DEVELOPMENT OF THERAPEUTIC PROTOCOL OF COGNITIVE BEHAVIOR THERAPY (CBT) FOR OBSESSIVE COMPULSIVE DISORDER (OCD) IN PAKISTAN

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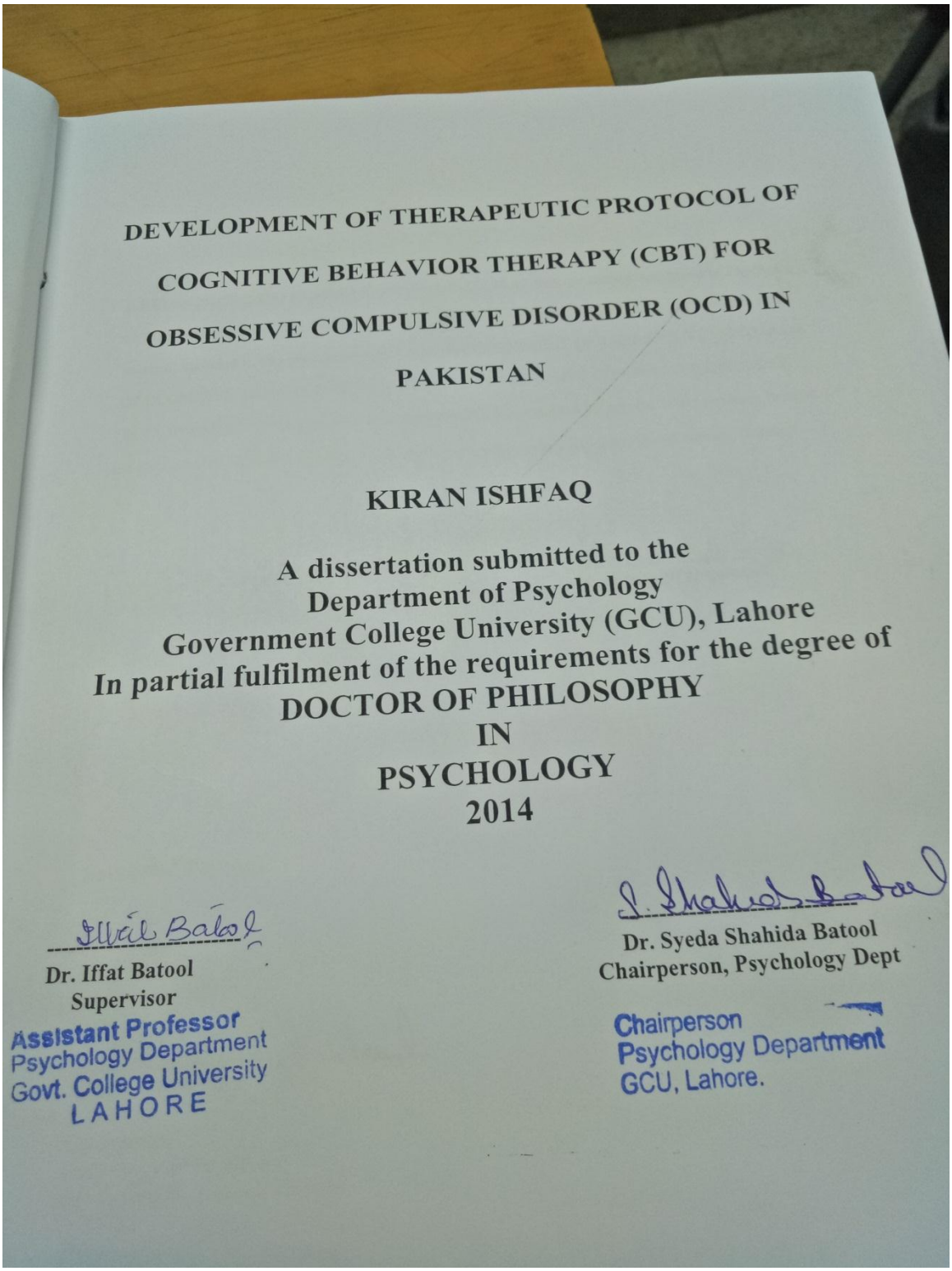

DEVELOPMENT OF THERAPEUTIC PROTOCOL OF COGNITIVE BEHAVIOR THERAPY (CBT) FOR OBSESSIVE COMPULSIVE DISORDER (OCD) IN PAKISTAN

KIRAN ISHFAQ

A dissertation submitted to the
Department of Psychology
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26-12-2014
Dated

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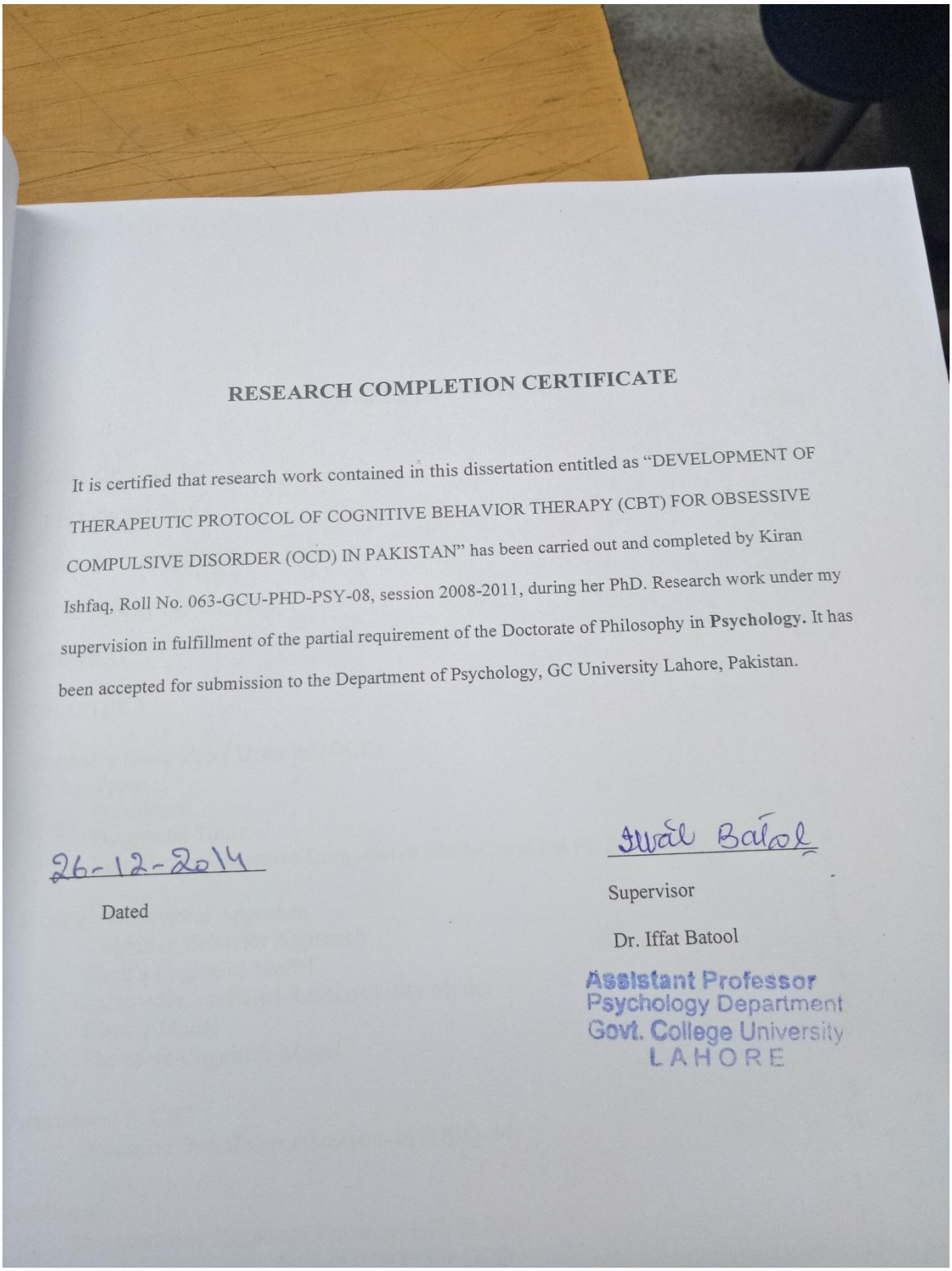

RESEARCH COMPLETION CERTIFICATE

It is certified that research work contained in this dissertation entitled as "DEVELOPMENT OF THERAPEUTIC PROTOCOL OF COGNITIVE BEHAVIOR THERAPY (CBT) FOR OBSESSIVE COMPULSIVE DISORDER (OCD) IN PAKISTAN" has been carried out and completed by Kiran Ishfaq, Roll No. 063-GCU-PHD-PSY-08, session 2008-2011, during her PhD. Research work under my supervision in fulfillment of the partial requirement of the Doctorate of Philosophy in **Psychology.** It has been accepted for submission to the Department of Psychology, GC University Lahore, Pakistan.

