject and confusion about her career choice increased severely. She also had a big gap

between her fantasy and reality. She also thought that her ideal life partner of her dream has not yet born in this world. Recently she was feeling that every thing should not be shared with her mother, so she was expecting someone whom she could share every thing.

Formulation

Ms. Kanij, a 19-year old, 1st year student came with the complaint of indecisiveness. The formulation of the problem can be done according to the cognitive model of depression.

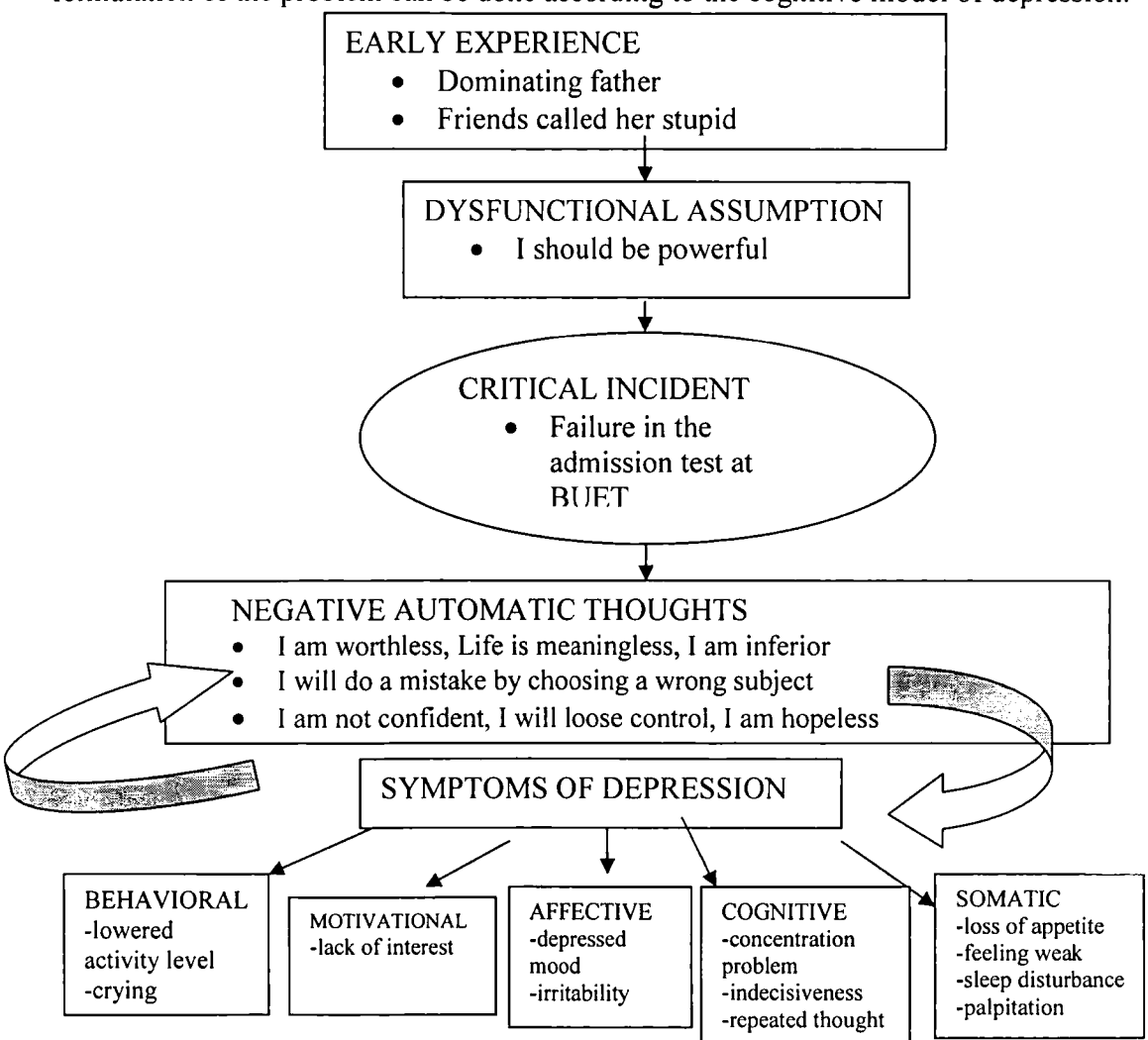


Figure 19. Presentation of Kanij's (case number-2) psychological problem after the cognitive model of depression by Beck (1967, 1976).

Goal setting for intervention

Few goals of intervention were set in the 2nd session. Anxiety and depression scales were administered in the first session and anxiety score was 44(below cut off point), and depression score was 123 (severe level). She rated the degree of her total problem 8, in the 0-10 point rating scale, where 0 indicates no problem at all and 10 indicates highest problem. Her General Health Questionnaire (GHQ)-12 score was 12. In this scale the score range was 0 to 12, where a high score indicated lower mental health. The following goals were set with her for psychological intervention:

Goal 1) to resolve conflict regarding her career choice

Goal 2) to select a "good subject" (different subject which is honorable to others) in the university

Goal 3) to involve in a creative work and plan to do something worthy in future

Psychological interventions and therapeutic process

This client was given 7 sessions. Cognitive behavior therapy was mainly used to handle the client. To give relief from her pent up emotion the therapist let her talk more at the beginning of the sessions. Ventilation of the client was done by supportive work and empathy. After that in the second session, formulation of her problem was shared with her by using cognitive model of depression by Beck (1967, 1976). Psychological

education on depression and relationship problem were also given to her. So formulation and psychological education helped her to understand how thought, feeling and behavior were affecting her life. After that she was understood why she was getting irritated with her father and friends. In the second session few goals of intervention were also set collaboratively.

Then her conflict regarding her career choice was dealt by pros and cons. She had some negative automatic thoughts (NATs), (i.e., "I am worthless", "Life is meaningless", "I am inferior", "I will do a mistake by choosing a wrong subject", "I am not confident", "I will loose control", "I am hopeless") which were identified and challenged by downward arrow technique in the 4th, 5th, 6th and 7th session. Downward arrow technique was mainly used to clarify her deeper meaning of each thought. As a result she was able to realize and accept the reality and also was able to think alternatively. She could differentiate between fantasy and reality. In the 6th session her wants and needs for choosing a life partner were discussed.

Outcomes

Results of rating scale, GHQ-12 score, Anxiety and Depression Scores which were reported by the client over different sessions.

Table 20. Results of rating scale, GHQ-12 score, Anxiety and Depression Scales (case number-2).

Sessions	0-10 Point Rating Scale*	GHQ-12 Score**	Anxiety Score***	Depression Score****
1st	08	12	44 (mild)	123(severe)
5th	4	01	10 (mild)	73(minimal)
7th (Last)	01	01	12 (mild)	64(minimal)

The table shows that the degree of problems, GHQ-12 score, anxiety score and depression score of the client decreased from 1st session to the last session.

* 0-10 point rating scale, where 0= no problem at all, 10= highest quantity of problems
** GHQ-12 score, where 3= cut off point which detect clinical level of psychiatric distress (case), in this scale the score range was 0-12, where a high score indicates lower mental health
*** Anxiety score, where 47.5= cut off point, 54 and less= mild, 55-66=moderate, 67-77=severe, 78-135 and above= profound
**** Depression score, where cut off point=94, 30-100=minimal depression, 101-114=mild depression, 115-123=moderate depression, 124- 150 = severe depression

Table 21. Results on the degree of goal achievement (case number-2)

List of Goals	Not at all (0)	Slightly (1)	Moderately (2)	Considerably (3)	Completely (4)
1) to resolve conflict regarding her career choice				3	
2) to select a "good subject" in the university			2		
3) to be involved in a creative work and plan to do something worthy in future				3	

Table 21 shows that goal 1 and 3 was achieved considerably and goal 2 was achieved moderately after intervention which was reported by the client.

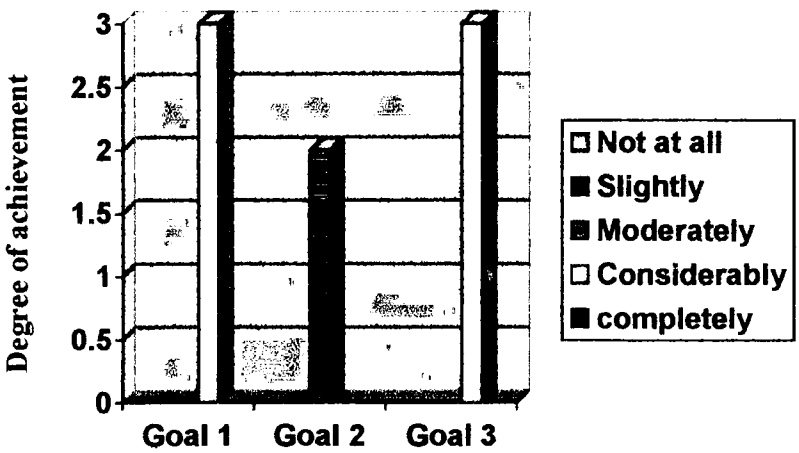


Figure 20. Degree of goal achievement of case number 2.

Therapist's observation

She was looking very depressed and upset and was crying excessively during the first two sessions. During termination she was in a very much smiling face and looked relaxed. A remarkable change in her appearance was noticed and she looked fresh and happy. This can be attributed to the benefits of having psychological interventions in which the client could resolve her conflicts related to career and subject choice.

Prognosis

Mainly Cognitive Behavior Therapy was used as psychological intervention. The client was quite normal during termination. She had been also under medication for severe depression. So it was not possible to see the outcome of psychological treatment separately due to her medication use. But from different studies it was found that cognitive therapy with medication works best for the treatment of depression. After termination of regular sessions, she was asked to contact after two months to have a follow up session, to see how much she can maintain her normal mental health and activities.

Case Study-3

Reason for referral

Ms. Nipa, a-21 year old student of Dhaka University, came at the Counseling and Guidance Centre for psychological help. She was referred by one of her friends for her depressed mood and self-harm behavior.

Presenting problems

Ms. Nipa came with the complaints of concentration problem, indecisiveness, irritability, loss of appetite, loneliness, depressed mood, chest pain, suicidal ideation, fear of loosing her best friend (fiancé), aggressive behavior and self-harm. Due to her those problems her level of activities was lowered. She was in low mood and cried a lot, became irritated and also did self-harm behavior. She thought that nobody was with her, nobody understood her. Her problem started at the end of her 2nd year honors about seven days before of her year final exam and faced room allocation problem in her attached hall. Due to political problem she could not get room and the political students and house tutors verbally harassed her. Her self-harming idea and ideation of suicide came severely after this incidence. She was also missing her sister who left abroad after her marriage. She used to bite her fiancé when she became angry. She complained that she could not like one aspect of her fiancé's behavior, as he frankly mixed with many girl friends and also touched them during chatting. According to her opinion beside this he is a very good boy. She was worried about her fiancé's health, father's health, mother's tension and brother's study related problem. When she came first she was looking very much depressed and

during telling her story she was crying. She was also very much upset about her fiancé as he wanted to break up the relationship.

Relevant background information/ Causes of problems

Ms. Nipa came from a middle class family. She had one sister and one brother. She is the second one. Her father was doing service and mother was a housewife. She loved her family members very much. Her academic result was always average or below than average and she was not bothered about it. In her childhood she was very much spontaneous in nature. Gender discrimination strikes her always. During her childhood her maternal uncle became depressed due to affair relationship problem, which was a very shocking experience to her, whom she loved very much. She lost her grand mother when she was a 1st year honors student. She started her friendship with her fiancé from the beginning of her 2nd year, during that time her boyfriend was refused by his ex-girlfriend and became lonely and slowly by sharing their emotional words they became dependent on each other. In the mean time her sister left abroad due to her marriage then she started to miss her and she was feeling insecure. Ms. Nipa and her fiancé had two different family types. She was having a very friendly family and he was having a very detached family. They have many similarities and also dissimilarities. Still due to their dependency they had decided to get married with the permission of their family. She complained that recently her boyfriend was not giving importance on her choices and she was also doing some aggressive behavior and possessive attitude to him, as a result a distance between them was creating. Both of them were involved in cultural activity of the Dhaka University. She also practiced guitar. She loved to enjoy with her friends in-

group. She was worried about her brother as he could not get chance anywhere to get admission. She was also tensed about her father's physical problem. She felt helpless when she saw her mother expressing tension about their family problem. Nipa was also worried about her fiancé's health and also worried about her close persons.

Ms. Nipa and her elder sister were attached in the same hall and they were residential student. She lived in her sister's room. After her sister's leaving to abroad she wanted to live in the same room. But due to political problem she could not stay at that room. She felt that it was illogical and house tutors were also against her and they were very much rude to her. All those happened about 7 days before of her exam. As a result she became very aggressive. According to the client, those behaviors of them were so rough that she was unable to express in her language. At that moment she was thinking that they were not allowing her to study. So, she wanted to teach them a good lesson and will take revenge. She was very much desperate and aggressive about them and decided to seek legal support against them. She started to harm herself and expressed her aggression to her fiancé. From that time she was feeling helpless and thinking that nobody was with her and even her parents could not understand her. At last she could not get that room and had to manage another one after a long struggle, and even her father had to come to resolve the problem. She started hitting her head and hands on walls, stretched her hand with knife. She phoned her sister for support, but she also blamed her that it happened due to her ego problem. Finally, due to her maintaining behavioral problem a distance between Nipa and her fiancé was creating and they were breaking their relationship repeatedly.

Formulation

Ms. Nipa, a 21-year old student came with the complaints of depressed mood and repeated relationship break up problem with her fiancé. The formulation of the problem is presented according to the cognitive model of depression after Beck (1967, 1976).

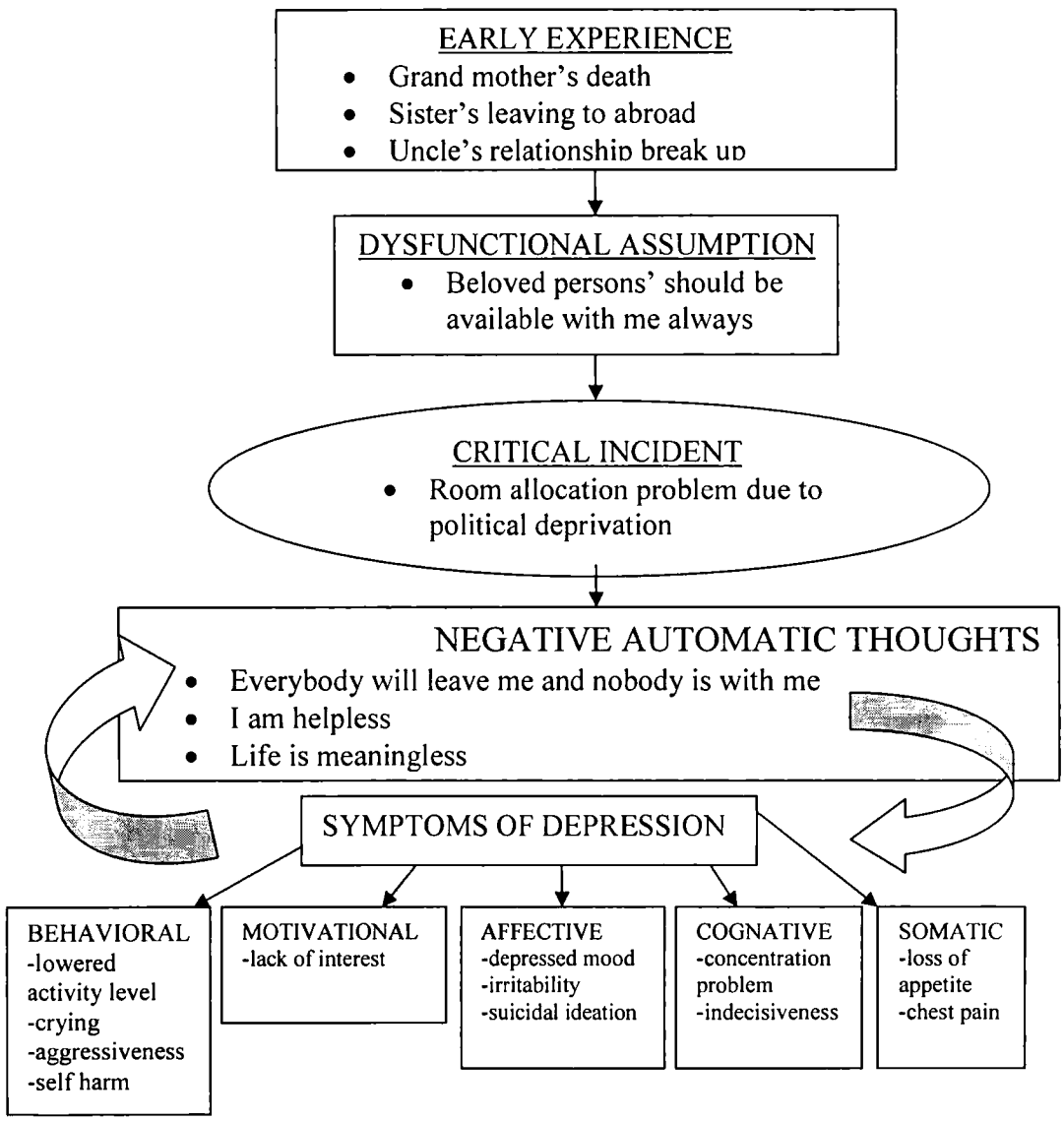


Figure 21. Presentation of Ms. Nipa's (case number-3) psychological problem after the Cognitive model of depression by Beck (1967, 1976).

Goal setting for intervention

Few goals of intervention were set for the client in the 3rd session. Anxiety and depression scales were administered in the first session and subsequent scores were 35(below cut-off point) and 96(minimal depression). She rated the quantity of her total problem 10, in the 0-10 point rating scale, where 0 indicated no problem at all and 10 indicated highest quantity of problem. Her General Health Questionnaire-12 (GHQ-12) score was 8. In this scale the score range was 0 to 12, where a high score indicated lower mental health.

The following goals were set for psychological intervention:

Goal 1) to help settle her brother

Goal 2) to find the ways to make her parents happy

Goal 3) to find the ways to establish herself

Goal 4) to take initiative to build communication with her sister who is living abroad

Goal 5) to reduce misunderstanding with her best friend (fiancé)

Psychological interventions and therapeutic process

At the beginning of the sessions, the client was allowed to tell her problem more and more for her bereavement. Her problem was listening to empathetically. In second session formulation of the problem was shared and psycho education on triangular theory of love (Sternberg, 1986) was given. At the beginning of the sessions, distraction was

given to keep her mood better on that moment. As she had self-harm behavior, a one-month contract was done with the client that she would not harm herself during that period, and then the duration was increased gradually.

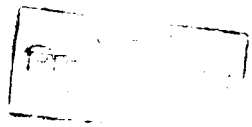
As she was angry with her fiancé, so she was trained anger management technique in the 3rd session, which she applied on the following days. In the same session graded task assignment was given to her to improve her depressed mood. As a result she took initiative to call her sister and write letter. She also took initiative in her other activities gradually. In the 4th session she was trained assertiveness training so that she could express assertively rather than aggressively. During therapy sessions her negative automatic thoughts ("Everybody will leave me and nobody is with me", "I am helpless", "Life is meaningless") were identified and then challenged. Her cognitive restructuring was happened due to psychological intervention which helped her overcome faulty thinking error by bringing them to a level of conscious awareness. As a result at the end of the sessions, misunderstanding with her best friend (fiancé) reduced.

Her assertiveness training and anger management helped her to communicate with others. So, she could support her family in a better way. To settle her brother she discussed about her roles in the therapy session and then took initiative to solve the problem. She was worried about her parents and wanted to make them happy. After talking on this issue during therapy session it was decided that primarily she could give them more time to make them happy. She also could realize that her parents' happiness depends on her

happiness. So, during therapy sessions she found some ways to make herself happy. She relieved herself through ventilation.

In the 5th session, she reported that her problem with fiancé started again. She was depressed on that session. After 5th session, as her exam started she could not continue the session during her exam period. But she practiced the techniques during this period, which she learned from therapy session. In the 5th session, the therapist worked on her needs and wants, and with priority basis the client accepted the situation and took steps, which helped her to find the ways to establish and settle down her. 3 months later after finishing her exam she came to the session and took 2 more sessions and reported that she practiced the techniques, which she learned from the sessions, and she was feeling better then before.

Outcomes



Results of rating scale, GHQ-12 score, Anxiety and Depression scales were administered and reported by the client.

Table 22. Results of rating scale, GHQ-12 score, Anxiety and Depression scale (case number-3).

Sessions	0-10 Point Rating Scale*	GHQ-12 Score**	Anxiety Score***	Depression Score****
1st	10	08	30 (mild)	87 (minimal)
5th	09	08	48 (mild)	96 (minimal)
7th (Last)	05	02	45 (mild)	78 (minimal)

Table 22 indicates that at the beginning of the sessions the quantity of the client's problem was 10 and during termination it decreased 5 in 0-10 point rating scale. At the beginning of the GHQ-12 score was 8 and during termination it decreased to 2, which is a good indicator of improvement. Her anxiety and depression scores in the 1st session were 30(mild anxiety) and 87(minimal depression) subsequently and during termination there was no considerable change in her score.

* 0-10 point rating scale, where 0= no problem at all, 10= highest quantity of problems
** GHQ-12 score, where 3= cut off point which detect clinical level of psychiatric distress (case), in this scale the score range was 0-12, where a high score indicates lower mental health
*** Anxiety score, where 47.5= cut off point, 54 and less= mild, 55-66=moderate, 67-77=severe, 78-135 and above= profound
**** Depression score, where cut off point=94, 30-100=minimal depression, 101-114=mild depression, 115-123=moderate depression, 124- 150 = severe depression

Table 23. Results on the degree of goal achievement (case number-3)

List of goals	Not at all (0)	Slightly (1)	Moderately (2)	Considerably (3)	Completely (4)
1) to help settle her brother				3	
2) to find the ways to make her parents happy				3	
3) to find the ways to establish herself				3	
4) to take initiative to build communication with her sister who is living abroad				3	
5) to reduce misunderstanding with her best friend(fiancé)				3	

The above table indicates that among five goals, all of them were achieved considerably after intervention which was reported by the client.

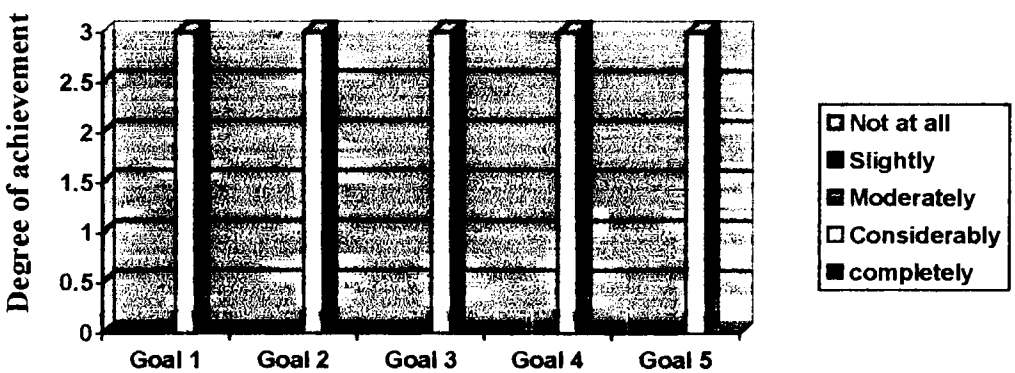


Figure 22. Degree of goal achievement of case number 3.

Therapist's observation

During termination after seven (7) sessions the client was looking slightly depressed but also confident and in smiling face. When she came first she was crying during telling her story. She was in low mood, depressed, helpless, lack of confidence. But after few sessions she could realize her condition, which made her more depressed, but at the end of the sessions she was looking more confident. Though she was depressed but accepted the reality.

Prognosis

The client took only 7 sessions, which was not enough, but due to her classes and various involvements in cultural activities she could not manage time to have more sessions. As a result during termination her anxiety and depression scores were not decreased in a considerable level. Moreover, she was very emotional by nature. In this case if she can continue practice the psychological techniques, it is assumed that her condition will be much better. But if she fails, she may need to come in the therapy session again.

Case Study-4

Reason for referral

Ms. Akhie, a 22-year old 2nd year student of Dhaka University, came at the Counseling and Guidance Centre for psychological help. She was referred by one of her friends as she was in depressed mood for long time.

Presenting descriptions

The client came with the complaints of frustration and excessive anger. According to the client she got her anger "genetically" and also for "excessive self-esteem". Her father and grandfather were very angry persons. And due to her excessive self-esteem she got angry. She became angry when others cheated her. She had been in low mood for long and often cried. She was disturbed, irritated, was having pain in her chest. She was also having memory problem, slowness in work, sleep disturbance and was unable to take initiative. Every day's worry came to her thoughts repeatedly. She thought that she was not pretty, she was inferior and worthless. Akhie was suffering from low blood pressure for long days. She also complained that recently she had been facing problem to mix with her friends. She had been communication problem with them. She complained that her friends did not understand her. And due to communication problem she got angry.

Relevant background information/ Causes of problems

The client came from a middle class family. She had one sister and one brother and she was the 2nd one. Her father was doing a job and mother was a housewife. Her mother was helpful but always interfered in her work, which made her irritate. In her school years she always did good result without one exceptional case, which was after her primary education she changed her school and in her new school she had to face pressure of study and also big social class difference i.e. her peer group was from upper class and she was from middle class which used to affect her and brought poor academic result. She also participated in games and cultural activities in her school. At that time she was suffering from inferiority complex about her out look as she thought that she was refused from a poem competition for her appearance. Due to her inferiority complex and anger she attempted suicide about 6 times in her school life. For long days she was feeling that her close relatives were not helpful and wanted to let their family down as they were not much solvent economically. So she was always trying to do some thing worthy so that she could show them that they were not inferior. In her college life she found that two of her close friends were lesbian, who affected her a lot and she was very much hurt after knowing that. In the mean time she started liking a boy but within few months she found that the boy liked her as a friend only. Then she started thinking that because of her ugly appearance the boy did not like her. After that she was admitted at Dhaka University but she did not get her expected subject. She was trying to cope with her subject. In her 1st year honors she started to like another boy but the boy got affair with one of her close friend. Again she started thinking that due to her ugly look the boy did not like her. Her

only elder sister was very close to her and she used to share her feelings and problems with her. But when her sister left abroad for educational purpose, then she became very much upset. She was also worried about her only younger brother who was mildly mentally retarded. She was anxious about her mother and father's health and she had to do many responsibility of their family as she was the elder child and also both of her parents were physically ill. Her family was in a crisis due to their maternal property. According to the client her physical condition was not good enough. She had been suffering from rheumatic fever and low blood pressure for long and she often felt sick. Recently she was feeling that her friends were not helpful. She had been facing relationship problem with her friends. She also found that she had started loosing her friends due to their marriage or affair.

Formulation

Ms. Akhie, a 22-year-old 2nd year student, came in the therapy session with depressive mood. The predisposing, precipitating and maintaining factors of her problems were as follows:

Table 24. The predisposing, precipitating and maintaining factors (case number-4).

Predisposing Factors	Precipitating Factors	Maintaining Factors
• When she was in class VI in her new school she did bad academic result • When she was in class VIII, she was rejected in a poem competition, because of her ugly look • During her school day she attempted suicide many times • During her college years she found that two of her best friends were lesbian • During her higher secondary school, she liked a boy but she was refused by him • She did not get expected subject at Dhaka University • During her 1st year honors she started liking another boy but found that her best friend got affair with him	• Her sister's leaving to overseas made her more upset. But no significant precipitating factor was found for her depressed mood specifically, rather it developed gradually.	• Pent up emotion and no person to share at home • Negative automatic thoughts ("For love life men must need a pretty face", "I am not pretty", "I am worthless") • Mother's interference in every work • Family crisis on property • Rheumatic fever • Brother's illness • Friends' involvement in affair or becoming married • Relationship problems with friends and relatives • Friends were not helpful

The formulation of the problem is also presented according to the cognitive model of depression, as follows after Beck (1967, 1976).

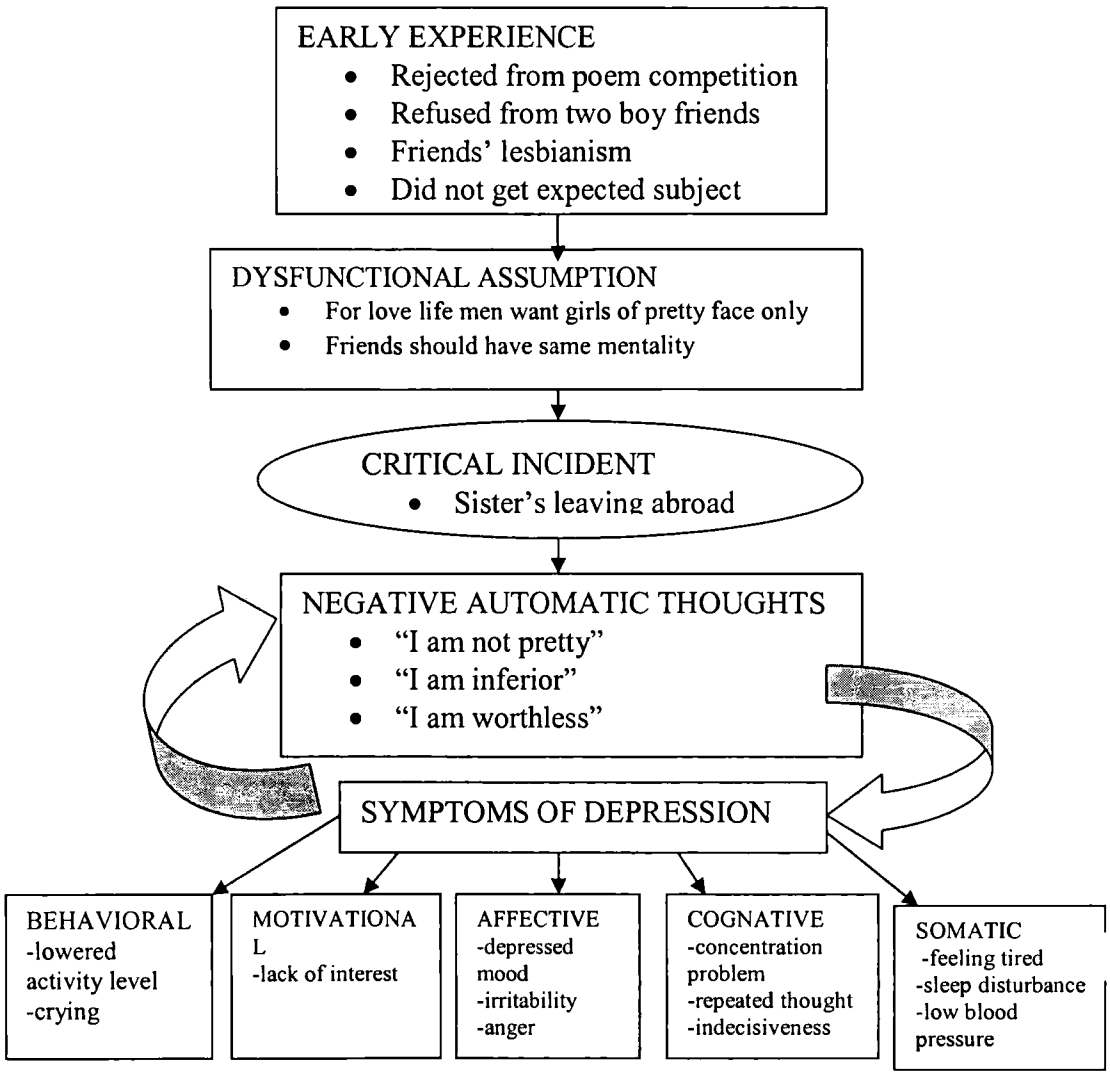


Figure 23. Presentation of Ms. Akhie's (case number-4) psychological problem after the cognitive model of depression by Beck (1967, 1976).

Goal setting for intervention

In the 2nd session few goals of intervention were set with the client. Anxiety and depression scales were administered in the first session and subsequent scores were 62, which was moderate level of anxiety and 107, which was mild level of depression. The client rated the quantity of her total problem 8, in the 0-10 point rating scale, where 0 indicated no problem at all and 10 indicated highest problem. Her General Health Questionnaire-12 (GHQ-12) score was 12. In this scale the score range was 0 to 12, where a high score indicated lower mental health. The following goals were set for her collaboratively, for conducting psychological intervention:

Goal 1) to solve relationship problems with her friends

Goal 2) to manage anger problem

Goal 3) to manage depression

Psychological interventions and therapeutic process

Ms. Akhie was given 10 sessions in total. To handle the client cognitive behavior therapy was mainly used. But at the beginning of the sessions to build up rapport and give relief from her pent up emotion the therapist let her talk more. Ventilation was used as a therapeutic technique by empathetic support from the beginning of the sessions. To give relief her problems were listened empathetically. In the 3rd session formulation of her problem was shared with her. Then psycho education on depression, anxiety and

relationship was given. Psycho education on sleep disturbance was also given as she was suffering from sleep disturbance for long. Some handouts related to her problems (anxiety, depression and sleep disturbance) were given to her, which helped to understand her problem.