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Abstract

Acknowledging the need of cultural adaptations in psychotherapy, the present study was comprised of four interlinked studies based on mixed approach research design to adapt Cognitive Behavior Therapy (CBT) for Pakistani population of Obsessive compulsive disorder (OCD) patients by developing a therapeutic protocol of CBT in Urdu.

Study 1 (Protocol Development), based on qualitative approach, aimed to inquire adaptations in CBT practice with OCD patients of Pakistan. The audio recorded interviews of five clinical psychologists, were analyzed through Thematic approach employing validation strategies indicated much similarities with western trends in therapeutic process but certain differences highlighted the role of religion and culture in implementation of CBT with Pakistani population. On the basis of this study, a CBT protocol was devised to be implemented in study 3.

The objective of study 2 was to translate required assessment and therapeutic tools in Urdu language and to assess the symptomatic and belief characteristics of Sample C. In phase I, the Yale-Brown Obsessive Compulsive Scale & Checklist (YBOCS-SC), Obsessive belief Questionnaire-44 (OBQ-44), and CBT forms were translated in Urdu through standardized procedures. The inter rater correlation coefficient (ICC) of YBOCS indicated satisfactory reliability (N= 30; α= .92, p >.01). The psychometric properties of OBQ-Urdu-44 indicated acceptable reliability of Urdu version (N=170; Sample B; convenient sampling; r=.87, p>.01; internal consistency, α=.85). The factor structure of OBQ-Urdu-44 indicated a different factor structure from original one. In phase II (study

2), the symptomatic and belief characteristics of 24 OCD patients (Sample C; Purposive sampling) were explored. The descriptive analysis indicated contamination and aggression obsessions, washing compulsions and scrupulosity obsessions as most prevalent symptoms. Whereas prominent obsessional beliefs related to Responsibility-Threat overestimation (RT) and Perfectionism-certainty (PC) domains of OBQUrdu-44 as compared to Importance and control of thoughts (ICT; M= 89.5, 85.2 & 58.6, respectively). The non-significant correlation between Y-BOCS and OBQ-Urdu-44 (r= .20) rejected the hypothesis of Study 2.

The study 3 (Outcome study), was conducted to evaluate the efficacy of Urdu protocol of CBT. In a randomized-control trial, two groups (CBT & Placebo/Waiting-PW; n= 12) of OCD patients were compared. The Two Way Mixed ANOVA (Between-Within groups) indicated highly significant efficacy of CBT ($\eta^{2=}$ .67) as compared to Placebo. The One Way Repeated Measures ANOVA with Post hoc tests using Bonferroni correction indicated excellent effect size of CBT (N= 24; η^2= .89, p > .01), although failed in relapse prevention indicated by significantly high mean score on Y-BOCS (p >.05) at 6- months follow-up. The One way Repeated Measures ANOVA for OBQ-Urdu-44 indicated non-significant mean differences (N= 24; η2=.25, p <.05) among scores which reflected Urdu CBT protocol failure to manage cognitive change.

To explore the cultural aspect of CBT practice with Sample C, the study 4 (Case Study) was planned in which eight randomly selected case studies from Study 3, were analyzed through thematic analysis. The analysis highlighted cultural and religious effects on CBT practice with Sample C.

Conclusively, the present research work is an important addition to research and practice of CBT with OCD in Pakistan by providing CBT protocol adapted for Pakistani population.

Mental health comprises psychological, emotional and social well-being. It affects ones' way of thinking, feeling, behaving and ones' coping mechanisms. Individuals' stress, work, and relationship management is also affected by mental health. Throughout the life span, mental health is crucial to ones' progress and life satisfaction whereas its deterioration results in mental disorders (World Health Organization [WHO], 2014). Mental disorders or illness affect all aspects of individuals' personality and life (Mayo Clinic Staff, 2014). There are number of mental disorders among those depressive disorders, psychotic disorders, anxiety and stress related disorders and Obsessive Compulsive disorder (OCD) is important (Kring, Davison, Neale, & Johnson, 2007).

Obsessive Compulsive Disorder (OCD)

Obsessive Compulsive disorder (OCD) is a mental illness formerly considered an anxiety disorder (American Psychiatric Association [APA], 2000), it has now been a distinct classification that is, "OCD and Related Disorders" (APA, 2013, p. 129) which depicts its importance as a psychological disorder. APA (2013) considers it a condition which has obsessions (recurrent and intrusive thoughts, images, impulses) and compulsions (repetitive mental acts or behaviors) that caused marked distress and dysfunction in person's social, academic or occupational life, without any direct effect of some substance or some physiological illness.

Types of OCD. Obsessive-compulsive disorder (OCD) is a heterogeneous and complex disorder, and its symptom presentation can take many forms such as washing, checking, hoarding, and harming obsessions. The diversity in symptoms, along with differences in treatment response and neurobiological differences, has led researchers and

clinicians to propose that important subtypes of OCD exist (Taylor, 2005). In the process of identification of subtypes of OCD, researches focused on symptom presentation which resulted in many replicable symptom subtypes such as contamination and washing/cleaning, harm obsessions and checking rituals, obsessions without overt compulsions, and hoarding (McKay et al., 2004). Besides differential treatment response, symptom subtypes also show information processing differences. For instance, checkers are characterized by slowness and indecisiveness (Rachman, 2002), and tend to have less confidence in their memory (Radomsky, Rachman& Hammond, 2001), whereas the hoarding subtype shows organization and categorization deficits (Frost & Hartl, 1996).

Saleem and Gul (2011) concluded that in Pakistan most frequent subtype of OCD is related to contamination and cleanliness. Findings indicated that 62% patients displayed obsessions related to dirt and contamination, and 63.8% patients displayed compulsions related to Washing & Cleaning. There were no major gender based differences found regarding obsessions and compulsions in this study. Nazar, Haq, and Idrees (2011) found that religious themes (60%), contamination themes (28%) and safety themes (20%) are common in Pakistan, whereas the role of religion was prominent in OCD phenomenology. Saleem and Mahmood (2009) revealed that the types of obsessions and compulsions are similar to those reported in other foreign studies but the form and content of obsessions seem to be influenced by social and religious backgrounds.

Prevalence of OCD. The lifetime prevalence of OCD in USA is 1.2% which is reported to be around 1.1 to 1.8% in world (APA, 2013). Community studies of children and adolescents have estimated a lifetime prevalence of 10% - 2.3% and I-year

prevalence of 0.7%. Research indicates that prevalence rates of Obsessive-Compulsive Disorder are similar in many different cultures around the world (APA, 2000). The prevalence of OCD is yet to be addressed in Pakistan.

Diagnostic tools of OCD. The symptoms of OCD overlap with other psychiatric and neurologic disorders (e.g., general anxiety, psychosis, and mood, pervasive-developmental, and tic disorders; Dell'Osso, Altamura, Mundo, Marazziti, & Hollander, 2007), therefore a thorough assessment is crucial to the differential diagnosis of OCD. Several methods of assessment have been developed that may facilitate a clinician's attempt to identify OCD. These include diagnostic interviews, clinician-administered inventories, self-report measures, and, for pediatric patients, parent-report and teacher-report measures (Merlo & Storch, 2006). Different measures can be used for diagnosis and screening of OCD for children and adults, among those Obsessive–Compulsive Inventory-Revised (OCI-R; Foa et al., 2002), Padua Inventory-Revised (PI-R; Burns, Keortge, Formea, &Sternberger, 1996), Florida Obsessive Compulsive Inventory (FOCI; Storch, Bagner et al., 2005), Schedule of Compulsions, Obsessions, and Pathological Impulses (SCOPI; Watson & Wu, 2005),Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010), Children's Obsessional Compulsive Inventory (ChOCI; Shafran et al. 2003), Child Obsessive Compulsive Impact Scale (COIS; Piacentini & Jaffer, 1999), Florida Obsessive-Compulsive Student Inventory (Merlo &Storch, 2005), and the most commonly used assessment instrument within clinical and research settings ,the Yale- Brown Obsessive Compulsive Scale (Y-BOCS) and its counterpart for children, the Children's Yale-Brown Obsessive Compulsive Scale (C-YBOCS) (Poyurovsky, Faragian, Shabeta & Kosov, 2008), are worth mentioning.