She was been depressed and anxious due to some negative automatic thoughts (i.e., "I am not pretty", "I am inferior", "I am worthless"). In the 4th session her Negative Automatic Thoughts (NATs) were challenged by cognitive therapy. Her negative automatic thoughts were identified by giving thought diary and also by downward arrow technique and then those were challenged cognitively on the following sessions. Due to NATs challenge technique she was able to think positive alternative thoughts, as a result her level of anxiety and depression decreased gradually.

Few more behavioral and cognitive techniques were used to resolve the client's problem. What were the mistakes she did everyday, used to come to her mind repeatedly, so worry postponement time was used by her in the 5th session. She followed it over the next sessions whenever worry came to her mind. In the same session imaginary relaxation and breathing retraining was given to her to reduce her anxiety level. As her level of activity was lowered before, to increase it graded task assignment was given to her in the 6th session. In the same session an anger diary was given to her with the training to manage it and express it. To solve relationship problem with her friends, assertiveness training was given to her. Handouts on how to express anger and assertiveness were given to her. After this training she started to express herself assertively rather aggressively. She was

trained and practiced those in the 6th session and the following sessions. As her sister proposed her to go abroad but she was confused. So pros and cons were done to take her decision through downward arrow technique. In that case she was able to see the full consequences of going abroad or not, which helped her to make decision. In the 7th session her wants and needs for choosing a life partner were discussed. Finally, she could realize what her wants were and also realized that those may be fulfilled or may not be fulfilled, but she could compromise with those. On the other hand, she could also find out her basic needs regarding her life partner with whom she could not compromise. This needs and wants technique helped her to resolve her confusion regarding her choosing a life partner. In the 8th session study skills training were given to her by SQ3R method. Over the next 3 sessions the therapeutic techniques, which were discussed in the sessions, were practiced and reviewed.

Outcomes

Result of rating scale, GHQ-12 score, Anxiety and Depression scale were reported and administered by the client.

Table 25. Results of rating scale, GHQ-12 score, Anxiety and Depression scale (case number-4).

Sessions	0-10 Point Rating Scale*	GHQ-12 Score**	Anxiety Score***	Depression Score****
1st	08	12	62(moderate)	107(mild)
5th	08	12	80(profound)	105(mild)
7th	06	09	39(mild)	94(minimal)
10th	2.5	01	25(mild)	63(minimal)
11th (Last)	2.5	01	12(mild)	41(minimal)

Table 25 depicts the client's self-rating regarding her problem at 4 different levels. It shows that her quantity of problem, GHQ-12 score, anxiety and depression score decreased considerably from 1st session to the end of the sessions.

* 0-10 point rating scale, where 0= no problem at all, 10= highest quantity of problems
** GHQ-12 score, where 3= cut off point which detect clinical level of psychiatric distress (case), in this scale the score range was 0-12, where a high score indicates lower mental health
*** Anxiety score, where 47.5= cut off point, 54 and less= mild, 55-66=moderate, 67-77=severe, 78-135 and above= profound
**** Depression score, where cut off point=94, 30-100=minimal depression, 101-114=mild depression, 115-123=moderate depression, 124- 150 = severe depression

Table 26. Results on the degree of goal achievement (case number-4)

No. of goal	Not at all (0)	Slightly (1)	Moderately (2)	Considerably (3)	Completely (4)
1. to solve relationship problems with her friends				3	
2. to manage anger problem			2		
3. to manage depression					4

Table 26 indicates that after intervention goal 1 was achieved considerably, goal 2 was achieved moderately and goal 3 was achieved completely, which was reported by the client.

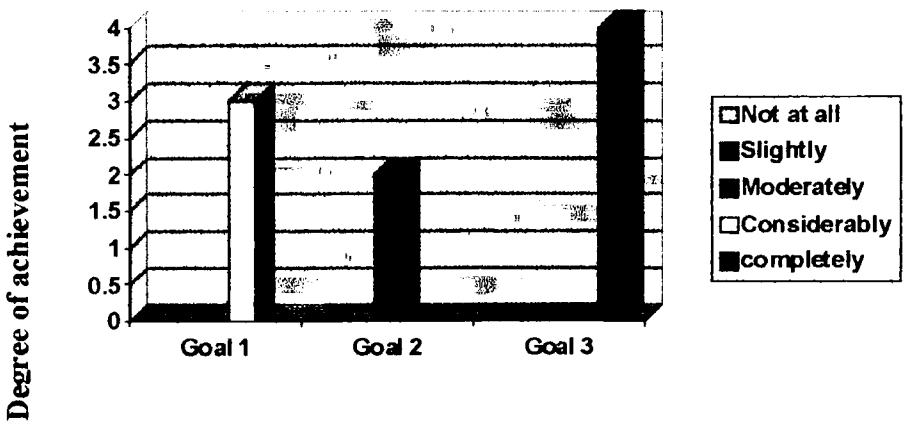


Figure 24. Degree of goal achievement of case number 4.

Therapist's observation

When she came first she was looking very depressed and during conversation she was taking deep breaths. In the first few sessions she was very depressed, and improved her mood gradually. Over the whole sessions she was very much motivated and tried best to improve her. And during termination she was looking content and relaxed.

Prognosis

At the beginning of the sessions the client's anxiety and depression level were moderate and mild respectively, but in the 5th session her level of anxiety was increased which was profound. The reason behind this score might be that there was nobody to share her pent up emotion but after sharing it in the session; the vivid picture came to her mind and her level of anxiety was increased. Then gradually her anxiety and depression were decreased. During termination she reported that she was benefited from the sessions, because she got a different place to listen to her problems where there was no blaming. She also could find out her problems through psychotherapy, where neutrally her problems were dealt. Her motivation and adaptations with psychotherapeutic skills indicate a positive indication of dealing her psychological problem in future.

Case Study-5

Reason for referral

Mr. Rafiq, a 20-year old 1st year residential student of Dhaka University, came at the Counseling and Guidance Centre to manage anxiety and to increase his level of confidence. He was referred by one of his roommate.

Presenting problems

Mr. Rafiq came with the complaints of tension, lack of confidence and indecisiveness. He was also feeling hot on his head, could not be lively for long. He was quiet pessimistic having depressed mood. Confusion and concentration problem started. He was facing problem in socialization. He was suffering from irritable bowel syndrome, gastric and having problem with his vision. He had been having sleep disturbance, restlessness, lack of initiative, and decline in memory. According to the client as his parents were not educated, so they could not understand other things of enjoyment in life and they only forced him for study. According to him, because of his parents' attitude he developed those problems. When he came first he was looking nervous, depressed, and restless. He complained palpitation, hot and cold responses and he was also feeling weak. He had inferiority complex about his appearance that he was short and was loosing his hair. He was always been anxious before his exam. According to his doctor he had no significant physical problem.

Relevant background information/ Causes of problems

Mr. Rafiq came from a middle class family from a rural area (a village) of Bangladesh. They were four siblings and he was the 3rd one. His father was a farmer and mother was a housewife. Both of his parents were not much educated. They were an economically solvent family.

From his childhood Rafiq was quiet, self centered and exposed to very few social activities. He was little bit physically ill from his childhood. He was good in all subjects, especially in Bengali and English during his school period. He could memorize things very well, but had a low capacity to write things by his own. He always achieved good academic result. Though he was facing a variety of problems before his Secondary School Certificate Examination (S.S.C. exam), he did excellent and unexpected result on that exam. When he was 13 years old due to his puberty change, his family thought that he got some sexual problem. So they took him to the traditional healer. After that he was almost healthy for next few years. His problem started again before his Higher Secondary Certificate Examination (H.S.C. exam). At that moment he thought that he had sexual problem, and impotency, as his elder brother faced similar problem during his puberty. When his family arranged his brother's marriage then he became alright. So they thought Rafiq had been also suffering from the same problem and after getting married he would also be normal. But rather getting married he took medication and he was living healthy life for next one and half year. But again at the age of 19 after he admitted at Dhaka University he became tensed about his subject. He got himself tensed, lack of confidence

and indecisiveness. His confusion started regarding selecting his own subject. His roommate came as a key informant, as he was apparently seemed suffering from manic episode, but after interviewing it was rather assumed that he was suffering from chronic anxiety.

Formulation

Mr. Rafiq, a 20-year-old student, came with the complaint of tension and indecisiveness. Due to those problems he could not concentrate on his study.

Table 27. The Predisposing, precipitating and maintaining factors of the case (case number-5).

Predisposing Factors	Precipitating Factors	Maintaining Factors
• Very anxious from his early life • Dependent and introvert • Very few exposure with other people and had very few friends • Parental and own high expectation on his academic result • Excessive stress	• His problem started after getting admitted to an unwanted subject at Dhaka University and getting of negative feedback from his teachers.	• Negative Automatic Thoughts or NATs ("I can not do it. Any good thing would not happen by me. I will do bad result. I will not get a good job. If I drop year or change subject other people will criticize me." etc.)

during puberty • Inferiority about his short height • Exam anxiety • Fever and digestion problem from early life was very common • Jaundice before H.S.C exam and got very stressed		• Dysfunctional assumption ("I must have a good job. I must be established" etc.) • Performance anxiety • Dependent, anxious and introvert personality • Avoidance

The formulation of the problem is also presented according to the cognitive model of anxiety, as follows after Beck (1967, 1976).

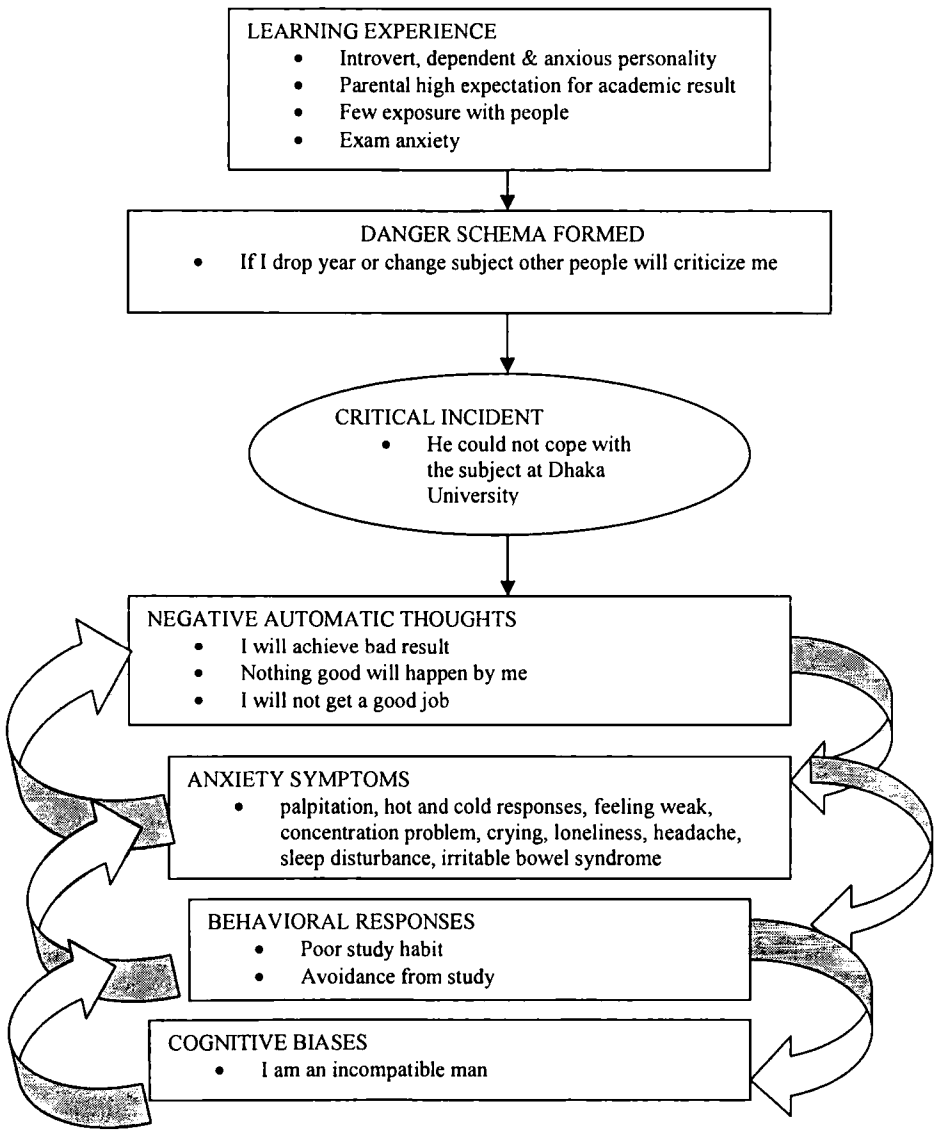


Figure 25. Presentation of Mr. Rafiq's (case number-5) psychological problem after the cognitive model of anxiety by Beck (1967, 1976).

Goal setting for intervention

In the second session few goals for intervention were set with the client. Anxiety and depression scales were administered in the first session and anxiety score was 97, and depression score was 135. He rated the quantity of his total problem10, in the 0-10 point rating scale. His General Health Questionnaire-12 (GHQ-12) score was 11.
The following goals were set for psychological intervention:

Goal 1) to take decision about subject choice

Goal 2) to manage time and improve study habit

Goal 3) to make ability to take decision in any thing

Goal 4) to increase motivation in any work

Psychological interventions and therapeutic process

The client was given 18 sessions in 7 months. During summer vacation of the university he stopped sessions for 1 month and then started again. Mainly cognitive behavior therapy was used to reduce his problem. At the beginning of the sessions the client talked about his problem, which was listened empathetically through which his pent up emotion was released and he felt relieved. To understand his daily activities, an activity schedule was given in the second session. From that schedule he was getting a clear picture about his activities which helped him to increase his activity level. The formulation of the problem was shared with him in the 3 rd session. During the therapy sessions some psychological education were given regarding performance anxiety.

At the beginning of the sessions he followed worry postpone strategy, which is an approach involves postponing worries to a "worry period" that is the same place, time and duration in a day. He was given a fixed time, about half an hour to think about his worry every day, so that he may not occupy on his worry for all day long. He was given minor to major worries gradually. As he had some anxiety symptoms, like concentration problem, sleep disturbance, headache etc., so to reduce his anxiety symptoms he was trained muscular relaxation in the 4th session, but he did not practice it for his restlessness.

He had poor study habit, poor time management during study as well as avoidance tendency from study. So in the 5th and 6th session to manage time and improve study skills, study skill training on SQ3R (Survey, Question, Read, Recite and Review) was given, which he practiced over the following sessions. His progress of study was monitored and feedback was obtained from him. As he could not enjoy things, some recreational activities and physical exercise were given to him in the 7th session. In the mean time the client complained that he used to feel anxious to talk with others. To reduce his anxiety some behavioral experiment and exposure was given to him over the 8th, 9th and 10th session.

He could not cope with his subject and was unable to take decision about his subject choice, so cognitive restructuring was needed for him. Over the next sessions the therapist worked with his cognition. By downward arrow technique his negative automatic thoughts (NATs) ("I will achieve bad result", "Nothing good will happen by

me", "I will not get a good job") were identified and then challenged. As he was confused about his subject choice (whether he should change the subject or not), so pros and cons were done regarding different subject. At last he could decide to choose a subject. At the end of the sessions, he was able to take decision in many things.

Outcomes

Table 28. Result of rating scale, GHQ-12 score, Anxiety and Depression scales (case number-5).

Sessions	0-10 Point Rating Scale*	GHQ-12 Score**	Anxiety Score***	Depression Score****
1st	10	11	97 (profound)	135 (severe)
5th	10	12	107 (profound)	138 (severe)
10th	7	11	100 (profound)	119 (moderate)
15th	5	7	67 (severe)	90 (minimal)
18th (Last)	3	4	39 (mild)	62 (minimal)

Table 28 reveals the client's self rating regarding her problem at 4 different levels. Results show that his quantity of problem, GHQ-12 score, anxiety and depression score decreased considerably from first session to the end of the sessions.

* 0-10 point rating scale, where 0= no problem at all, 10= highest quantity of problems
** GHQ-12 score, where 3= cut off point which detect clinical level of psychiatric distress (case), in this scale the score range was 0-12, where a high score indicates lower mental health
*** Anxiety score, where 47.5= cut off point, 54 and less= mild, 55-66=moderate, 67-77=severe, 78-135 and above= profound
**** Depression score, where cut off point=94, 30-100=minimal depression, 101-114=mild depression, 115-123=moderate depression, 124- 150 = severe depression

Table 29. Results on the degree of goal achievement (case number-5).

No. of goal	Not at all (0)	Slightly (1)	Moderately (2)	Considerably (3)	Completely (4)
1. to take decision about subject choice					4
2. to manage time and improve study habit				3	
3. to make ability to take decision in any thing			2		
4. to increase motivation in any work				3	

Table 29 indicate that after intervention goal 1 was achieved completely, goal 2 and 4 were achieved considerably and goal 3 was achieved moderately, which was reported by the client after intervention.

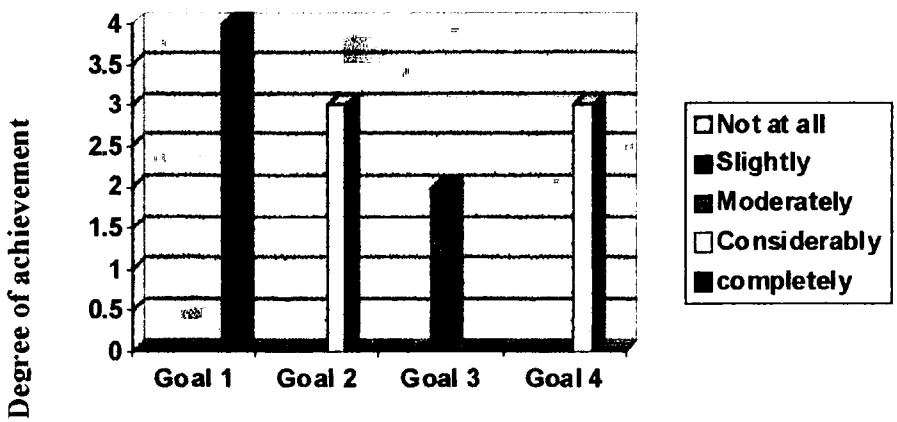


Figure 26. Degree of goal achievement of case number-5.

Therapist's observation

At the beginning of the sessions the client was looking very restless and anxious. He could not contact eye with the therapist. Within 13th session no considerable changes were appeared on his face and activities. After that his condition was improving. During termination he was looking relaxed and content. During the last 3 or 4 sessions he was in smiling face.

Prognosis

He was suffering from anxiety disorder for long and also had severe depression. He was under medication when he started session. But after few sessions he stopped having medication with the consultation of his doctor. On the other hand, it was a good sign of his improvement that without dependency on medication he was leading a healthy and lively life during termination. As he had about 10 years' history of psychiatric problem and it became as his personality pattern, so he might require further psychological help in future.

Case Study-6

Reason for referral

Ms. Nina a 22-year-old 2nd year student of Dhaka University came at the Counseling and Guidance Centre for psychological help. Her friend referred her for her depressed mood.

Presenting problems

Ms. Nina at first complained about her excessive anger, memory problem, crying and indecisiveness. Then she gradually said the other problems. She lost her appetite. She was feeling tired, having poor sleep, headache, palpitation, nausea and also she lost weight significantly. Due to these problems, her cognitive level of functioning was impaired. Nina was blaming herself that as those types of bad events were only happening with her, so she thought that she was unlucky. She was also suffering from concentration problem. Her level of activity was lowered, she lost interest in almost all activities, and she also lost her confidence and patience. She was feeling depressed, irritated, disturbed, suffocated and restless. As she was rejected by her boy friend, her friends laughed at her and teased her. Her problem started significantly one month before she came to the therapy session after being rejected by her boy friend.

Relevant background information/ Causes of problems

The client came from a middle class family. They were two sisters and she was the eldest. She was living with her maternal uncle and aunt from class V due to her study, as her parents lived outside the city. Her father was a businessman and mother was a housewife. From her early life she was very much sensitive and rigid. She was also fun loving. She liked the good-looking boys. She had very few exposures with boys before being admitted at Dhaka University. When she was a 1st year honors student, she started liking a senior boy of her department. After few months, 9 months before she came to the therapy session, she knew that the boy was engaged with another girl. She became a bit upset on that. In the mean time one of her class met (boy) started to mix with her. He was very much caring and helpful to her. According to the client, which seemed that the boy liked her and also loved her, though the boy never committed for their affair relationship, but indirectly behaved as a fiancé. When she was in her second year honors, 1 month before she came to the therapy session, the boy denied about their affair. But in the mean time she fell in love and became weak to him. Due to this incidence she became very dishearten and depressed. When she had been depressed she used to write diary and talk with her friends over phone to release her distress, but she had to stop calling due to her family's restriction and interference.

Formulation

Ms. Nina, a 22-year old 2nd year student came with the complaints of excessive anger, memory problem, crying and indecisiveness. Her symptoms started due to her depressed mood, which came from loosing her boy friend. The formulation of the problem can be according to the following predisposing, precipitating and maintaining factors.

Table 30. The Predisposing, precipitating and maintaining factors (case number-6).

Predisposing factors	**Precipitating factors**	**Maintaining factors**
• Parental extra attention • Anger • Rigid personality • Very few exposure with boys before admitted at the Dhaka University • When she was 1st year honors student she liked a boy, but he was already engaged and she was disappointed • In partner choice over emphasis on external factors	• Boy friend's denial about their affair	• Anger • Feeling insulted • Family's interference • Boy friend's present attitude • Negative Automatic Thoughts ("I am stupid", "I am inferior", "As a human being I am nothing", "Every body plays with me", "I am worthless").

Goal setting for intervention

In the 2nd session few goals of intervention were set with the client. Anxiety and depression scales were administered in the first session where anxiety score was 100, and depression score was 121. She rated the quantity of her total problem 10, in the 0-10 point rating scale, where 0 indicated no problem at all and 10 indicated highest problem. Her General Health Questionnaire-12 (GHQ-12) score was 12. The following goals were set for psychological intervention:

Goal 1) to resolve relationship problem

Goal 1) to control anger and express it in positive way

Goal 2) to increase capacity to take any decision

Psychological interventions and therapeutic process

Ms. Nina was given 14 sessions in total. Ventilation of the client was done by supportive work from the beginning of the sessions and her problem was listened empathetically. In the second sessions few goals of intervention were set collaboratively. Those were regarding her relationship problem, anger and decision making. To deal her problems some psychological therapeutic techniques were chosen to work with her. In the second session, to increase her activity, activity schedule was given to her from where she was getting a feedback and a clear picture of her activity level. Then she was gradually involved from the easy task to the hard one. In the 3rd session formulation of the problem

was shared with her that how thought, feeling and behavior affects on her life. Psycho education was given regarding her problem. Handouts on love, anger management, and assertiveness were given to her. Those handouts and psycho education helped her to understand her problems.

As she was worried about her study and due to her boy friend's rejection she could not concentrate on her study. So from the 3rd session she followed worry postpone method to stop her worry during study and then could concentrate on her studies. The goal of anger management is to reduce both emotional feelings and physiological arousal that anger causes. To manage her anger and to express it in a constructive way anger management technique was discussed with her in the 4th session. Handout on anger management was also provided to her. Then she realized that a person can not get rid of or avoid anger, rather he can learn to control his reactions. Her boy friend was annoying her in different ways but she could not "forbid" him to stop. So, in the 5th and 6th session assertiveness training was given to her how to say "no". She practiced in the session, but failed to perform in the real situation. Handout on assertiveness was also given to her, which she read and rehearsed.

Due to her sleep disturbance, headache, restlessness etc. imaginary relaxation was given to her in the 7th session to make her relax. As she was feeling relax after having relaxation, she started to practice it at her home. To increase her study habit she followed SQ3R (Survey, Question, Read, Recite and Review) method and then could memorize things in a better way. Reinforcement is good for better performance. So, self-reward

technique was used by her. In the 8th session, to increase her study habit she was asked to identify the things which were easily accessible to her and rewarding. Then she set a time limit and selected some topic, she also set a reward for that. After completing that topic she was rewarded by herself. By this way she was rewarding herself.

In the 9th session, her wants and needs for choosing a life partner were discussed, then she could realize about her wrong partner choice. To make her cheerful she was asked to make a hope and see dream regarding her future. Making hope and dream helped her to overcome depressed mood. In the 10th session she was very upset and crying. She said, she was insulted by her boy friend but could not reply, so few role-play was done to practice how to forbid her boy friend to stop him from flattery. As a result her social skills were developed. Due to role-play she could apply it in the practical situation. After that she could face her boy friend, which made her happy.

In the 11th and 12th session, her Negative Automatic Thoughts (NATs) ("I am inferior", "I am stupid", "As a human being I am nothing", "Everybody plays with me", "I am worthless") were identified then challenged. The therapist worked on her NATs over the previous few sessions as well. Working with NATs helped her to overcome depressed mood and assisted to think positively. In the 13th and 14th session the therapeutic techniques were reviewed which were discussed and used in the previous sessions. At the end of the sessions she was able to take decision in many cases. Her level of anger was decreased and was more assertive.

Outcomes

Results of rating scale, GHQ-12 score, Anxiety and Depression scale were reported and administered by the client.

Table 31. Result of rating scale, GHQ-12 score, Anxiety and Depression scales (case number-6).

Sessions	0-10 Point Rating Scale*	GHQ-12 Score**	Anxiety Score***	Depression Score****
1st	10	08	100 (profound)	121 (moderate)
5th	05	05	20 (mild)	69 (minimal)
10th	06	09	73 (severe)	117 (moderate)
14th (Last)	02	02	19 (mild)	32 (minimal)

The above table indicates the client's self rating regarding her problem at 4 different levels. Results show that her quantity of problem, GHQ-12 score, anxiety and depression score decreased considerably from 1st session to the end of the sessions.

* 0-10 point rating scale, where 0= no problem at all, 10= highest quantity of problems
** GHQ-12 score, where 3= cut off point which detect clinical level of psychiatric distress (case), in this scale the score range was 0-12, where a high score indicates lower mental health
*** Anxiety score, where 47.5= cut off point, 54 and less= mild, 55-66=moderate, 67-77=severe, 78-135 and above= profound
**** Depression score, where cut off point=94, 30-100=minimal depression, 101-114=mild depression, 115-123=moderate depression, 124- 150 = severe depression

Table 32. Results on the degree of goal achievement (case number-6).

No. of goal	Not at all (0)	Slightly (1)	Moderately (2)	Considerably (3)	Completely (4)
1. to resolve relationship problem					4
2. to control anger and express it in positive way				3	
3. to increase capacity to take any decision			2		

Table 32 shows that goal 1 was achieved completely, goal 2 was achieved considerably and goal 3 was achieved moderately, which was reported by the client at the end of the sessions.

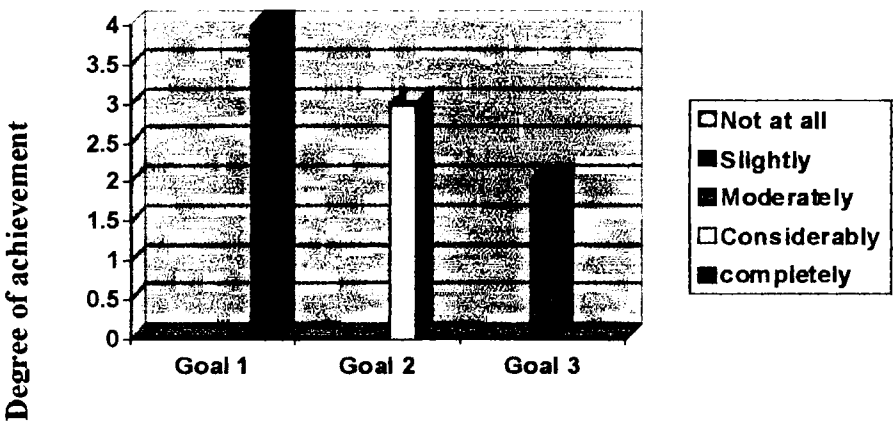


Figure 27. Degree of goal achievement of the case number-6.

Therapist's observation

The client was looking very restless, nervous, helpless, upset and she was appeared tearful at the beginning of the sessions. Over the first few sessions she was very depressed and burst out with crying. After 4 or 5 session comparatively she became calm and quiet. Again in the 10th session she became very upset and was crying due to rejection by her boy friend. After 10th session her condition was developing gradually and within 14th session she was able to resolve her problem. During termination she was in happy mood, which was completely different from her first look.

Prognosis

The therapist saw the client over 4 months. As the client's depressed mood was due to loss of her boy friend it could not be diagnosed as depression, though she had every symptoms of depression. Rather it was one type of bereavement, so after few months of psychological support she was quiet ok. But if the case could not get support in time, there was a possibility to suffer for long and also had possibility to become psychiatric case. As the client could handle her problem during termination, so it is assumed that she would be able to face this kind of difficult situations successfully in future.

Case Study-7

Reason for referral

Ms. Bokul, a 20-year old 2nd year (honors) student of Dhaka University, came at the Counseling and Guidance Centre for psychological help. Her friends referred her for her depressed mood as she was rejected by her boy friend.

Presenting problems

Ms. Bokul came with the complaints of depressed mood and inferiority complex. She had also complained about her lack of interest in study, headache, tiredness, and lack of patience. She complained memory problem, irritability, and slowness in work. She had also repeated thinking about almighty Allah and his punishment. She complained that no body loved her and no perfect person as a partner would come in her life, if come she would loose him in any way. She was also feeling guilty in any kind of activities.

Relevant background information/ Causes of problems

Ms. Bokul came from an upper middle class family. She had only one brother and she was the eldest one. Her father was a businessman who died one and half years back just before her 1st year honors final exam and mother was a housewife. Before her father's death they were a very solvent family. After death of her father their family started to live

with their maternal uncle's house and also was facing financial crisis. Before her father's death she got affair with a phone friend and after few months of her father's death she had to break up the relationship as her boy friend lied and cheated her.

During her school life she had no interest on boys and phone friends. Before getting admitted in Dhaka University she had no exposure with boys as she studied in girls' school and college. She had very little exposure to mix with boys during her coaching for Dhaka University admission test. Her attitude about boys changed, after hearing from one of her best friend, that she had good experience with phone friends (male). Then she developed affair relationship with a boy. But, within few days the boy rejected her. This made her very upset and came to seek psychological help. When Bokul was in school, her friend's younger brother was kidnapped and afterward was murdered. Currently when she makes any mistake, she was being worried that almighty Allah might punish her only brother due to her mistake.

Formulation

Ms. Bakul, a 20-year old 2nd year student, came with the complaint of low mood and inferiority complex. The predisposing, precipitating and maintaining factors of the case are as follows:

Table 33. The predisposing, precipitating and maintaining factors (case number-7).

Predisposing factors	Precipitating factors	Maintaining factors
• Very little exposure with boys • Inferiority complex about her appearance • Friend's brother's murder	• Father's death	• Economic crisis • Cheated by 1st fiancé • Inferiority complex about appearance • 2nd boyfriend's rejection • Extreme fear on God • Negative automatic thoughts ("I am making a great sin", "nobody likes me", "may be I am cheap", "I hate myself", "I am afraid that bad things may happen")

Goal setting for intervention

In the 1st session few goals of intervention were set with the client. Anxiety and depression scales were administered in the first session. Anxiety score was 47 (below cut off point), and depression score was 99(minimal depression). She rated the quantity of her total problem 10, in the 0-10 point rating scale, where 0 indicates no problem at all

and 10 indicates highest problem. Her General Health Questionnaire-12 (GHQ-12) score was 10, out of 12, where a high score indicates lower mental health.

The following goals were set for psychological intervention:

Goal 1) to clear the confusion about the affair relationship

Goal 2) to find identity and importance in her surroundings

Goal 3) to clear up the complex within the client and her uncle's family environment

Goal 4) to reduce tension regarding loosing of her brother

Psychological interventions and therapeutic process

Ms. Bakul was given 12 sessions in total. In the 2nd session few goals of intervention were set collaboratively. Mainly cognitive behavior therapy was chosen to work with her. But, in the first and second session person centered approach was followed to ventilate the client, which was done by empathetic listening of her problems and emphasized more on emotion. In the 3rd session formulation of her problem was shared with her and was explained how the vicious cycle of thought, feeling and behavior affects on her mood. Then psycho education on love and relationship problem was given. Due to this psycho education she could resolve confusion about her affair relationship. Psycho education on love and relationship helped her to understand her problem. According to Sternberg, R.J. (1986) love can be conceptualized as consistency of three primary components: passion, intimacy and commitment, which is known as the triangular theory of love. This helped her to understand her affair relation with her boy friend. She realized that in case of her

love relation there was passion and intimacy, but there was no commitment and then she realized that there was no love.