Yale- Brown Obsessive Compulsive Scale (Y-BOCS). Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989a, 1989b), is "a gold standard measure of OCD" (Abramowtiz, 2006, p.410). It is a semi-structured interview that consists of a symptom checklist and a severity measure. The Y-BOCS was devised to provide a specific measure of the severity of symptoms of obsessive-compulsive disorder that is not influenced by the type of obsessions or compulsions present. The scale's core composition reflects a conceptualization of OCD in which the severity of obsessions and compulsions contribute independently to the global severity of the disorder (Deacon & Abramowitz, 2005).

The inter-rater reliability for the total Yale-Brown Scale score and each of the 10 individual items was excellent, with a high degree of internal consistency among all item scores demonstrated with Cronbach's alpha coefficient. The intra class correlation coefficient was found to be good (r = .98) for the total Y-BOCS score and for Obsessions and Compulsions subscales (r= .97 & .96, respectively; Goodman et al 1989a). Woody, Steketee, and Chambless (1995) found an acceptable level of internal consistency (α = .69), strong inter-rater reliability (r= .93), and low level of test-retest reliability (r=.61) for total score. Y-BOCS was also proved to be reliable for assessing obsessive compulsive symptoms in non-clinical sample (Frost, Steketee, Krause, & Trepanier, 1995).

In its validity study, the total Yale-Brown Scale score was significantly correlated with two of three independent measures of obsessive-compulsive disorder (r=.74) and was weakly correlated with measures of depression and of anxiety. This provides evidence for a good convergent and discriminant validity of the scale (Goodman et al.,

1989b). Woody et al. (1995) also found the evidence of good convergent validity for Y-BOCS. Factor analysis by Moritz et al. (2002) provided evidence of three-dimensional model of Y-BOCS. This model comprised of three factors, including severity of obsessions, severity of compulsions, and symptom resistance. Deacon and Abramowitz (2005) found a two-factor solution, the severity subscale and the resistance/control subscale. On the other hand, factor analysis by Anholt et al. (2010) revealed a three-factor model, consisting on obsession, compulsion and resistance/control dimensions.

Results from a placebo-controlled trial of fluvoxamine in 42 patients with obsessive-compulsive disorder showed that the Yale-Brown Scale is sensitive to drug-induced changes and reductions in Yale-Brown Scale scores specifically reflect improvement in obsessive-compulsive disorder symptoms (Goodman et al., 1989b). Considering good psychometric properties and wide use of YBOCS-SC for OCD diagnostic assessment, current study selected this tool as main outcome measure.

Etiology of OCD

Behavioral perspective. The learning theorists consider OCD as result of maladaptive and inappropriate learned associations which are acquired through classical conditioning but maintained through operant conditioning (Mowrer, 1960; as cited in Tracy, Ghose, Stecher, McFall, & Steinmetz, 1999). According to behavioral perspective, the classical and operant conditioning is the phenomenon that may lead towards the development and maintenance of obsessions and compulsions. (Neziroglu, Henricksen, & Yeryura-Tobias, 2006).

Cognitive approaches to OCD. Cognitive paradigm emphasizes on the cognitive structuring of the events, their interpretations, and belief systems. Cognitive theorists

describe that OCD patients usually have dysfunctional, illogical and irrational beliefs and patients of OCD misinterpret their disturbing and disruptive indiscrete thoughts that may lead to cause obsessions and compulsions (Veale, 1999). Everyone experience intrusive and disruptive thoughts, according to this theory, but OCD patients misinterpret such thoughts, consider them very important for their healthy survival, catastrophize the disturbing thoughts again and again (Clark, 2004). This repetition leads towards the development of obsession within an individual. Obsessional thoughts are extremely stressful, disturbing, and worrying that people with obsessional thoughts lead to some compulsions to get rid of these obsessions. Usually the compulsive patterns include resistance, block, or counterbalancing of obsessional thoughts. CBT focused on the idea that disruptive, intrusive thoughts, images, doubts, impulses are misinterpreted by the individuals that are critical for the experience of stress and distress and for initiation of compulsive behavior (e.g.,avoidance, suppression, reassurance seeking ;Freeston, Ladouceur, Rheaaume, &Leager, 1998; Freeston, Rheaaume, & Ladouceur, 1996).

According to cognitive behavioral model of OCD , all intrusive doubts, images and thoughts are nearly universal with similar content of clinical obsession in general population across the world. For instance, an impulse to pull some one down on a rail tracks of train. The distinction that is found between the normal invasive and disruptive thought and Obsessional thoughts is in two factors. One in the meaning that OCD patient associates to the occurrence or content of disturbances whereas second includes the reactions in response to the thoughts, doubts or images (Rachman & de Silva, 1978). Some commonly found dysfunctional beliefs are inflated responsibility, perfectionism,

over importance of and need to control thoughts, and thought-action fusion (Clark, 2004; Wells, 1997).

Different models of CBT for OCD. Cognitive-Behavior therapy is an approach which helps individuals to manage and to change their dysfunctional beliefs related to obsessions (Overholser, 1999). Carr presented first cognitive theory of OCD which suggested that obsessive symptoms are result of subjective estimation of inflated responsibility that something bad would happen (Clark, 2004). McFall and Wollersheim (1979) conceived etiology of OCD in terms of a primary threat appraisal involving the overestimation of the probability and intensity of negative outcomes associated with unfavorable and undesirable events followed by a secondary appraisal process in which the individual underestimates his/her ability to cope with the threat.

Cognitive model of Beck. Cognitive model of Beck (1976) suggests that anxiety disorders are rooted in dysfunctional cognitive schemas related to danger and that these schemas represent misperception are exaggeration of the amount of danger that exists in particular situation (Beck & Emery, 1985). This model comments that distorted beliefs have a causal relationship with psychopathology. According to this model, the content of people's automatic thought express these underlying beliefs or schemas. Schemas are viewed as generalized organizing frameworks or rules which are used to interpret events. Schemas therefore influence individuals' perceptions of themselves, others, and the environmental information an individual attends. The assimilation of new experiences into existing schemas may therefore be biased in favor of these underlying assumptions. Such biases, included selective abstraction, over-generalizing, arbitrary inferences, and

personalization are termed cognitive distortions and these are viewed as the active processes that form a bridge between schemas and automatic thoughts (Beck, 1976).

Salkovskis's inflated responsibility model. Salkovskis (2007) presented a comprehensive theory of CBT for OCD based on Beck's cognitive theory in which cognitive and behavioral concepts were integrated. The hallmark of Salkovskis' model was focusing upon importance of appraisal of intrusions, with special emphasis on concept of inflated responsibility, rather than content of intrusive thoughts (Wells, 1997). In Salkovskis approach, obsessions are conceptualized as normal intrusive thoughts, which the sufferer misinterprets as a sign that harm to themselves or to others is a serious risk and that they are responsible for such harm or its prevention. This interpretation has several effects, such as: increased discomfort, including (but not confined to) anxiety and depression; the focusing of attention both on the intrusions themselves and triggers in the environment that may increase their occurrence increased accessibility to and preoccupation with the original thought and other related ideas; behavioral responses, including 'neutralizing' reactions in which the person seeks to reduce or escape responsibility overtly or covertly. The inflated sense of responsibility that the sufferer attaches to his or her activities leads them into a pattern of mental and behavioral effort characterized by both over control and pre-occupation (Salkovskis, 2007).Wells (1997) commented that the Salkovskis model concentrated on modifying automatic thoughts and beliefs concerning responsibility for harm.

Clark's model of OCD. Cognitive theory suggested by Clark (2004) focuses on cognitive control of thoughts. Main problematic situation in OCD was supposed to be efforts for the control of intrusive thoughts or obsessions and recent cognitive factors

were accumulated primary and secondary appraisal processes. Consistent with Rachman (1997, 1998), Clark (2004) put the determination of the meaning of obsessions and existence of threat for the person in the primary appraisal process. Patients with OCD generally interpret them as threatening and opposite of their personality and deliberately perform effort to remove intrusion from awareness; hence, they try to control them. However, during the review at the secondary appraisal, person appraises failure, because of the perceived insufficient control. Then, maladaptive appraisals based on on-going danger, threat, personal responsibility and possibility of serious negative consequences lead to increase in distress and salience of the obsessions and great thought control efforts; thus, compulsive acts are oriented to the prevention. Mental control emphasis seems to be as a core element in the recent model (Clark & Purdon, 1995).