As she was worried about her brother and other relationship and she was thinking those repeatedly, so she was asked to postpone her worry during her study and also asked to think about her worries in a specific fixed time each day. This worry postpone technique was used during her exam, and from which she got benefited. Then she was comparatively relaxed. After 5th session due to her exam she discontinued her session and joined again after finishing her exam. From the 6th session, after finishing her exam, her NATs ("I am making a great sin", "Nobody likes me", "May be I am cheap", "I hate myself", "I am afraid that bad things may happen") were identified and then challenged. This helped her to find out her identity in her surroundings and think positively. Cognitive therapy also helped her to reduce tension about her brother and to accept the complex family situation of her uncle.

In the 9th and 10th session, her wants and needs were discussed then she could realize what type of life partner she really wanted, as she was very upset about her affair relationship and for choosing a life partner. As she had negative attitude about her self, she was asked to write down her 5 positive aspects on herself each day what she believed and by practicing this, her self esteem was empowered. She practiced it, which helped her to get relief from her depressed mood. In the 11th and 12th session the previous sessions were reviewed and discussed.

Outcomes

Results of rating scale, GHQ-12 score, Anxiety and Depression scales in different sessions were reported and administered by the client.

Table 34. Result of rating scale, GHQ-12 score, Anxiety and Depression scales (case number-7).

Sessions	0-10 Point Rating Scale*	GHQ-12 Score**	Anxiety Score***	Depression Score****
1st	10	10	47 (mild)	99 (minimal)
5th	7.5	07	55 (moderate)	93 (minimal)
10th	03	02	29 (mild)	71 (minimal)
12th (Last)	2.5	02	15 (mild)	65 (minimal)

Table 34 indicates that the client's self rating regarding her problem decreased from 10 to 2.5 from first session to the end of the sessions. Her GHQ-12 score was also decreased from 10 to 2 at the end of the sessions. At the beginning of the session her anxiety and depression mild and minimal respectively and at the end of the sessions the level of anxiety and depression was same. But anxiety and depression score decreased from first session to the end of the sessions, which was from 47 to 15 in case of anxiety and from 99 to 65 in case of depression.

* 0-10 point rating scale, where 0= no problem at all, 10= highest quantity of problems
** GHQ-12 score, where 3= cut off point which detect clinical level of psychiatric distress (case), in this scale the score range was 0-12, where a high score indicates lower mental health
*** Anxiety score, where 47.5= cut off point, 54 and less= mild, 55-66=moderate, 67-77=severe, 78-135 and above= profound
**** Depression score, where cut off point=94, 30-100=minimal depression, 101-114=mild depression, 115-123=moderate depression, 124- 150 = severe depression

Table 35. Results on the degree of goal achievement (case number-7)

No. of goal	Not at all (0)	Slightly (1)	Moderately (2)	Considerably (3)	Completely (4)
1. to clear the confusion about the affair relationship					4
2. to find identity and importance among her surroundings				3	
3. to clear up the complex within the client and her uncle's family environment			2		
4. to reduce tension regarding loosing of her brother				3	

Table 35 shows that after intervention goal 1 achieved completely, goal 2 and 4 were achieved considerably and goal 3 was achieved moderately, which was reported by the client.

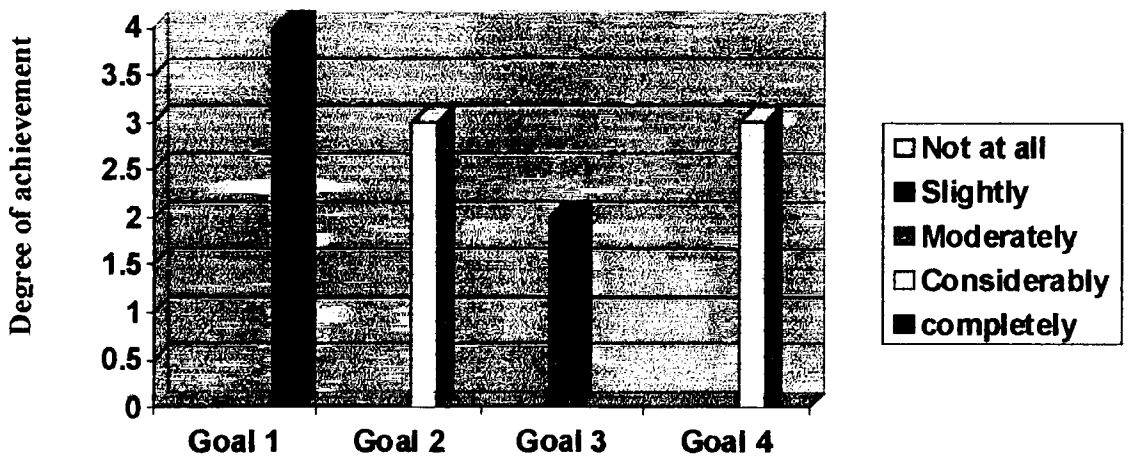


Figure 28. Degree of goal achievement of case number-7.

Therapist's observation

The client was looking very absent minded, confused, depressed and upset at the beginning of the sessions. Within 5th session she was comparatively relax. After few sessions she was looking confident. During termination she was looking relaxed and in smiling face.

Prognosis

From goal achievement table it is found that, within 4 goals 2 of them were achieved considerably, 1 completely, 1 moderately. Her GHQ-12 score was also decreased from 10 to 2. All these indicate good sign of improvement. From the 1st to the end of the sessions her problems decreased gradually. As her anxiety and depression was in mild and minimal level in the first session and her depressed mood was not chronic, rather due to rejection from her fiancé, so only 12 sessions were sufficient to deal her problems. Over the sessions she developed awareness about her problem and accepted the reality. As a result, it is assumed that she would be able to manage her very well in this kind of conditions in future.

3.4 Causes of Mental Health Problems among 7 Cases

Table 36. Causes of Mental Health Problems among 7 Cases

Major Causes	Specific Causes
1. Personality factor	• Introvert personality
	• Anxious personality
	• Dependent personality
	• Rigid personality
2. Academic Problem	• Own and others high expectation for academic result
	• Previous poor result
	• Failure in admission test
	• Room allocation problem at university due to politics
	• Do not getting expected subject at university
	• Can not cope with selected subject
	• Getting negative feedback from the teacher of the university
3. Developmental hazard	• Loneliness during adolescence
	• Friend's homosexuality
	• Friends' teasing
	• Friends' involvement in affair relationship or got married
	• Excessive stress during puberty

4. Communication problem	• Relationship break up • Friends are not cooperative
	• Refused by boy friend
	• One sided liking
	• Boy friend's negative attitude
	• Cheated by fiancé
	• Relationship problem with friends and relatives
5. Negative Automatic Thoughts (NATs)	• "I am a failure person in affair relation" • "I am worthless"
	• "Life is meaningless"
	• "I am inferior"
	• "For love life men must need a pretty face, I am not pretty"
	• "I am not confident"
	• "I am hopeless"
	• "I will loose control"
	• "Any good thing will no happen by me"
	• "If I drop year or change subject other will criticize me"
	• "I am making a great sin"
	• "Nobody likes me"
	• "I am stupid"

	• "As a human being I am nothing"
6. Family problem	• Dominating father
	• Grand mother's death
	• Sister's leaving to abroad
	• Uncle's relationship break up
	• Family's interference in work
	• Family crisis for property
	• Brother's illness
	• Parental high expectation for academic result
	• Parental extra attention
	• Father's death
	• Economic crisis
7. Emotional	• Pent up emotion of the client
	• Suicidal attempt
	• No sharing person at home
	• Inferiority complex about height
	• Exam anxiety
	• Anger
	• Extreme fear
	• Avoidance

	• Performance anxiety
	• Feeling insulted
	• Inferiority complex about appearance
	• Death of friend's brother
8. Social problem	• Rejection from competition for ugly look
	• Few exposure with people
	• Very few friends
	• Few exposure with opposite sex
	• For partner choice emphasizing on external factors
	• Room allocation problem due to political deprivation
9. Physical problem	• Rheumatic fever
	• Fever and digestion problem
	• Jaundice

From the above table it is found that the major causes of mental health problem among the 7 cases were personality factors, developmental hazard, physical problem, family problem, social problem, academic problem, negative automatic thoughts, emotional problem and communication problem.

3.5 Presentation of the Findings of 7 Case Reports

1) Demographic Information:

Table 37. Demographic Information of the Cases.

Case No.	Age	Sex: M/F	Year	Marital Status	Residential /Non Residential	Personal Income: Yes/No	Socio-economic Status	Major Problem
Case 1	23	M	3rd	Single	Non Residential	Yes	Middle Class	Relationship problem with fiancé
Case 2	19	F	1st	Single	Non Residential	No	Upper Middle Class	Conflict about career choice
Case 3	21	F	3rd	Single	Residential	Yes	Middle Class	Relationship problem & depression
Case 4	22	F	2nd	Single	Non Residential	No	Middle Class	Anger, Relationship problem & Depression
Case 5	20	M	1st	Single	Residential	No	Middle Class	Excessive anxiety & Conflict about career choice
Case 6	22	F	2nd	Single	Non Residential	Yes	Middle Class	Depressed mood due to rejection from fiancé
Case 7	20	F	2nd	Single	Non Residential	Yes	Upper Middle Class	Depressed mood

Table 37 shows that among 7 cases the age range was from 19 to 23 and 2 of them are male and 5 are female. All of them are single and from 1st year to 3rd year students. 2 of them are residential student and other 6 are non-residential students. The above table also indicates that 4 of them had personal income and 3 of them had no income. 2 of them are from upper middle class family and 5 are from middle class family. The major problems of the cases were relationship problem, conflict about career choice, anger, anxiety and depression.

ii. Outcome of Psychological Intervention

Table 38. Results of GHQ-12 among 7 cases.

(GHQ-12 score, where 3= cut off point which detect clinical level of psychiatric distress (case), in this scale the score range was 0-12, where a high score indicates lower mental health)

Case No.	Pre-intervention Score	Post-intervention Score
Case 1	10	08
Case 2	12	01
Case 3	08	02
Case 4	12	01
Case 5	11	04
Case 6	08	02
Case 7	10	02

Table 38 indicates that the GHQ-12 scores decreased from pre-intervention to post-intervention in all cases. It is also found that in 5 cases the post intervention score was below the cut-off point 3 and only in 2 cases it was over the cut-off point.

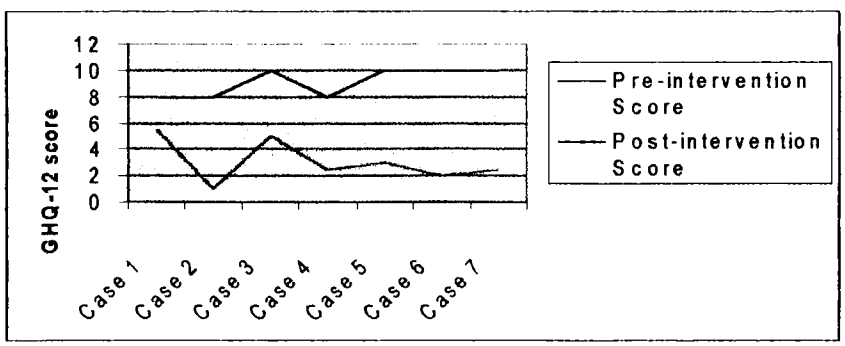


Figure 29. Result of GHQ-12 among 7 cases.

Table 39. Results of 0-10 Point Rating Scales among 7 cases.

(0-10 point rating scale, where 0= no problem at all, 10= highest quantity of problems)

Case No.	Pre-intervention Score	Post-intervention Score
Case 1	08	5.5
Case 2	08	1.0
Case 3	10	5.0
Case 4	08	2.5
Case 5	10	3.0
Case 6	10	2.0
Case 7	10	2.5

Table 39 indicates that the pre intervention scores of 10 point rating scale were decreased after intervention in all 7 cases. For case 1 the pre-intervention score 8 and the post intervention score decreased to 5.5. For case 2, 3, 4, 5, 6 and 7 the scores decreased from 8, 10, 8, 10, 10 and 10 to 1, 5, 2.5, 3, 2 and 2.5 respectively from pre-intervention to post-intervention.

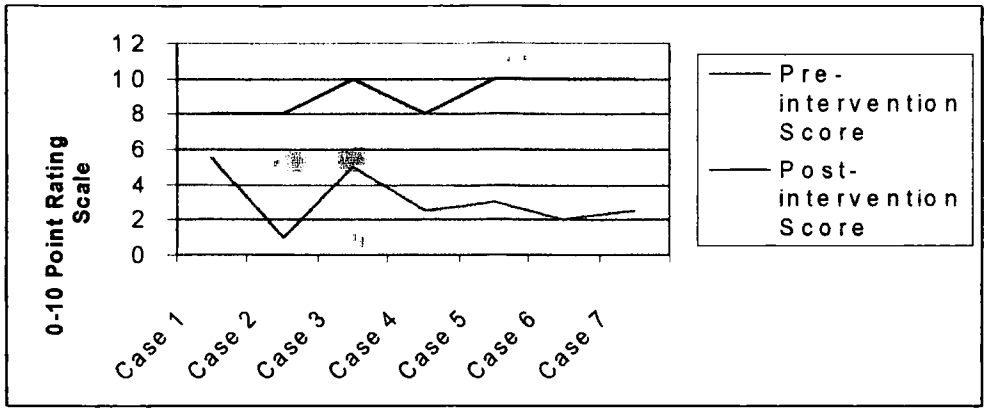


Figure 30. Result of 0-10 point rating scale among 7 cases.

Table 40. Results of Anxiety Scale among 7 cases.

(Anxiety score, where 47.5= cut off point, 54 and less= mild, 55-66=moderate, 67-77=severe, 78-135 and above= profound)

Case No.	Pre-intervention Score	Post-intervention Score
Case 1	35 (mild)	28 (mild)
Case 2	44 (mild)	12 (mild)
Case 3	69 (moderate)	45 (mild)
Case 4	62 (moderate)	12 (mild)
Case 5	97 (profound)	39 (mild)
Case 6	100 (profound)	19 (mild)
Case 7	47 (mild)	15 (mild)

Table 40 shows that in 7 cases the anxiety scores decreased from pre-intervention to post intervention. It is also found that for the cases 3, 4, 5 and 6 the pre-intervention scores were above the cut-off point and after intervention the scores decreased significantly which are below the cut-off point.

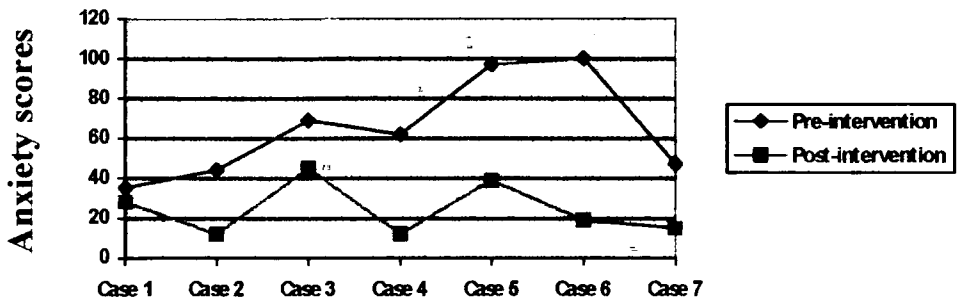


Figure 31. Pre-intervention and post-intervention anxiety scores among 7 cases.

Table 41. Results of Depression Scale among 7 cases

(Depression score, where cut off point=94, 30-100=minimal depression, 101-114=mild depression, 115-123=moderate depression, 124- 150 = severe depression)

Case No.	Pre-intervention Score	Post-intervention Score
Case 1	96(minimal)	89(minimal)
Case 2	123(severe)	64(minimal)
Case 3	124 (severe)	78 (minimal)
Case 4	107(mild)	41(minimal)
Case 5	135(severe)	62 (moderate)
Case 6	121 (moderate)	32 (minimal)
Case 7	99 (minimal)	65 (minimal)

Table 41 reveals the pre and post intervention scores of depression among 7 cases. In 6 seven cases the depression scores were in minimal level and in one case it was in moderate level. It is also found that in all cases the depression scores decreased from pre-intervention to post-intervention.

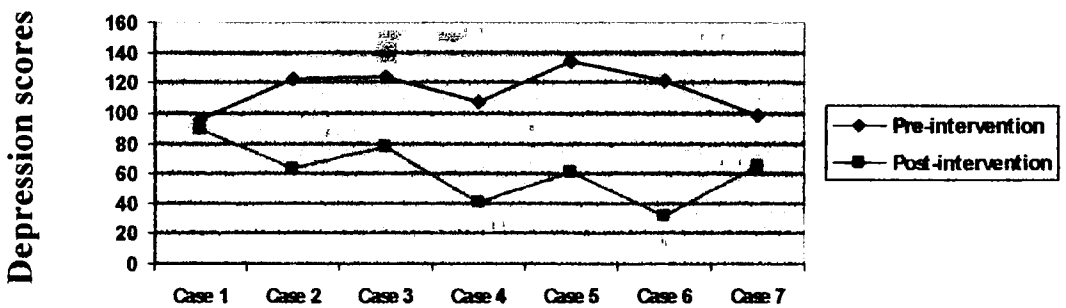


Figure 32. Pre-intervention and post-intervention depression scores among 7 cases.

Table 42. Results on the Degree of Goal Achievement among 7 cases.

List of Goals	Not at all (0)	Slightly (1)	Moderately (2)	Considerably (3)	Completely (4)
1. to reduce anxiety about the unstable relationship and social stigma around breaking of a relationship			2		
2. to develop concentration in study		1			
3. to change both partners' attitude to keep relationship	0				
4. to resolve conflict regarding her career choice				3	
5. to select a good subject in the university			2		
6. to involve in a creative work and do something worthy in future				3	
7. to help settle her brother				3	
8. to find the ways to make her parents happy				3	
9. to find the ways to establish herself				3	
10. to take initiative to build communication with her sister who is living abroad				3	
11. to reduce misunderstanding with her best friend(fiancé)				3	
12. to solve relationship problems with her friends				3	

13. to manage anger problem			2		
14. to manage depression					4
15. to take decision about subject choice					4
16. to manage time and improve study habit				3	
17. to make ability to take decision in any thing			2		
18. to increase motivation in any work				3	
19. to resolve relationship problem					4
20. to control anger and express it in positive way				3	
21. to increase capacity to take any decision			2		
22. to clear the confusion about the affair relationship					4
23. to find identity and importance among her surroundings				3	
24. to clear up the complex within the client and her uncle's family environment			2		
25. to reduce tension regarding loosing of her brother				3	

Table 42 shows list of 25 goals set by 7 clients and therapist before intervention and to what extend those were achieved after intervention reported by the clients.

Table 43. Percentage of goal achievement among 7 cases.

Degree of Goal Achieved	Not at all	Slightly	Moderately	Considerably	Completely	Total
Number of Goal Achieved	1	1	6	13	4	25
Percentage	4%	4%	24%	52%	16%	100%

Table 43 shows that among 25 goals of 7 clients 4% was not achieved at all and 4% slightly achieved. It also shows that 24%, 52% and 16% goals were achieved moderately, considerably and completely respectively.

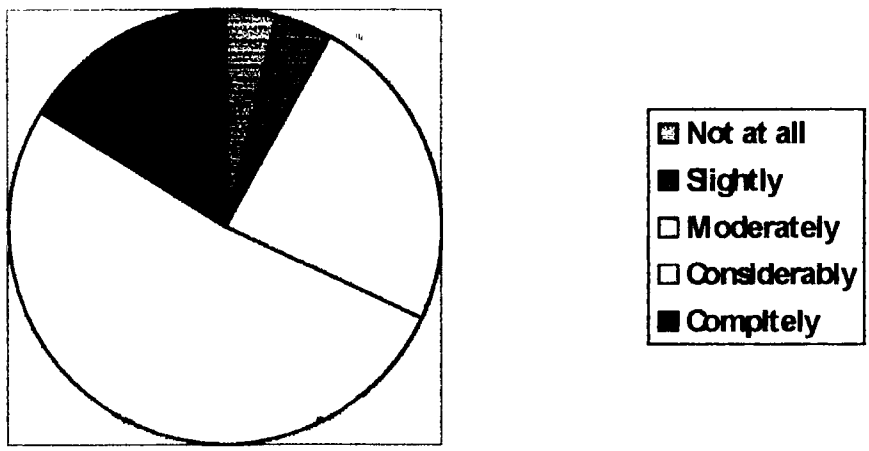


Figure 33. Percentage of the degree of goal achievement of the 7 cases.

Chapter 4

DISCUSSION

This final chapter deals with interpretations of the study findings and implications, presented into two parts. In part-I mental health problems among the students of Dhaka University is discussed and in part-II outcome of psychological treatments on few selective Dhaka University students is focused.

4.0 Part-I Mental Health Problems among the Students of Dhaka University

In part-I, mental health problems among the students of Dhaka University were described, as derived from the relation between GHQ-12 scores and other variables such as gender, marital status, religion, origin, living status, faculty, educational level, income of family, income of student, number of sibling, family size, age and birth order.

To see the mental health problems among the students of Dhaka University GHQ-12 was used to detect clinical level of psychiatric distress (cases). In the present study the researcher selected 3 as the cut-off point. Cut-off point 3 was used based on different published studies (Banu & Akhter,1996; Banu & Chowdhury,1999; Huq, Sarker & Uddin,2000; Jahan & Akhter,2000 and Zaman & Rahman,2003). In this section the relationship of GHQ-12 score with different variables were also seen. The correlation

coefficient of age, level of education, birth order, number of sibling, family size, family income, and personal income with GHQ-12 were also found. In part I the sample of the study comprised 402 students; among them 221 (55%) were cases and 181 (45%) were non-cases. This result indicates that 55% students of Dhaka University have clinical level of psychiatric distress, which is supported by the findings of a private university of Karachi, in which 60% students had anxiety and depression (Inam, Sakib & Alam, 2003).

The above findings detected the distressed cases only, which did not give the impression how many of them immediately needed services. For further investigation the researcher used GHQ-12 among 20 students who came first to take psychological services at the Students Guidance and Counselling Centre of Dhaka University. Interestingly, the average GHQ-12 score among those 20 students were 9. As all of them came for psychological intervention, so the researcher selected the cut-off point 9, assuming that those who scored 9 or above on GHQ-12, might need immediate psychological support. As per cut-off point 9, the number of cases was 38 which comprised 9.5 percent of the study population. This means immediate need of psychological support is 9.5% of the students of Dhaka University. This finding is supported by a WHO study where it is stated that at least 10% of the population of any society suffers from mild mental disorders, (NIMH, 2002).

To identify association, $\chi 2$ test was carried out between GHQ-12 scores and different variables using cut-off point 3. In terms of gender no significant association was found

(male case 57%, 53% female case). This finding is supported by Makaremi (2000), who found no significant difference on depression scores between sexes.

In terms of origin (urban and rural), a significant association was found between rural group and psychological morbidity (60% cases, 40% non-cases). But, in case of urban students, the figures were equal (50% cases, 50% non-cases). As the percentage of rural case is higher than that of urban group, it can be said that the students who came from rural areas are facing more adjustment problems. The rate of clinical level of psychiatric distress is higher among the students who came from rural areas than those of urban areas. On the other hand, in terms of living status (residential and non-residential) though no significant association was found, the percentage of residential case (59%) was considerably higher than the non-case (41%). This shows that the residential students face more adjustment problems than non-residential students.

Interestingly enough, in terms of level of educational stage (1st year Honours, 2nd year Honours, 3rd year Honours, 4th year Honours, Masters and above) a significant association was found between GHQ-12 scores and level of education. In Honours level the percentage of cases (1st year=55%, 2nd year60%, 3rd year64%, and 4th year=57%) are higher than non-cases (1st year=45%, 2nd year40%, 3rd year36%, and 4th year=43%). On the other hand, in Masters and above (M. Phil and Ph. D) level the percentage of cases (41%) is lower than the non-cases (59%). From this findings it is also seen that from 1st year to 3rd year the percentages of case increased gradually. But from 4th year to Masters and above it decreased. This indicates that because of facing examination and new

educational system in the university and also due to gap between expectation and achievement, their mental health condition worsens during 1st, 2nd and 3rd year, where as on the 4th year the students start to face reality of struggle for their career building. The findings of the present study also indicate that the percentage of 2nd year case is higher than that of the 1st year case, which supported by the study of Aktekin, Karaman, Senol, Erdem, Erengin and Akaydin (2001). They found that psychological test scores on the GHQ, the STAI and BDI rose significantly in medical students from first year to the second year.

In respect of marital status a significantly high proportion of cases were found among unmarried students compared to married ones (56.5% and 38.2% respectively). It means unmarried students are more under psychiatric distress. This is obvious because married students get support from their spouses, but unmarried students feel lonely or seek for partners. In terms of religion, these results revealed a significant association between Muslim and Non-Muslim students. Among them Muslim case was 53% and non-case was 47%, which is approximately similar. But in terms of Non-Muslim 70% was case and 30% was non-case. So, in case of Non-Muslim the percentage of case was higher than the non-case. These findings demonstrate that as a minority group the Non-Muslim students are more in psychiatric distress. This is an interesting finding. Because, in Bangladesh there is no racial discrimination. Hence, this needs in-depth study to find out the real causes.

In respect of number of sibling 57% was case and 43% was non-case in 0-2 sibling group; 54% case and 46% non-case in 2+ sibling group. In terms of personal income, 49% was case and 51% was non-case for those having income, 58% was case and 42% non-case for those having no income. And in terms of family size 54% case and 45% non-case in small family group, 56% case and 44% non-case in large family group. Here no significant association was found within the group. These findings show that irrespective of there is no influence on mental health problem as far as family size, number of siblings, and personal income mental health is not affected.

On the other hand, in terms of family income, a significant association was found within different family income groups. Up to TK. 5,000 income group, the percentage of case was 65 and non-case was 35. From TK. 5,001 to TK. 10,000 income group, the percentage of case was 62.5 and non-case was 37.5. From TK. 10,001-TK. 20,000 income group, the percentage of case was 47% and non-case 53%. And above TK.20,000 income group the percentage for case and non-case was equal i.e. 50%. The results also show that the groups having monthly income of TK.10 thousands or below have higher rate of clinical level of distress than higher income groups. From different studies (Dew, Penkower & Bromet, 1991; Dooley & Catalano, 1980) it was found that economic difficulties and unemployment have repeatedly been linked to enhanced vulnerability and thus to elevated rates of abnormal behavior. The findings of this study and others reveal that economic solvency is an important factor for sound mental health.

In the present study the correlation coefficient between GHQ-12 score and variables such as age, level of education, birth order, number of sibling, family size, family income, and personal income were worked out, where the cut-off point was 3. In terms of age and level of education significant negative correlation coefficients were found with GHQ scores. This shows that, with the increase in level of education or age, mental health problem decreases. Interestingly, in respect of family income a significant negative correlation coefficient was also found with GHQ-12 scores. It means with the increase in family income, mental health problems deteriorate. On the other hand, in terms of personal income a positive correlation was found with GHQ-12 score, which shows that with the increase in personal income, mental health condition also improves. This may be due to mental stress for earning money side by side with study. But, in terms of birth order, number of sibling and family size, no significant correlation coefficients were found with GHQ scores. This means there is no relation of birth order, family size, or number of sibling with mental health problem.

In part I, with the cut-off point 3 of GHQ score the percentage of cases (clinical level of psychiatric distress) was 55%, and with the cut-off point 9 the percentage of cases was 9.5%. This result reflects that about 10% students of Dhaka University needs immediate psychological support, whereas, 55% students are in clinical level of psychiatric distress and may need psychological services at any time. Whether such direction is a situational specific momentary distress or an enduring one, needs further in-depth study. There are around 30 thousand students at Dhaka University. Among them approximately 3

thousand students need immediate psychological support. Therefore, Dhaka University should extend its psychological service facilities to help mentally disturbed students.

4.1 Part-II Outcome of Psychological Treatment on the Students of Dhaka University

In part II, outcome of psychological treatment on Dhaka University students was stated. Causes of mental health problems were also found in this section. In this part, the researcher herself saw 7 cases, who came at the Students Guidance and Counselling Centre of Dhaka University for psychological support. From the 7 case studies it was found that, in maximum cases, GHQ score decreased noticeably from pre-intervention to post-intervention phase. On the 10-point rating scale all the clients also indicated that their intensity of problems decreased from pre-intervention to post-intervention phase. The results also revealed that anxiety and depression scores decreased from pre-intervention to post-intervention condition in all cases. There were in total 25 goals which were set with 7 clients collaboratively. Among 25 goals, 4% goal was not achieved at all; 4% goal was achieved slightly; 24% of them was achieved moderately; 52% of them was achieved considerably and 16% of them were achieved completely, as reported by the clients. The above results demonstrated positive outcome of psychological treatment. This positive outcome is supported by contemporary research findings.

A large and growing body of literature mentions that both the presence of psychologists as members of the primary care team and a variety of specific psychological interventions

reduce unnecessary medical visits, reduce overall health care costs, and enhance patient care (Friedman, Sobel, Myers, Caudill & Benson, 1995; Kenkel, 1995). From another study on effectiveness of psychological intervention it was found that psychological interventions can reduce the inappropriate medical care utilization (Cummings, 1991; Gold man & Fedman, 1993). Therefore, for the promotion of mental health of the Dhaka University students, adequate psychological services should be made available.

In part II, the causes of psychological problems were also found. It was found that there are varieties of causal factors which contributed to the development of the problems of the subjects. Those problems are summarized into 9 major causal factors. These are personality pattern, academic problems, developmental hazard, communication difficulties, negative automatic thoughts, family problems, emotional problems, social problems and physical ailments. Considering case-1 of the present study, the predisposing factors of his problem were introvert personality, poor H.S.C result, high expectation for academic result, friend's homosexuality and loneliness during adolescence. The problems related to case number-1 also matched with axis II and axis IV of DSM-IV-TR. According to Srivastava (2008), personality types/ traits influence the mental health of primary and secondary school teachers and extrovert teachers enjoy better mental health as compared to introvert teachers in educational institutions. This study supports that because of introvert personality, case-1 was suffering from mental health problem. Case-2 of the present study was in depressed mood and had conflict about career choice, and the predisposing factors of her problem were dominating father and friends' bulling. According to Beck(1967,1976), different forms of psychopathology

are characterized by different maladaptive schemas that have developed as a function of adverse early learning experiences and that lead to the distortions in thinking characteristic of certain disorders such as anxiety, depression and personality disorders. Case-3 was facing communication problem, family and social problem. Due to her grand mother's death and sister's departure to abroad she was doing the grief reactions. Riches (1998) found that within 8 individuals the major loss and grief are death of family members, broken relationship and separation from family. Because of her loss the client was depressed and the reaction of the client was usual. Psychological service helped her to accept the reality and adapt with the situation. Case-4 was suffering from multiple problems. She had academic problem, developmental hazard, communication problem, family problem, emotional, social and physical problem. As a result, she was suffering from depression. According to Bowlby (1980) the onset of many cases of depression has been linked repeatedly with the prior occurrence of negative life events, such as illness, divorce, or a serious financial setback. According to the client, in her childhood she had a poor academic result, because her peer group was from upper class and she was from middle class. She also thought that as they were not solvent economically, their rich close relatives always wanted to let their family down. Economic difficulties and unemployment have repeatedly been linked to enhanced vulnerability and thus to elevated rates of abnormal behavior (Dew, Penkower & Bromet, 1991; Dooley & Catalano, 1980). Case-5 had excessive anxiety and conflict about career choice. The main causes of his problem was anxious, introvert and dependent personality, less exposure with people, parental and own high expectation on his academic result, excessive stress during puberty, physical health problems, getting unexpected subject and after that

getting negative feedback from his teachers etc. He was given 18 sessions in total, and after intervention at the end of the sessions among 4 goals 1 was achieved completely, 2 goals were achieved considerably and 1 goal was achieved moderately, which was reported by the client. All these showed good indication of improvement. Considering case-6 it is found that due to communication problem the client got upset about their affair relationship. And finally, case-7 was in depressed mood. Her problem started after death of her father and the predisposing causes of her problem are less exposure with boys, inferiority complex about appearance and friend's brother's murder. There are usually very complex 'causes' involving a combination of biological, psychological and social factors. These include: genetics, exposure to trauma, harmful learned behavior patterns, unhealthy family environment, cumulative stress and adverse life events. From a study of the University of Western Sydney (2004) it was found that mental disorders are more common in young adults than at any other age. The rates of depression and anxiety are high and the peak age range for the first onset of problems is between 18-24, coinciding for many people with their time as a student. This study supports the findings of the present study, where the age range of the subjects in part II was between 19-23 years, which is similar age group to those of the University of Western Sydney.