The Meta-cognitive model of Wells and Matthews. Wells and Matthews (1994) present a prototypical model of OCD mapped on a detailed cognitive processing framework of vulnerability to emotional disorder. They proposed that the beliefs supporting the fusion of thought and action, and positive and negative beliefs about rumination and neutralizing strategies are relevant in conceptualizing OCD (Wells, 1997).

Assessment of OCD in CBT. CBT assumes dysfunctional patterns of thinking as core to OCD, so it focuses on identification and measurement of thought errors (Wells, 1997). Different scales are used to assess cognitions, thoughts and beliefs regarding OCD, some of them including Irrational Beliefs Regarding Obsessions (Freeston, Ladouceur, Gagnon,& Thibodeau,1993), Multidimensional Perfectionism Scale (Frost, Marten, Lahart, &Rosenblate,1990), Guilt Inventory (Kugler& Jones,1992), Thought-

Action Fusion Scale (Shafran, Thordarson,&Rachman, 1996),The Responsibility Attitudes Questionnaire (RAS; Salkovskis et al, 2000), The Interpretation of Intrusions Inventory (III; Obsessive Compulsive Cognitions Working Group [OCCWG], 2001), Obsessive Belief Questionnaire (OBQ; OCCWG, 2001) and many more.

OBQ assesses the several dimensions of cognitive beliefs regarding OCD (OCCWG, 2001). Thus it has an advantage on other measures described above.

Obsessive Beliefs Questionnaire (OBQ). In 1995, Obsessive Compulsive Cognitions Working Group (OCCWG) started work to develop a measure to assess obsessive beliefs. The measure was called Obsessive Belief Questionnaire (OBQ). Initially it comprised of 129 items but later reduced to 87 items that represent different dysfunctional assumptions containing six domains: tolerance of uncertainty, control of thoughts, importance of thoughts, overestimation of threat, perfectionism, and responsibility (OCCWG, 2001).Later, a shorter version of OBQ, consisting of 44 items, was developed. It contained three subscales based on dysfunctional beliefs: importance and control of thoughts, perfectionism/certainty, and responsibility and threat estimation. Items are scored on 7-point Likert scale, ranging from 1= totally disagree and 7 = totally agree (OCCWG, 2005).

Initial analysis of reliability and validity of OBQ-87 provided evidence for remarkable reliability and validity. Correlation coefficient for test-retest reliability of subscales was found to be between .75 and .90(OCCWG, 2001). Evidence has shown good criterion and convergent validity of OBQ-87 (OCCWG, 2003) .OBQ-44, high internal consistency was found for total OBQ and its three subscales, ranging from .89 to

.95. Evidences were found for good criterion related and convergent validity and promising but a little bit weaker discriminant validity (OCCWG, 2005).

It has been observed that the score of OCD patients on OBQ and its all subscales is higher than other non-clinical individuals. Moreover, some subscales of OBQ has also been found to have significant correlations with other measures of OCD symptoms (OCCWG, 2001, 2003, 2005). This shows the usefulness of OBQ in assessing dysfunctional beliefs in patients with OCD. On the other hand, a study found medium effect size of behavior therapy, exhibited by OBQ-87 (.61) and OBQ-44 (.60). This low effect size showed doubts regarding the use of OBQ as main test to examine treatment change. The similarity between affect size of both versions of OBQ showed no effect of revision on its sensitivity to treatment change (Anholt et al., 2010).

OBQ has also been widely used in different cultures, for instance it has been translated and psychometrically analyzed in Italian (Sica et al., 2004), French (Julien et al., 2008), Turkish (Cagin& Dag, 2009), Arabic (Rahat, Rahimi, &Mohamadi, 2012), Brazilian (Bortoncello, Vivan, Gomes, &Cordioli, 2012) and many others.

In present study, OBQ-44 was selected to use for the assessment of obsessive beliefs' intensity.

Treatment of OCD

Literature that is available on OCD treatment suggests the importance of behavior therapy, cognitive behavior therapy (CBT) and pharmacotherapy. Medication and CBT are thought to be the first line treatment for OCD and related disorders (Dell'Osso et al., 2007).

Exposure and Response Prevention. Behavioral approaches for the treatment of OCD are based on theory of learning. It hypothesizes that due to the process of conditioning an association develops between obsessions and anxiety. Several compulsions and avoidance behaviors avert the extermination of this anxiety (Veale, 2007). To reduce this anxiety it is required to expose the person with obsessive stimuli and prevent him to respond (Wells, 1997). On the basis of this theory the technique of 'exposure and response prevention' (ERP) was formed, in which an individual is exposed to an anxiety provoking obsessional stimuli and then helped to avoid compulsions and rituals (Veale, 2007). By repeating this strategy again and again anxiety habituates and this leads to extermination of compulsive rituals (Wells, 1997).

ERP has been proved effective for treatment of OCD and the symptoms proved to be maintained up to five months (Abramowitz, 1998), two years (Marks, Hodgson, & Rachman, 1975). ERP also proved effective in intensive treatment (Abramowtiz, Foa & Franklin, 2003). Although different studies have proved the efficacy of ERP yet its results must be considered according to the rate of dropout of patients from the treatment. Stanley and Turner (1995) stated that 20 to 30 percent patients tend to refuse to participate in treatment or may drop from treatment. Similarly another survey indicated that 25% patients refused to take ERP as treatment or drop the sessions (National Collaborating Centre for Mental Health, 2005; as cited in Veale, 2007). Poor prognosis is related to severe avoidance; expressed hostility from family members; overvalued ideation; hoarding (Veale, 2007). It has also been observed that comorbidity (particularly with depression) also affects the outcome of ERP (Abramowitz &Foa, 2000; Abramowitz, Franklin, Street, Kozak, & Foa, 2000).

New methods and conceptualizations are required for considerable advances in treatment efficacy. Cognitive behavioral approaches and treatment hold promise in this view (Whittal & McLean, 1999). When ERP was compared to CBT, it was revealed that ERP affect 59% participants at post treatment and 58% at follow up while CBT proved to be effective for 67% participants at post treatment and 76% at follow up (Whittal, Thordarson, & McLean, 2005). Group ERP was found to be more effective than Group cognitive therapy (Whittal, Robichaud, Thordarson, & McLean, 2008). Patients treated with ERP exhibit more improvements in their symptoms as compare to patients who received Cognitive therapy without ERP (van Oppen et al., 1995).

Cognitive Behavioral Therapy (CBT) for OCD

Cognitive behavioral treatment for obsessive-compulsive symptoms is based on the idea that development and maintenance of OCD is because of negative and false appraisals of intrusive thoughts, impulses, or images as a dreadful and highly significant cognition that must be dealt with some compulsive action, neutralizing behavior or avoiding response (Rachman, 1997). Therefore the general aim of treatment is to target and modify dysfunctional beliefs and appraisals regarding intrusive experience. Therapy usually focuses on beliefs regarding the threatening nature of intrusions, beliefs concerning ritual or checking behaviors, and fusion in actions and thoughts (Wells, 1997). Clark (2004) identified six main objectives of CBT for the treatment of OCD:

- To regulate the obsessions;
- To decrease the importance of the obsessions;
- To reduce compulsive actions and other ways of neutralization;
- To discover unique patterns of appraisal of client;

- To alter core faulty beliefs;
- To relinquish efforts of mental control;

For this purpose, it is important to manipulate the rumination and behavioral strategies of individual in a way that increases the capability for belief change (Wells, 1997).To alter and modify faulty appraisals and beliefs CBT manipulates both cognitive and behavioral interventions (Clark, 2005).

CBT Role in OCD Management

Various studies have discussed the role of CBT in treating OCD. The studies conducting CBT with reference to its effectiveness for OCD can be divided mainly into five types mainly which are: (i) studies conducted to evaluate CBT models' accuracy, (ii) outcome studies based on individual sessions and based on group sessions, (iii) single case studies, (iv) comparative studies with medication and Behavior therapy, and (v) meta-analysis of outcome studies of OCD. Overall these studies have proved the effectiveness of CBT in management of OCD in different settings, formats, and patterns.