Considering DSM classification there were some external factors which affect on the mental health of the students. According to axis IV of DSM-IV-TR and DSM 3R V-codes there are some psychosocial and environmental factors in the cases of the present study. From case-3 it is found that due to political disturbances, the client faced room allocation problem in her attached accommodation hall. After that incident she was depressed. This was a problem related to social environmental as well as a housing

problem. Other psycho-social and environmental factors were found in case -4. Once during her adolescence, she was rejected from a poem competition for her ugly appearance. This incident made her depressed and she attempted for suicide. She attempted suicide many times due to many psychosocial external factors. Another example is case - 5. His parents had high expectation on his academic result. As a result, he was always been under mental pressure and had performance anxiety. When he was a student of Dhaka University, he got some negative feedback from his teachers. Which increased his level of anxiety and he was doing poor academic result. From the findings of the present study it is found that many psycho-social and environmental factors played a great role to develop mental health problems of the students. So Dhaka University should take initiatives to minimize these problems.

4.2 Implications of the Findings of the Study

The University can extend its psychological services to the students to prevent or minimize these causal factors of mental health problems. Firstly, to face developmental hazard and other family problems, the students' family members can take initiatives. Parental awareness on psychological issues should be developed in the society. Secondly, workshops can be organized for the teachers of Dhaka University on counseling and mental health issues, so that they can suggest appropriate referral and communicate with students positively. Thirdly, to reduce the students' communication, emotional and social problems, social skills training should be given to the university students. And finally, Dhaka University can play the most important role for reducing or solving academic,

emotional, communication and social problem of the students. For the career choice of the students, Dhaka University can assist the students. After admitting the students the University can organize vocational and career counseling services for selected students. Moreover, the University should pay more attention to the Honours students than the Masters students. As the Honours students start their university life with a new environment, it takes some time to cope up with the situation. So, the junior students should get more attention than the senior students. The University can also provide financial supports for the poor students in the form of managing part time jobs or scholarships for them, as financial insufficiency can affect the mental health. And the most important thing is to provide available counselling services for the students and disseminate information about the available counselling services. There is a medical centre of Dhaka University, but unfortunately there is no mental health service provision. The university can create a post of counselor or clinical psychologist at the medical centre, as well as the university can develop appropriate referral system from the medical centre to the counseling centre. There are about 18 residential halls at Dhaka University. To prevent suicide and other psychological problems mental health services are essential here and psychiatrist, clinical psychologist and counsellor can work here as a team.

From the findings of part-I and part-II, it is clear that, there is a tremendous need for psychological services at Dhaka University. Considering the severity of the problem Dhaka University took good initiative, recently recruited three clinical psychologists for three residential (female) halls to provide mental health services. Moreover, at the Students Guidance and Counselling Center of Dhaka University, the trainee clinical

psychologists of the department of clinical psychology are providing clinical psychology services voluntarily. But this is not sufficient at all in respect of demand. More clinical psychologists should be recruited for the Students Guidance and Counselling Center. Although there is a medical center at Dhaka University, only physical health services are available, but mental health services are not available. According to World Health Organization (WHO), "Health is a complete state of physical, mental, social and spiritual well being and not merely an absence of disease or infirmity in all matters, so that each citizen can lead a socially and economically productive life". So, the mental health is essential along with physical health. Hence both mental and physical health services should be incorporated.

The present study results showed that, students do not know the availability of students' mental health services at Dhaka University. Many of them even do not know that psychological services are available at the Students Guidance and Counselling Centre of Dhaka University. For example, among 7 cases of the present study, 5 cases were referred by their roommate or friend as they did not know before about this service. Because of delayed coming to get help, their level of distress was increasing day by day and performance of academic result was decreasing. So, from the findings of the present study it is highly recommended that clinical psychological services should be extended at the Students Guidance and Counselling Centre, medical center and residential halls of Dhaka University. A comprehensive infrastructure including required service facilities and personnel is depicted in figure 34.

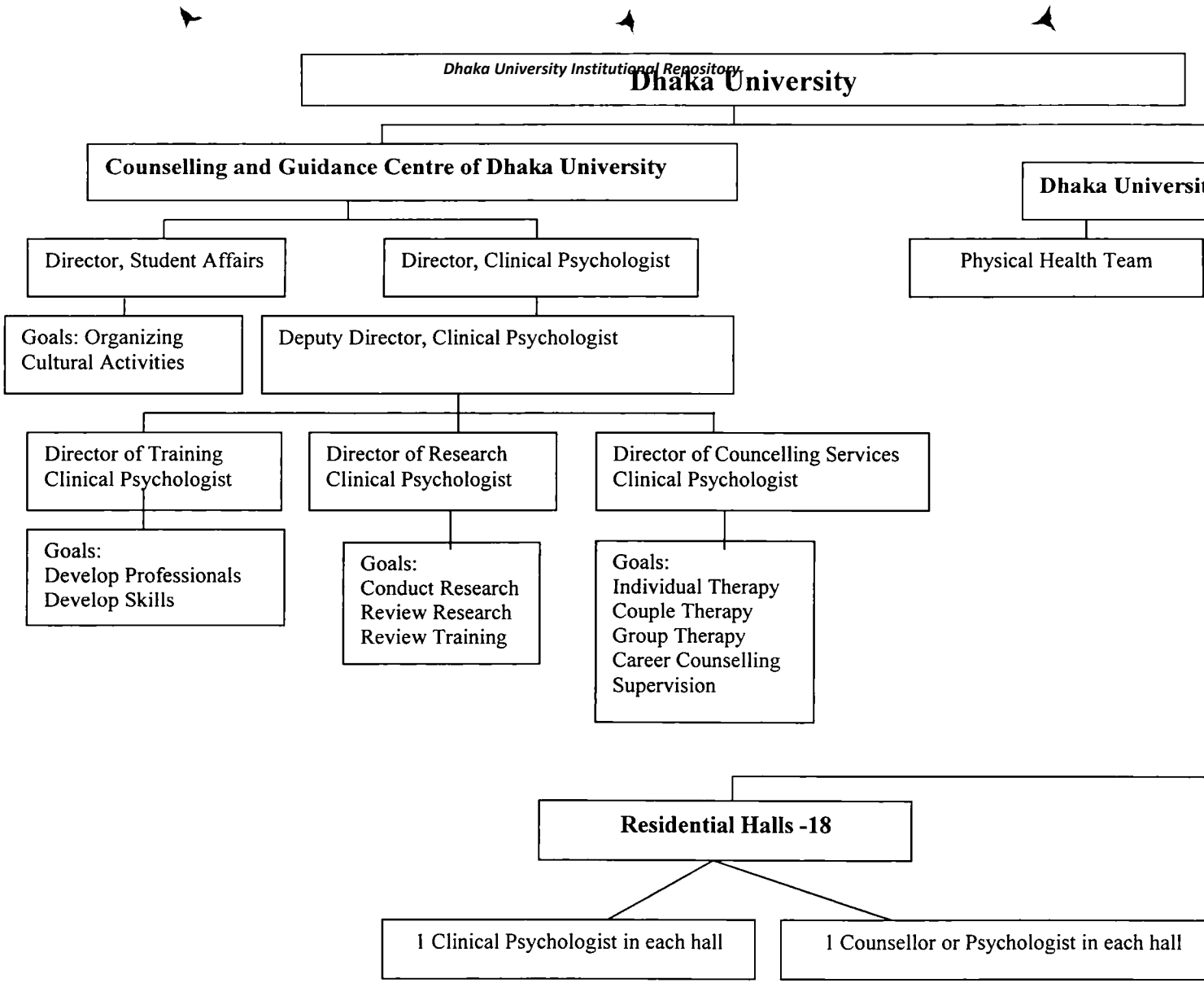


Figure 34: Proposed Model for Mental Health Services at Dhaka Univer

4.3 Limitations of the study

A number of the limitations of the present study provide the basis for further research in the area of mental health of the university students.

In part I of the present study, GHQ-12 was chosen to see the mental health problems among the students of Dhaka University, which only detect the cases who are in clinical level of psychiatric distress. This scale is only for all adult people, not a student specific scale. And this scale also can not measure the severity of the problems. But unfortunately there is no scale in Bangladesh to see the mental health problem among the students of Dhaka University and severity of their problem. If this subject matter is considered in future, more accurate results could be expected.

A small number of samples, in both part of the study have been taken. In part I only 402 students have been taken, due to time limitation and cost. Instead of purposive sampling technique, if probability based sampling technique could be used; more appropriate results could be expected and generated. Another lacking of the study, sample units were not proportionate. There were big gaps between two groups. For example, the number of married students was only 34 and unmarried 364, and the number of Non-Muslim students was only 40 and Muslim 362. So, in future research these factors should be considered. In part II only 7 case studies have been conducted. So, it is very difficult to generalize the outcome of psychological intervention and to know the causes of mental

health problems with such few cases. Moreover, the study was more on outcome focused than cause focused.

Moreover, due to strike, "Hartal", vacation the researcher had to discontinue therapy sessions. So the sessions took a long time to see the outcome of psychological treatment. The continuation of sessions has been broken many times due to political crisis, as a result the students missed the session, and few of them did not have any contact number, as a result some sessions had to go through a lengthy process.

Beside all these limitations, the study has a unique contribution to understand the mental health condition of Dhaka University students. A guideline has been found from the previous section on how to get mental health services from the university and how they can benefit out of services. The results illustrate that mental health condition of the students are very poor. Maximum cases are under clinical level of psychiatric distress. Those cases that have been given psychological treatment, have found many causal factors. The result of the present study indicates a strong need for psychological services for the university students. Currentl suicides at Dhaka University residential halls are on the increase. These incidences, especially girl students, prompted the authorities to go for appointing psychologists in the residential halls and already three psychologists have been appointed for three residential halls.

4.4 Suggestion for further study

On the basis of the findings of the current study the following suggestions are made:

1) Further study is needed with larger samples to include proportionate sample units for different variables to generalize the results.
2) Further study should be also cause-focused rather than outcome-focused, so that detailed measures can be taken to address psychological problems of the university students.
3) In depth study with a few causative variables should be conducted to elucidate the mental health problems.
4) Further study is also needed for standardized scale development based on students' characteristics only rather than general adult people.
5) At last, but not the least, other universities, both government and private should be equipped with mental health care, side by side with physical health care.

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GLOSSARY

Glossary

Activity Schedule: In activity schedule patients record their hour by hour activities, rating them (on 0-100 scales) for salient features such as anxiety, fatigue, pleasure, and mastery. Activity schedules can be used in a variety of different ways.

Anger Management: The goal of anger management is to reduce both emotional feelings and the physiological arousal that anger causes. We can't get rid of, or avoid, the things or the people that enrage us, nor can we change them, but we can learn to control our reactions (APA, 2008).

Assertiveness Training: In assertive training the person develops the ability to express negative and positive feelings, in an open, direct and honest manner. And also the person develops the ability to stand up for our rights while respecting the rights of others. Assertive training helps to develop the ability to take responsibility for ourselves and our actions without judging or blaming other people. On the other hand, it helps to find a compromise where conflicts exists (Holland & Ward,1990).

Behavioral Experiment: Behavioral experiment directly test the validity of the patients' thoughts or assumptions and are an important evaluative technique, used alone on accompanied by Socratic questioning. These experiments can be done in or out of the office.

Breathing Retraining: Learning new breathing techniques will help you move more air in and out of your lungs. This helps decrease shortness of breath. Breathing techniques to control breathing include:

Diaphragmatic Breathing - Breathe in slowly and deeply through your nose. While breathing in, push your stomach out. Place your hand on your stomach so you can feel your stomach going out. This promotes the use of the diaphragm and the lower respiratory muscles. Breathe out slowly and deeply through your mouth. While breathing out, let your stomach relax. You can feel your stomach going in with your hand. Count 1,2, 3, 4 while you slowly breathe out all the way (NJH, 2008). Normal breathing is slow, effortless, regular, fluid, and quiet with virtually no movement above the diaphragm. Some master breathing retraining quite rapidly, while others may require months of practice. The goals are to change from erratic breathing to slow regular, rhythmic abdominal breathing and to make this kind of breathing automatic. This shift in breathing results in long-term changes in the nervous system and anxiety symptoms (ASCA, 2004).

Cognitive Restructuring: Cognitive restructuring in cognitive therapy is the process of learning to refute cognitive distortions, or fundamental "faulty thinking," with the goal of replacing one's irrational, counter-factual beliefs with more accurate and beneficial ones (Wikipedia, 2007). Cognitive Restructuring is a process of changing subconscious thoughts. The goal is to help people overcome faulty thinking errors by bringing them to a level of conscious awareness of their incorrect programming (Ninemsn, 2004).

Contact: It is an agreement between therapist and client to control a negative or unexpected behavior. Contact might be for a specific period of time to control undesired behavior.

Distraction: Distraction can be used at times when unpleasant thoughts become prominent. It may be particularly appropriate early on therapy in therapy before patients have learned to challenge effectively their negative thoughts. Distraction involves carrying out some activity which directs attention away from the unpleasant feelings, for example, work exercise, or some cognitive strategy such as imagining or recalling success experience.

Downward Arrow Technique: A downward arrow technique can be used to uncover core beliefs (Burns, 1989). Repeating cue phrases can help to focus the client on the thoughts, behavior and feelings that are associated with his belief. This technique involves identifying in the usual way a problem situation and the unpleasant emotions and negative thoughts experienced within that situation (Burns, 1980). Rather than challenging the thoughts themselves, the therapist ask questions repeatedly until it is possible to formulate a statement and can be applied in other similar situations.

Empowering Self: It helps a person to enhance his awareness, clarify his decisions, harmonize his health, and activate his healing with his own heart and mind (Knapp 2004). It is a process to write a number of positive self each day which the person believes and this way his self esteem is empowered.

Exercise: A definite relationship exists between exercise and improved mental health. This is particularly evident in the case of a reduction of anxiety and depression. There is now considerable evidence derived from over hundreds of studies with thousands of subjects to support the claim that "exercise is related to a relief in symptoms of depression and anxiety" (Landers, 2007).

Exposure: Exposure treatments within cognitive-behavior therapy emerged in response to the need for more intensive, direct, and effective interventions for crippling anxiety and stress disorders. Successful in the treatment of agoraphobia, panic disorder, social anxiety, simple phobias, and obsessive-compulsive disorder, these therapies have more recently been applied to the treatment of post-traumatic stress disorder (PTSD). There are many behavioral techniques that are circumscribed by the term exposure therapy including: systematic desensitization, in vivo and imaginal (4): flooding, in vivo and imaginal (5); implosive therapy (6); and certain extinction-based procedures such as graduated extinction (7), covert extinction (8), and participant modeling (NCPTSD, 2007).

Graded Task Assignment: Where patients experience difficulty in carrying out tasks, these may have to be broken up into component parts and only the simplest parts undertaken first. When a person's level of activity is lowered then graded task assignment helps a person to increase his activity level gradually.

Imaginary Relaxation: One common use of relaxation imagery is to imagine a scene, place or event that you remember as safe, peaceful, restful, beautiful and happy. You can bring all your senses into the image with, for example, sounds of running water and birds, the smell of cut grass, the taste of cool white wine, the warmth of the sun, and so on. Use the imagined place as a retreat from stress and pressure (Mind Tools, 2008).

Making Hope and See Dream: To make a person cheerful, it is a positive thinking or imagination. When a person is very much depressed and can not see any positive thing in life, hope and dream helps the person to overcome depressed mood. Repeated negative experience makes a person very depressed, in that case hope and dream at least makes that person happy for the time being. As the person can not think cognitively in a very depressed mood, this emotional support (hope and dream) helps to think rationally later on.

Muscular Relaxation: In muscular relaxation the body is usually divided up into a series of large muscle groups and each group is tensed and then relaxed. By alternating tension and relaxation patients are taught to discriminate between these two states and to become more aware of the parts of the body in which they are particularly tense.

Needs and Wants: This is a kind of activity where the client is asked to make lists of his needs and wants separately. In this case needs reflect the necessary things I desire or want to fulfill immediately. Needs are essential for his life. And wants reflects everything he wants, but has less priority to fulfill. If he can not fulfill his wants, it will not hamper his

normal life style. During therapy session, on the basis of priority therapist and client work collaboratively with needs and wants.

Negative Automatic Thoughts (NATs): Negative Automatic Thoughts are usually challenged by cognitive therapy. It is usually identified by thought diary and challenged cognitively by downward arrow technique.

Pros and Cons: To resolve conflict pros and cons are widely used. When a person is confused pros and cons helps to take a decision.