Significance of CBT models of OCD. The CBT theorists and researches have studied the validity of CBT models and assumptions by assessing the convergent validity of CBT-based tools with diagnostic tools of OCD, also by measuring the sensitivity to change in scores after CBT implementation on OCD patients, and comparing non-clinical population with OCD on CBT-based tools. The assumption behind these studies is that if CBT models are authentic in their OCD explanation then tools measuring dysfunctional thoughts should have positive correlation with OCD severity and also should be change (in OCD symptoms) sensitive.

Several studies were conducted in this reference for example; relationship between obsessive compulsive symptoms and OCD relevant obsessive beliefs was investigated by Faull, Joseph, Meaden, and Lawrence (2004) on a sample of 154 participants including clinical and non-clinical population. Analysis of data indicated strong inter-correlation among the domains of obsessive beliefs. When depression and anxiety was controlled, a significant relationship was found between total obsessive beliefs and subtypes regarding obsessional symptoms.

Similarly, in 2009, Julien, O'Connor and Aardema conducted a study to explore whether there is a difference in context of occurrence and content of intrusive thoughts between non-clinical population and clinical patients with OCD. Thirty-three participants with OCD and 90 non-clinical subjects participated in the study. Results suggested that the intrusive thoughts in OCD patients and non-clinical participants were similar in content yet they were different in context of occurrence. Results of chi square analyses indicated that intrusions experienced by OCD patients were more probably to be associated directly with triggers in the environment at the time of occurrence. On the other hand, non-clinical subjects were more possibility be directly associated with observations in here and now. This reflects the difference of thinking patterns between OCD and non-clinical people thus confirming the CBT assumption.

Tolin, Worhunsky, Brady and Maltby (2007) conducted a research to study the relationship between obsessive beliefs and use of maladaptive thought control strategies in a sample of 77 OCD patients and 35 anxious control patients. Regression analyses indicated that beliefs about the Importance/Control of Thoughts accounted for the relationship between OCD and the use of Punishment as a thought control strategy. In

addition to prove the construct validity for the OBQ-44, the results of that study also suggest that OCD patients, believing their intrusive thoughts to be particularly important and perceiving a need to control them, overuse maladaptive thought control strategies but instead of being helpful, these strategies backfire and trigger additional intrusive thoughts.

CBT suggests certain types of cognitive distortions being prominent among thought pattern of OCD patients which are responsibility, perfectionism, thought action fusion and need to control thoughts (Clark, 2004). Studies also addressed to evaluate the role of these specific logical errors in OCD occurrence. Among those studies, a research conducted by Shafran, Thordarson, and Rachman (1996) studied the construct of thought action fusion (TAF) and evaluated its relatedness to responsibility and OCD. Results of the study showed TAF as a very reliable construct among obsessional people. Results also showed a relationship between likelihood type of TAF and checking behavior, and this relationship was significant after controlling for depression.

Current cognitive models of OCD proposed the contribution of three kinds of dysfunctional beliefs in developing and maintaining the obsessive compulsive symptoms. These three kinds of beliefs included over-importance and desire to control the intrusive thoughts (ICT), Perfectionism and the intolerance of uncertainty (PC), and Inflated subjective responsibility and the overestimation of threat (RT). For better understanding of the association between beliefs and symptoms Taylor et al. (2010) assessed the data of a large non-clinical sample. Data regarding beliefs and symptoms of OCD of 5015 participants was analyzed through structural equation modeling. Results showed the relationship of ICT with obsessions, washing and neutralizing compulsions beyond the

effects of PC and RT. Ordering rituals were predicted by PC beyond the effects of RT and ICT. Similarly, far from the effects of ICT and PC, all of the six main kinds of obsessive compulsive symptoms (obsessing, checking, washing, hoarding, ordering, and neutralizing) were significantly predicted by RT. All the three kinds of beliefs were also found to be strongly associated with one another thus by affecting one another these sequentially influence the obsessive compulsive symptoms.

Clinical observations suggest that OCD patients suffer from feelings of excessive responsibility for harms to self and others. These observations persuaded many researchers to investigate the role of inflated perception of responsibility for harm among OCD patients. A study conducted by Foa, Amir, Bogert, Molnar and Przeworski (2001) compared the non-anxious control patients (NACs), Anxious control group with generalized social phobia (GSPs), and with OCD patients (OCs) on the Obsessive-Compulsive Responsibility Scale (OCRS) with N=45 (n=15). The researchers concluded that results supported partially the hypothesis that an inflated perception of personal responsibility underlies the pathology of OCD.

Wilson and Chambless (1999) also studied the role of inflated responsibility in the maintenance of OCD. It was hypothesized that there is an association between obsessive compulsive symptoms and responsibility. Relationship between automatic thoughts about causing harm, pervasive responsibility, and severity of obsessive compulsive symptoms was assessed by using different measures. Findings supported the contribution of pervasive responsibility in predicting obsessive compulsive symptoms. Moreover, automatic thoughts about causing harm appeared to mediate this relationship.

Cougle, Lee, and Salkovskis (2007) assessed the significance of cognitive model that support the role of inflated responsibility in OCD symptom development. Researchers aimed to evaluate the effects of inflated responsibility on obsessive compulsive (OC) checkers. Results supported the cognitive model that patients with OCD tend to experience greater sense of responsibility.

Parrish and Radomsky (2006) also studied the contribution of inflated perceptions of responsibility in compulsive checking by conducting an experimental study with a sample of non-clinical participants (N = 100). As predicted, manipulations of perceived responsibility/threat had a significant impact upon participants' urges to check, their urges to seek reassurance, and their confidence in outcome. The higher levels of perceived responsibility/threat were associated with the maintenance of compulsive urges and performance-related doubt following the completion of a complex experimental task. Also, as predicted, neither manipulations of responsibility/threat, nor manipulations of reassurance affected memory accuracy. These findings provided additional support for leading cognitive-behavioral models of OCD which emphasize the importance of perceived responsibility and threat perception in maintaining obsessional thinking.

Similar topic was studied by Radomsky, Lavoie and Dugas (2005) in an experimental study to assess the cognitive factors in compulsive psychopathology. Responsibility was manipulated and participants were allocated in two groups, one with high responsibility and the other with a low level of responsibility. They were demanded to check substance having two levels of harm seriousness, and two levels of harm probability. Time taken in checking behavior and frequency of checking was observed. Results revealed that inflated responsibility and increased harm perception resulted in

more time spending in checking. This association was observed more in individuals diagnosed with OCD which confirmed the CBT assumptions for OCD.

Bouchard, Rhéaume, and Ladouceur (1999) studied the role of perfectionism and increased responsibility in the development and maintenance of OCD. It was concluded that there was an association between checking behaviors and perception of greater responsibility. Perfectionist tendencies were also found to be linked with increased responsibility and personal influence.

It was speculated that certain obsessional beliefs patterns are related to specific OCD subtypes and/or symptoms. O'Leary (2005) explored the relationship between obsessive compulsive symptoms and different cognitive beliefs and appraisal processes. On the basis of models of Salkovskis and Rachman, a series of three studies was conducted. Results indicated significant associations between symptom-based subtypes of OCD and cognitive beliefs. Specially, thought-action fusion was found to be higher in hording subgroup than contamination group. The symmetry subgroup showed higher scores on perfectionism as compare to contamination group and also demonstrated significantly higher levels of anxiety than the aggressive group while working on perfectionism task. Lastly, beliefs related to overestimation of threat were found to be high in contamination subtype. There were no statistical differences between groups for intolerance of uncertainty, responsibility and controllability of thoughts. In conclusion, all the studies exhibited that in certain cases of OCD some beliefs seem highly relevant, however in others they are not.

Abramowitz, Khandker, Nelson, Deacon, and Rygwall (2006) also addressed this issue by conducting a study to prospectively examine the role of dysfunctional beliefs in

the development of OCD. Study found that when OCD symptoms were assessed according to a dimensional perspective, dysfunctional beliefs were found to be associated with washing, checking, and obsessional symptoms but not with hoarding, ordering, or neutralizing symptom dimensions. The findings of this research support the cognitive model that focus on dysfunctional beliefs as vulnerability factor for OCD.

Rector, Cassin, Richter, and Burroughs (2009) studied the cognitive vulnerability model in familial context. Cognitive vulnerability model proposed that dysfunctional beliefs and negative appraisals work behind the development of OCD. Results suggested that first degree relatives of OCD patients used to experience more dysfunctional beliefs of overestimation of danger and exaggerated sense of responsibility as compared to non-clinical community controls. For relatives of OCD patients with an early onset achieved higher scores on OBQ domains of both inflated responsibility and overestimation of threat and also on domains of intolerance of uncertainty and perfectionism. These results supported the familial cognitive vulnerability model for OCD.

In essence, the research data available on CBT models' validity is indicative of the role of cognitive distortions and dysfunctional thinking in OCD occurrence and maintenance.

CBT with specific types of OCD. The efficacy studies of CBT became so advance and refine that CBT efficacy was determined with specific types of OCD such as Pure 'O', hoarding, perfectionisms and so forth. As example of these types of studies, Ladouceur et al. (1996) assessed the effectiveness of a cognitive therapy for treating OCD. A multiple baseline across subjects design was used to treat the checking rituals in four patients diagnosed with OCD. Cognitive therapies were used to target inflated

responsibility but ERP was not used. All the patients reported 52-100% decrease in the scores of Y-BOCS and significant reductions in problems associated with rituals and in the level of perceived responsibility. For three patients, advantages of the therapy were also maintained at 6 and 12 months follow up. Results indicated cognitive therapy as an effective alternative of ERP in targeting inflated responsibility.

The treatment of obsessional thoughts without any compulsions (Pure 'O') has been a challenge for E/RP but CBT claims to be effective in dealing with this symptom too. Freeston et al. (1997) assessed the effects of cognitive behavioral treatment in treating obsessive thoughts in 29 Pure 'O' patients in a randomized-control trial. Participants were randomly divided into two groups one received the treatment and other was in controlled condition. Patients in the treatment condition received cognitive behavioral treatment including a thorough description of the development and maintenance of obsessive thoughts, exposure to these obsessive thoughts, prevention from maladaptive rituals, cognitive restructuring, and relapse prevention. An improvement was seen in patients who received psychotherapeutic treatment as compared to wait-list controls. Patients who got benefit from the therapy reported low scores on self-report OCD symptoms, measures of obsessional severity, anxiety and current functioning. When patients who were in the waiting list received treatment they also exhibit improvements. These gains remained the same at 6-month follow-up. Overall results indicated the effectiveness of CBT in treating obsessions.

Whittal, Woody, McLean, Rachman, and Robichaud (2010) also examined the cognitive behavioral method of Rachman for treatment of obsessions without noticeable overt compulsions. A comparison was made among cognitive behavioral treatment,

waitlist control and stress management training (SMT) on a sample of 73, among those 67 completed the treatment and 58 were available for 1 year follow up assessment. Results showed a significant reduction in OCD related cognitions, Y-BOCS scores and depression in both groups who received active treatments as compared to waitlist controls. Improvement in social functioning was also observed in participants receiving some treatment. No specific differences were observed between SMT and CBT for reducing the symptoms.. Comparing to SMT, OCD-related cognitions were affected largely by CBT. The cognitive changes remained constant at 12 months follow-up. The strong and lasting effects of both treatments challenge the old conviction that obsessions are unaffected by treatment.

In the line of this, Belloch, Cabedo, Carrió, and Larsson (2010) studied the differential effectiveness of cognitive therapy for autogenous and reactive obsessions on a sample of 70 participants 81.40% completers 72.82% were available for one year follow up. Pre-treatment assessment indicated clear differences between the two obsession modalities. Patients with reactive obsessions were observed to be more severe in terms of co morbidity, worry proneness, compulsions, longer duration of symptoms, and medication requirement. They also scored high on measures of perfectionism, intolerance of uncertainty, and thought suppression. On the other hand, patients experiencing autogenous obsessions exhibited over-importance regarding thought beliefs. Post treatment assessment showed that all the patients gained benefit from cognitive treatment. A reduction was seen in obsessive compulsive symptoms, dysfunctional beliefs, and neutralizing strategies. For patients with autogenous obsessions rate of recovery was 73.33% at post-treatment, while reactive obsessional group exhibited only

33.33% recovery rate. This showed that patients experiencing autogenous obsessions achieved significantly better outcomes at both post-treatment and one year follow up assessments.

Tolin, Frost, and Steketee (2007) studied the effectiveness of a cognitive behavioral treatment for compulsive hoarding. Fourteen adults with hoarding as main symptom and whose ages were 18 years or above were included in the sample through a semi-structured interview. Participants who were not receiving any psychological treatment received CBT in 26 sessions. Participants were assessed by using Saving Inventory-Revised (SI-R), Clutter Image Rating (CIR) and Clinician's Global Impression (CGI). Ratings were taken at both pre- and post- treatment levels. Results suggested significant reduction in ratings of SI-R and CIR. No improvement was seen in CGI-severity index but ratings on improvement domain of CGI, at mid-treatment, showed 40% of treatment completers as much improved or very much improved. When ratings were taken again at post-treatment, they identified 50% treatment completers, who were improved due to therapy. Adherence with homework assignments exhibited a strong link with improvement in symptoms. CBT techniques that focus on specific problems of motivation and organizing, acquiring and removing clutter were found to be promising interventions to treat compulsive hoarding.

Perfectionism is acknowledged as a predisposing factor for the development and maintenance of depressive and obsessive compulsive symptoms. The aim of the study by Pleva and Wade (2007) was to investigate the efficacy of a cognitive-behavioral self-help therapy for dealing with perfectionism, and to observe the influence of such treatment on the symptoms of OCD and depression. Two groups of patients were compared regarding

the effectiveness of two treatment protocols, Guided-self help (GSH) and Pure self-help therapy(PSH). Results indicated the effectiveness of both PSH and GSH in reducing perfectionism as well as the decreasing the symptoms of OCD and depression. Benefits of treatment also continued up to 3-month follow-up. Overall the finding of the study highlights the effective role of self-help in reducing perfectionism and the symptoms of OCD and depression, with PSH being inferior to GSH.

The article by Ferguson and Rodway (1994) illustrated an empirical social work study that tested the usefulness of cognitive behavioral treatment of perfectionism. The change in symptoms due to treatment was analyzed through a single-system design. Data were collected through three measures, one self- anchored and two standardized, around the stages of the ABA design. The study was repeated with nine patients. Data analysis showed a significant decline in the levels of perfectionism due to the use of CBT. Findings also highlighted important issues related to perfectionism, including procrastination, self-criticism, idealistic goal setting, and problems in dealing with feedback.

Conclusively, these studies reflect the widely effective remarkable role of CBT in dealing with different types of OCD and of cognitive distortions.

CBT efficacy for cognitive change. Dysfunctional beliefs are thought to underlie the symptoms of OCD and CBT claims to address logical errors causing and maintaining obsessional symptoms. Efficacy studies of CBT focused the role of CBT in managing these dysfunctional thought patterns which consequently lead to minimize the severity of disorder. In 2004, Dalfen studied the role of CBT in changing these dysfunctional beliefs. Cognitive behavioral treatment was given to 32 treatment resistant patients with OCD.

The objectives of the study were to examine the relationship between OCD symptoms and dysfunctional beliefs at pre-treatment, to identify the amount of change in OCD symptoms and beliefs during CBT, and to evaluate the relation between symptom change and belief change. Different diagnostic and obsessional thoughts' related tools were used as study measures. Findings showed that severity of dysfunctional beliefs, assessed at pre-treatment, affect the symptomatic response of patients during the treatment. Especially scores on overestimation of threat (OBQ domain), and change, unpredictability, and newness (domains of VSS) predicted patients' symptomatic response. Patients whose symptoms were reduced also exhibited reduction in beliefs due to therapy. Similarly, patients whose symptoms remained unchanged also showed no change in beliefs. Change in symptoms was predicted by changes in over estimation of threat and over-control of disturbing thoughts. Overall, results provided evidence that dysfunctional thoughts regarding threat have importance to determine the response of patients towards CBT treatment.

Meta-cognitive Therapy (MCT) is a different form of CBT that is based on meta-cognitive model that aims to target the maladaptive meta-cognitive beliefs instead of reducing the content of anxious beliefs. MCT integrates behavioral strategies and cognitive techniques. Rees and van Koesveld (2008) conducted a study in which they used MCT as the treatment strategy for eight adult patients experiencing different complaints of OCD. The results of this randomized control trial were proved to be promising, and effectively reduced the symptoms of seven out of eight clients at 3-month follow-up. All the patients exhibited reduction in scores of Y-BOCS and measures of metacognitions.