Psycho-education: Psycho-education is a specific form of education. It is aimed at helping persons with a mental illness or anyone with an interest in mental illness, to access the facts about a broad range of mental illnesses in a clear and concise manner. It is also a way of accessing and learning strategies to deal with mental illness and its effects. Psycho-education is not a treatment. It is designed to be part of an overall treatment plan. For example, knowledge of one's illness is crucial for individuals and their support network to be able to design their own relapse prevention plans and strategies (Mental Health Matters, 2005).

Recreational Activities: Recreational activities help to overcome depressed mood or distract from negative thoughts.

বিবৃতি সমূহ	একেবারেই প্রযোজ্য নয় (১)	প্রযোজ্য নয় (২)	মাঝামাঝি (৩)	কিছুটা প্রযোজ্য (৪)	পুরোপুরি প্রযোজ্য (৫)
১৭. আমি আজকাল অনেক কিছুতেই মনোযোগ দিতে পারিনা					
১৮. আমি আগের মতো মনে রাখতে পারিনা					
১৯. আমি দূর্বল বোধ করি এবং অল্পতেই ক্লান্ত হয়ে পড়ি					
২০.আমি এখন কম ঘুমাই					
২১. আমি এখন বেশী ঘুমাই					
২২. আমার মেজাজ খিঁটখিঁটে হয়ে গেছে					
২৩. আমার ক্ষুধা কমে গেছে					
২৪. আমার ক্ষুধা বেড়ে গেছে					
২৫. আমার ওজন কমে গেছে (ইচ্ছাকৃত ভাবে ওজন নিয়ন্ত্রণের চেষ্টা করার ফলে নয়)					
২৬. আমার মনে হয় যে আমার কাজকর্মের গতি কমে গেছে					
২৭. হাসির কোন ঘটনা ঘটলেও আমি আর হাসতে পারিনা					
২৮. যৌন বিষয়ে আমার আগ্রহ কমে গেছে					
২৯. সামাজিক কাজকর্মে আগের মতো অংশগ্রহণ করতে পারিনা					
৩০. শিক্ষা বা পেশাগত কাজকর্ম আগের মতো করতে পারিনা					

94 Depressed
30-100 Minimal
101-114 = Mild
115-123 = Moderate
124-150 Severe

Appendix –7 : Anxiety Scale

উদ্বেগ বা Anxietyপরিমাপের জন্য একটি মানক

১. তারিখ.....

এই বিবৃতিগুলো আপনার ক্ষেত্রে প্রযোজ্য কিনা তা 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" ,"বেশী হয়", "অনেক বেশী হয়" । প্রশ্নমালায় প্রদত্ত বামপার্শ্বের বিবৃতি গুলো পড়ে গত এক মাসের মধ্যে এই বিবৃতিগুলো 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 উত্তর দিয়েছেন কিনা।

আপনার সহযোগিতার জন্য ধন্যবাদ। অনুগ্রহ করে এবার প্রশ্নমালার বিবৃতিগুলোর উত্তর দিন।

বিবৃতি সমূহ	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 কাপেঁ					
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 তাপ 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					

Role Play: Role playing is a technique that can be used for a wide variety of purposes. Role play uncovers automatic thoughts to develop a rational response, and to modify intermediate and core beliefs. Role playing is also useful in learning and practicing social skills.

Self Reward: In self reward the client is asked to identify the things which are rewarding to him and also easily accessible. After doing the desired behavior the client reward him, such as after finishing exam successfully he may watch a movie or bye a dress. SQ3R (Study Skills Training) is a method by which a person can increase his or her study habit. By following this method the person cam memorize things in a better way. SQ3R is a five-step reading strategy: Survey (or Skim), Question, Read, Recite (or Recall) and Review.

Ventilation: Ventilation is one kind of emotional disclosure, where the client was allowed to talk as much as he wanted, only with very few interruptions, which is slightly similar to free association.

Worry Postpone: Worry Postpone strategy is an approach involves postponing worries to a "worry period" that is the same place, time and duration in a day. It is best way to give minor concern onto major worries gradually. Worry postpone is fixed time given to the client to think about his worries only. It can be five, six minutes or more daily so that he may not occupy on his worry for all day long.

APPENDICES

Appendix – 1: INSTRUCTION TO THE STUDENTS

ছাত্র- ছাত্রীর জন্য নির্দেশনা

মনোবৈজ্ঞানিক একটি গবেষণা কাজে অংশগ্রহণ করে সাহায্য করার জন্য আপনাকে বিনীত অনুরোধ করছি।

ঢাকা বিশ্ববিদ্যালয় সাধারণ ছাত্র-ছাত্রীদের স্বাস্থ্য সম্পর্কে জানার জন্য এ গবেষণাটি করছি। এ জন্য আপনাকে একটি প্রশ্নমালা General Health Questionnaire (GHQ-12) পূরণ করতে হবে। একই সাথে কিছু ব্যক্তিগত তথ্যাবলী কাগজে পূরণ করতে হবে। আপনার প্রদত্ত তথ্যাবলীর সম্পূর্ণ গোপনীয়তা রক্ষা করা হবে।

গবেষণার কাজে সহযোগীতা করার জন্য আপনাকে আন্তরিক ধন্যবাদ।

নুসরাত শারমিন
চিকিৎসা মনোবিজ্ঞানী (প্রশিক্ষণরত)
এম ফিল শেষ পর্ব, ক্লিনিক্যাল সাইকোলজি বিভাগ
ঢাকা বিশ্ববিদ্যালয়

বিশেষ দ্রষ্টব্য: শারীরিক স্বাস্থ্যের পাশাপাশি মানসিক স্বাস্থ্যের গুরুত্ব কম নয়। তাই আপনি যদি কোন মানসিক চাপ বা সমস্যায় ভুগতে থাকেন তা লাঘবের জন্য ঢাকা বিশ্ববিদ্যালয়ের টি এস সি'তে অবস্থিত কাউন্সেলিং ও গাইডেন্স সেন্টারে (৩য় তলা) মনোবৈজ্ঞানিক সহায়তা প্রদানের ব্যবস্থা রয়েছে। আপনি যদি কোন কারণে দীর্ঘ দিন ধরে মানসিক চাপে থাকেন তবে এখানে ফ্রি সার্ভিস নিতে পারেন।

Appendix –2 STUDENT'S INFORMATION SHEET

ছাত্র-ছাত্রীদের তথ্যাবলী

তারিখ	:
গবেষণা সহকারীর নাম	:
ছাত্র/ছাত্রীর নাম (যদি দিতে চান)	:
বয়স	:
লিঙ্গ	: পুরুষ/ মহিলা
শ্রেণী	:
বিষয়	:
আবাসিক/ অনাবাসিক	:
পূর্বে বেশীরভাগ সময় কোথায় বড় হয়েছেন	: ঢাকা / ঢাকার বাহিরে
বৈবাহিক অবস্থা	: অবিবাহিত/বিবাহিত/ বিচ্ছিন্ন বিধবা/ তালাকপ্রাপ্ত পূণবিবাহিত
র্ধম	: ইসলাম/হিন্দু/ বৌদ্ধ/ খৃষ্টান/ অন্যান্য
পরিবারের মোট সদস্য সংখ্যা	:
পারিবারিক আয় (মাসিক / বাৎসরিক)	:
ব্যক্তিগত আয় (মাসিক/ বাৎসিরিক)	:
ভাইবোনের সংখ্যা(নিজেকে সহ)	:
ভাইবোনদের মধ্যে কত নম্বর	:

Appendix-3 : General Health Questionnaire (GHQ-12)

General Health Questionnaire (GHQ-12)

অনুগ্রহ করে লেখাটি মনোযোগ সহকারে পড়ুনঃ

গত কয়েক সপ্তাহ ধরে আপনার কোন শারিরীক অভিযোগ আছে কিনা এবং আপনার স্বাস্থ্য মোটামুটি ভাবে কেমন আছে তা জানতে আমরা আগ্রহী। অনুগ্রহ করে পরবর্তী সকল প্রশ্ন সমূহের উত্তর দিন এবং সেই উক্তিটির নীচে দাগ দিন যে উত্তরটি আপনার ক্ষেত্রে সবচেয়ে বেশী প্রযোজ্য। মনে রাখবেন যে, আমরা আপনার বর্তমান ও সাম্প্রতিক অভিযোগ সমূহ সমন্ধে জানতে আগ্রহী, যা অতীতে ছিল তা নয়। সব গুলো প্রশ্নের উত্তর দিতে চেষ্টা করুন। কারণ বিষয়টি খুব গুরুত্বপূর্ণ। সহযোগীতা করার জন্য আপনাকে অনেক ধন্যবাদ।

	প্রশ্নমালা	মোটেই না	কিছুটা	বেশ খানিকটা	সর্বাধিক পরিমাণ
১.	ইদানিং আপনি যা করছেন তাতে কি মনোনিবেশ করতে পারছেন?				
২.	ইদানিং দুশ্চিন্তায় আপনার নিদ্রায় অত্যন্ত ব্যাঘাত ঘটে কি?				
৩.	আপনি আজকাল প্রয়োজনীয় কাজে মনোযোগ দিতে পারেন কি?				
৪.	আপনি কি বর্তমানে কোন কিছু সম্পর্কে সিদ্ধান্ত গ্রহণ করতে সমর্থ?				
৫.	আপনি কি ইদানিং সর্বদা মানসিক চাপের মধ্যে থাকছেন?				
৬.	আপনার কি মনে হয় ইদানিং আপনার অসুবিধা গুলি দূর করতে সক্ষম হচ্ছেন না?				
৭.	আপনার দৈনন্দিন কাজ গুলি উপভোগ করতে সক্ষম হচ্ছেন কি?				
৮.	আপনি কি ইদানিং আপনার সমস্যা গুলির মোকাবেলা করতে সক্ষম?				
৯.	আপনি কি ইদানিং অসুখী ও বিমর্ষ বোধ করছেন?				
১০.	বর্তমানে আপনি কি আত্মবিশ্বাস হারিয়ে ফেলেছেন বলে মনে করেন?				
১১.	ইদানিং আপনি কি নিজেকে একজন অযোগ্য ব্যক্তি হিসাবে গণ্য করেন?				
১২.	সবদিক বিবেচনা করে বর্তমানে আপনি কি নিজেকে মোটামুটি ভাবে সুখী মনে করেন?				

Appendix–4: Semi Structured Interview Schedule

SEMI STRUCTURED INTERVIEW SCHEDULE

গবেষণা সহকারীর নাম	:	তারিখ	:
ক্লায়েন্টের নাম	:	পিতার পেশা	:
ক্লায়েন্টের বয়স	:	পিতার বয়স	:
জন্ম তারিখ	:	পিতার শিক্ষাগত যোগ্যতা	:
ক্লায়েন্টের লিঙ্গ	:	মাতার পেশা	:
বিষয়	:	মাতার বয়স	:
শ্রেণী	:	মাতার শিক্ষাগত যোগ্যতা	:
আবাসিক / অনাবাসিক	:	ক্লায়েন্টের ভাইবোনের সংখ্যা	:
পূর্বে বেশীর ভাগ সময় কোথায় বড় হয়েছেন : ঢাকা/ঢাকার বাহিরে		ক্লায়েন্টের জন্মক্রম	:
বৈবাহিক অবস্থা	:অবিবাহিত/বিবাহিত/ বিচ্ছিন্ন বিধবা/ তালাকপ্রাপ্ত/ পূণবিবাহিত	পরিবারের মোট সদস্য সংখ্যা	:
		পারিবারিক আয় (মাসিক / বাৎসরিক):	
ধর্ম	: ইসলাম/হিন্দু/ বৌদ্ধ/ খৃষ্টান/ অন্যান্য	ব্যক্তিগত আয় (মাসিক/ বাৎসিরিক):	
		টেলিফোন নং	:
		ঠিকানা	:

অন্যান্য প্রশ্নাবলী :

১. প্রধান সমস্যা কি কি?

২. সমস্যার কারণসমূহ কি কি হতে পারে বলে মনে করেন?

৩. সমস্যা কবে থেকে শুরু হয়?

৪. কিভেবে আপনি এখানে এসেছেন?

৫. কিভাবে এখানে এসেছেন (Referral)?

৬. এতদিন আসা হয়নি কি কারনে?

৭. পরিবারে কারো মানসিক সমস্যা আছে কি? হ্যাঁ / না

৮. হ্যাঁ হলে সেই সদস্যের সাথে সর্ম্পক কি?

৯. এই প্রথম মানসিক স্বাস্থ্যর সাহায্য নিতে এসেছেন কি?

১০. যদি পূর্বে মানসিক স্বাস্থ্য সাহায্য নিয়ে থাকেন তবে কি ধারনের সাহায্য নিয়েছেন? ঔষধ, কাউন্সেলিং/ সাইকোথেরাপী/ কবিরাজ/ তাবিজ/ ঝাড়ফূক/ অন্যান্য

১১. যদি পুর্বে মানসিক স্বাস্থ্য সাহায্য নিয়ে থাকেন তবে এখন ও কি তা চালিয়ে যাচ্ছেন? হ্যাঁ / না

১২. আপনি কি করে মানসিক স্বাস্থ্য সমস্যা দুর করতে চান?

Appendix-5: GOAL ASSESSMENT SHEET

GOAL ASSESSMENT SHEET

Name.....

Pre- Treatment dated.....

Goal 1.....

Goal 2.....

Goal 3.....

Goal 4.....

Goal 5.....

Post-Treatment dated.....

To what content has goal 1 been achieved?

Not at all	Slightly	Moderately	Considerably	Completely
1	2	3	4	5

To what content has goal 2 been achieved?

Not at all	Slightly	Moderately	Considerably	Completely
1	2	3	4	5

To what content has goal 3 been achieved?

Not at all	Slightly	Moderately	Considerably	Completely
1	2	3	4	5

To what content has goal 4 been achieved?

Not at all	Slightly	Moderately	Considerably	Completely
1	2	3	4	5

To what content has goal 5 been achieved?

Not at all	Slightly	Moderately	Considerably	Completely
1	2	3	4	5

Appendix – 6: Depression Scale -DS

বিষন্নতা পরিমাপক (Depression Scale -DS)

নিচের বিবৃতি গুলো পড়ে গত এক মাস মধ্যে এই বিবৃতি গুলো আপনার ক্ষেত্রে কতটা প্রযোজ্য তা বিবৃতির পার্শ্বের সম্ভাব্য পাঁচটি উত্তরের যেটি প্রযোজ্য সেটির ঘরে টিক (√) চিহ্ন দিয়ে নির্দেশ করুন। আপনাকে সম্ভাব্য এই পাঁচটি উত্তর থেকে যে কোন একটিকে বেছে নিতে হবে এবং সবগুলো প্রশ্নের উত্তর দিতে হবে। অনুগ্রহ করে লক্ষ্য করুন সবগুলো বিবৃতির উত্তর দিয়েছেন কিনা।

বিবৃতি সমূহ	একেবারেই প্রযোজ্য নয় (১)	প্রযোজ্য নয় (২)	মাঝামাঝি (৩)	কিছুটা প্রযোজ্য (৪)	পুরোপুরি প্রযোজ্য (৫)
১. আমার অশান্তি লাগে					
২. ইদানিং আমি মন মরা থাকি					
৩. আমার ভবিষ্যত অন্ধকার					
৪. ভবিষ্যতে আমার অবস্থা দিন দিন আরো খারাপ হবে					
৫. আমার সর 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 পাইনা					
৯. নিজেকে খুব ছোট মনে হয়					
১০. সব কিছুতে আমার আত্মবিশ্বাস কমে গেছে					
১১. আমার মনে হয় মানুষ আমাকে করুনা করে					
১২. জীবনটা অর্থহীন					
১৩. প্রায়ই আমার কান্না পায়					
১৪. আমি প্রায়ই বিরক্ত বোধ করি					
১৫. আমি কোন কিছুতে আগ্রহ পাইনা					
১৬. আমি ইদানিং চিন্ত করতে ও সিদ্ধান্ত নিতে পারিনা					

বিবৃতি সমূহ	একেবারেই হয় না (০)	খুব সামান্য হয় (১)	মোটামুটি হয় (২)	বেশী হয় (৩)	অনেক বেশী হয় (৪)
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 দুঃশ্চিন্তাগ্রস্থ অবস্থায় থাকি					
২৭. আমি প্রায়ই চমকে উঠি					
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 আমরা জন্য বেশ কষ্টকর					
৩৫. আমার মনে হয় আমি এখনই মারা যাচ্ছি					
৩৬. আমার মৃত্যু ভয় হয়					

Severity of anxiety	Corresponding scores of Anxiety Scale
Mild	54 and less
Moderate	55-66
Severe	67-77
Profound	78-135 and above

Use 47.5 as the cut – off point