In 2008, Fisher and Wells also evaluated the metacognitive therapy of OCD. An AB replication across participants design was applied on four patients with OCD. Total 12 sessions of MCT were delivered to participants except one who received 14 sessions. The goal of MCT is to make patients aware of their thoughts regarding obsessions and compulsions not as facts but as mere mental events that have no need to process further. For this, it is required to modify these metacognitive beliefs regarding obsessions and compulsions, to reduce levels of distress, rumination and self-focused attention and to replace maladaptive coping strategies with adaptive strategies. Fisher and Wells assessed the participants at baseline, post-treatment, and at 3-month and 6-months follow-up. Results showed significant reductions in obsessive and compulsive symptoms at post-treatment and at 3-month and 6-months follow-up. Therapy also produced changes in metacognitive beliefs of patients about obsessions and compulsions. Results proved effectiveness of therapy in cognitive change.

Another form of CBT is integrative cognitive therapy that focuses on dealing with cognitive schemas and was developed by Sookman and colleagues in 1994 for treatment resistant patients. Multiple cognitive factors regarding OCD, ranging from appraisals to beliefs, are studied in this therapy. The therapy targets various domains like response to change, unpredictability and newness; vulnerability; and response view to strong effect, along with perfectionism, increased responsibility, and over importance of thoughts. In a study, integrative cognitive therapy was applied on seven treatment resistant subjects. Therapy was found to be effective in improving patients' symptoms from moderately severe to subclinical level. A reduction in the severity of dysfunctional beliefs was also observed (Sookman & Pinard, 1999).

CBT with specific groups. The effectiveness of CBT in treating OCD patients with limited cognitive functioning was studied by studied by Pence Jr et al. (2011). CBT was applied on three adults with borderline intellectual functioning. The therapy was adapted according to the intellectual abilities of patients and the modifications include use of simplified language, addition of strategies regarding contingency management, reduced dependence on cognitive techniques, increased parental involvement and role modeling by caregivers. All the patients exhibited significant decreased in symptoms of OCD at post treatment.

Williams et al. (2010) carried out a randomized controlled trial of CBT for children and adolescents in a standard outpatient clinic, where the focus used to be on cognitions. Twenty one young people, between 9-11 years of age, with OCD were randomly allocated either to the group who received 10 sessions of CBT or to the waitlist control group. Patients who received treatment exhibited significant improvement are compared to the participants who waited for 12 weeks, for treatment, but when control group received treatment they also showed similar improvements. The study concluded that CBT can be effectively delivered to children and adolescents with OCD in typical outpatient settings. Collectively, these two studies' findings are indicative of satisfactory efficacy of CBT with individuals with low comprehension level thus encouraging CBT application with uneducated and/or less educated persons, after tailoring CBT according their intellectual and comprehension levels. This pattern was adopted in current study in which protocol was devised not only in first language of target population but also in simple language and style so that less educated persons of target population could be benefited from CBT.

Different formats of CBT. The extensive work on CBT effectiveness with OCD is reflected from researches conducted to assess its effectiveness in different forms such as in individual and group settings, in intensive and weekly patterns, and so forth.

Such as, Storch, Merlo, Lehmkuhl et al. (2008) conducted a research to evaluate the efficacy of CBT for adult patients with OCD. A comparison was made between intensive and weekly approaches of CBT, in order to assess that which is more effective in treating obsessive compulsive symptoms. Sample consisted on 62 OCD patients. Thirty patients received CBT on weekly basis in 14 sessions and 32 patients received CBT sessions daily. Raters who were not aware of treatment group at pre-treatment measurements conducted the assessments at pre-treatment, post-treatment, and 3-month follow-up. Both intensive and weekly treatment programs showed large effect sizes (2.94 for intensive and 2.04 for weekly program). Treatment gains were maintained at 3-months follow-up. This shows the short term effectiveness of CBT.

The study by Oldfield, Salkovskis, and Taylor (2011) enhances applicability and efficacy of intensive format treatment. They also compared weekly and intensive treatment formats while using integrated formulation-driven CBT approach. A comparative analysis was conducted between weekly and intensive treatment format. Twenty-two patients received CBT treatment in intensive time format and were matched with patients in the other group format regarding gender, age and initial symptoms. The participants were assessed at the end of the treatment and at 3 months follow up. Results of the study concluded that therapy given in intensive format was as effective in treating the symptoms of OCD as weekly treatment.

Tolin et al. (2007) conducted a study to compare the effectiveness of therapist-administered and self-administered cognitive behavioral therapy in 41 adult patients with OCD. The sample was taken from an outpatient psychiatry clinic, associated with a hospital. Participants were experiencing chronic symptoms with moderate severity and had received some medication earlier but were unaware of exposure and response prevention (EPR) that was used in the study as basis therapeutic technique. Patients were randomly assigned to self-administered therapy and therapist-administered therapy. In self-administered therapy a clinician helped and guided the patients to understand and to apply the technique and in therapist-administered therapy treatment was delivered by a trained doctoral-level psychologist. Ratings were taken at pre-treatment, post treatment and after 1, 3 and 6 months of treatment. Results suggested a significant decrease in symptoms in both treatment conditions. Although both treatment conditions proved to be effective in reducing OCD symptoms yet therapist-administered therapy showed significantly higher symptom reduction that self-administered therapy. It also found to be more effective in improving quality of life of patients, assessed by functional capacity to work, family life and social life. Overall, treatment completers exhibited a 46% decrease in Y-BOCS scores. These results highlighted the importance of taking proper CBT from trained professional. It also reflects the CBT role as self-therapy for those where proper relevant services are not available.

Similar to previously mentioned research, Rosqvist, Thomas, and Egan (2002) conducted a study to assess the effectiveness of home based cognitive behavioral treatment in four patients diagnosed with OCD. Before this, all the participants received different interventions including pharmacotherapy and CBT in various settings (e.g. day

program, inpatient, and outpatient), but they failed to respond all these treatments and were considered chronic and non-compliant to treatment. Assessments through Y-BOCS were carried out before treatment, after treatment and at 18-month follow-up. Results of the study suggested that three out of four patients responded positively towards treatment. Significant benefits due to therapeutic treatment were achieved by the three patients at post treatment and two patients also exhibited similar gains after 18 months of treatment. Data proposed overall improved adjustment for three of the patients at follow-up. This study establishes the efficiency of home-based CBT for prolonged, refractory OCD.

Himle et al. (2006) assessed the efficacy of CBT given by video conference. It is very difficult for everyone, especially in rural areas, to gain access to the treatment and to obtain benefit from therapy. For this, Himle and his colleagues organized some video conference sessions of CBT for treating three patients. Structured clinical interviews were conducted for identifying the presence of OCD and outcome measures were completed by evaluators who were blind to the treatment procedure. A multiple baseline design across participants was used to assess the data. Patients received treatment over 12 weeks and post-treatment measurement showed a significant reduction in total Y-BOCS scores and in checking/repeating, hoarding, and cleaning/contamination rituals. Follow up ratings also supported the consistency of videoconferencing based CBT. Improvements in social and work adjustment were also observed.

CBT has proved to be an effective treatment for OCD but access to therapist is a little bit difficult. In this case internet based cognitive behavioral therapy (ICBT) through therapist can be a more easily accessible treatment protocol. The study by Andersson et al. (2011) aimed to explore the efficacy of ICBT for the treatment of OCD. Twenty-three

patients participated in an open trial and attend an ICBT program with therapist support for 15 weeks. The program consisted on cognitive restructuring, psycho-education, and ERP. Participants were assessed before and after treatment. Primary assessment measure was Y-BOCS, while secondary measures included self-rated measures of depressive symptoms, OCD symptoms, anxiety, quality of life and general functioning. Results exhibited significant reductions in symptoms of OCD with a large within-group effect size (Cohen's d = 1.56). Symptoms of 61% of patients improved significantly and 43% of patients did no longer meet the OCD criteria. Significant improvements in self-reported depression, obsessive compulsive symptoms and general functioning were also observed. Overall, ICBT proved an effective technique for the treatment of OCD.

Cordioli et al. (2002) conducted a study to develop a technique of cognitive-behavioral group therapy (CBGT) and to prove its efficacy in reducing the symptoms of OCD. Thirty two patients with OCD participated in an open clinical trial, in which a CBGT technique was applied in 12 sessions. Therapy sessions were consisted on two hours and were provided on weekly basis. Hamilton Depression (HAM D) scale, Hamilton Anxiety (HAM A) scale and Y-BOCS were used to assess the symptom severity at post treatment and after three months of the treatment. A significant decrease in the scores of HAM D, HAM A and Y-BOCS scales was found after treatment irrespective the use of medications. There was a decrease of 35% or more in Y-BOCS scores and the rate of patients who improved was 78.1%. The effect size of1.75 was calculated for Y-BOCS scale. Overall, the study results recommend that CBGT lessens symptoms of OCD and patients show good compliance to the therapy.

Braga et al. (2005) assessed the relapse prevention effects of cognitive behavioral therapy (CBT) in group settings on the patients with obsessive compulsive disorder (OCD) and effects of demographic variables of subjects on CBT efficacy was also evaluated. Twelve sessions of CBT were conducted for a group of 42 patients with OCD. Subjects were also followed for one year. Results indicated cognitive behavioral group therapy as a good treatment for OCD. A clear symptom reduction was observed at the end of the treatment and the effects were sustained during 1 year. Overall 31 (73%) subjects were observed to be improved but after one year one more subject showed improvement. In the subsample of 31 subjects 11 (35.5%) subjects relapsed over the 1 year period of follow up. Only intensity of reduction in symptoms and full remission strongly predicted non-relapsing.

In 2007, Anderson and Rees conducted a controlled study to compare group cognitive behavioral treatment and individual cognitive behavioral therapy. CBT including both cognitive and behavioral components was applied in either individual or group settings. Subjects were randomly allocated to either 10 week of group CBT sessions, 10 weeks of CBT in individual sessions, or 10 weeks waiting list. To improve generalizability of findings, patients with secondary comorbid conditions were incorporated in the sample. Completer analysis and intention to treat analysis were applied on the data and results showed significant reductions in OCD symptoms in both group and individual settings. Effect sizes for both conditions were found to be large. Results indicated equivalence of both therapeutic conditions at follow up.

Reflecting on these findings, it can be claimed that CBT has been found much effective for the management of OCD in its diverse formats and its effectiveness is not limited to conventional individual-clinic-based intervention style.

CBT and Quality of Life (QOL). An important diagnostic criteria of DSM-V for OCD is personal and psychosocial distress level which consequently affects ones' quality of life. Although, the efficacy of CBT in reducing OCD symptoms is well documented, less is known about its effects on quality of life (QOL). In the study conducted by Diefenbach, Abramowtiz, Norberg and Tolin (2007), functional impairment aspects of QOL were assessed among 70 adult outpatients with OCD before and after CBT. Statistically significant improvements in QOL and large pre- to post-treatment effect sizes were observed for work, social, and family functioning. Improvements in social and family functioning were predicted by improvements in OCD symptom severity even after controlling for improvements in depressive symptoms. In addition, clinically significant change in OCD symptoms and QOL were highly related. These results suggested that the effects of CBT may extend beyond OCD symptom reduction to improvement in quality of life.

Similar to this, Cordioli et al. (2003) designed a research to validate the effectiveness of Cognitive Behavior Group Therapy (CBGT) in decreasing symptoms of OCD and the strength of overestimated thoughts, as well as in increasing the quality of life of patient. A sample of 47 patients diagnosed with OCD was randomly allocated to either treatment group or control group. The treatment group received 12 sessions of CBGT weekly while control group was consisted on participants who were placed in waiting list. A 3-months follow was also conducted for treated patients. A significant

reduction was found in symptoms and a significant improvement was observed in quality of life. Benefits of therapy maintained and even the symptoms were reduced more at 3-months follow up assessment. The results propose that CBGT effectively reduces the OCD related thoughts and symptoms and is also helpful in improving the quality of life of patients with OCD.

Meta analysis. A considerable data is available on meta analysis of efficacy studies on the basis of which it can be concluded that CBT has established its reasonable effectiveness with psychiatric disorders. For example, Podea, R. Suciu, Suciu, and Ardelean (2009) conducted a systematic review of the literature regarding the development of a valuable psychological treatment for OCD. Results of the review indicated that cognitive behavioral treatment is an effective treatment for dealing with anxiety disorders. Amongst all these techniques, exposure and response preventions (ERP) was found to be first psychological method validated by empirical researches. Various researches have proved the efficacy of ERP, and on a minor level, of cognitive therapy, alone and in combination with other treatments. However, complete remission of symptoms due to treatment is rarely seen. The effectiveness of psychotherapy is found to be similar to the efficacy of SSRI pharmacotherapy, but its effects didn't maintain over time. The research has also shown that CBT is effective in modifying the functions of brain in the cortical-subcortical circuit that is accountable for the physiopathology of OCD.

Cordioli (2008) studied the literature that described CBT as a treatment of OCD. The researcher reviewed the specialized articles and textbooks and studied the fundamentals, origins, and strategies of CBT for treating the symptoms of OCD. The

efficacy of CBT was also highlighted by reviewing the meta-analyses and randomized clinical trials. Results indicated that approximately 70% of the patients who show compliance with treatment is effectively treated the symptoms of OCD. It was concluded that the cognitive and behavioral model of OCD allowed a better awareness of obsessive compulsive symptoms. It also exhibited a range of therapeutic techniques for reducing the obsessive compulsive symptoms in most of the cases.

Overholser (1999) reviewed the literature on cognitive behavioral treatment for obsessive compulsive disorder in order to provide a brief and meaningful description for psychological treatment of OCD. Researchers concluded that CBT contains four common components: preparation before starting therapy, increase in useful coping skills, exposure with ritual prevention, and prevention to relapse. CBT has proved to be an effective treatment for reducing obsessive compulsive symptoms. It focuses on teaching new and improved coping strategies to patients that can help them in dealing with their anxious thoughts, emotional distress and compulsive rituals. The four component treatment model of OCD can be used and modified according to the needs of each client. This model is most beneficial for the patients with the symptoms of hoarding, cleaning and checking. Sometimes CBT alone cannot benefit the client, due to severity of disorder, and then it is useful to combine medication with it. Overall, study argued that CBT is valuable to use cognitive, and behavioral factors, as well as biological and social elements for treatment of OCD. In short, meta-analysis is suggestive of satisfactory role of CBT in management of OCD.

Overall, western data is suggestive of remarkable capacity of different forms of CBT in management and relapse prevention of OCD, and also in managing dysfunctional

thinking patterns and quality of life. This data is quite rich and diverse in terms of its method and application.

CBT in eastern cultures. Considering its popularity in research and clinical practice in west, the efficacy of western origin CBT has been evaluated in eastern culture too. The eastern researches also followed the similar pattern and nature of researches such as outcome studies, comparative studies of different interventions with CBT and of different forms of CBT, confirming CBT models of OCD, and also single case studies.

In 2005, Ghassemzadeh, Bolhari, Birask and Salavati, examined the responsibility attitude and its role in OCD symptoms among Iranian OCD patients. They took 3 groups (n=20) of OCD, other anxiety disorders and non-clinical participants. All of the participants completed the Responsibility Attitude Scale (RAS), Responsibility Interpretation Questionnaire (RIQ), Y-BOCS, Maudsley Obsessive Compulsive Inventory (MOCI), BDI and BAI. Multiple comparisons on the RAS showed that Obsessional subjects have significantly higher mean scores on the RAS than non-clinical control subjects ($p < .001$) and then anxious control subjects ($p < .001$). To test the second hypothesis that the responsibility interpretation in Obsessional group is higher than control groups the three groups were compared on RIQ by using ANOVA and Scheffe test for post-hoc comparisons. Results showed that Obsessional participants had significantly higher scores on both frequency and extent of belief than the non-clinical comparison group and then the comparison group with other anxiety disorders ($p < 0:001$). Overall, the results are consistent with the theory of Salkovskis that people suffering from Obsessional problems experience an inflated sense of responsibility for possible harm, linked to the occurrence and/or content of intrusive cognitions.

Altin (2004) studied the influences of locus of control, responsibility attitudes, and their interactions on overall symptoms of OCD and their dimensions in a Turkish student sample (N=385). A significant and positive relationship was found between obsessive compulsive symptoms and responsibility attitudes. On the other hand, locus of control did not predict obsessive compulsive symptoms significantly. However, the interaction of responsibility attitudes and locus of control significantly affected symptoms of OCD. When dimensions of OCD symptoms were assessed, responsibility was found to moderately predict checking and cleanliness symptoms and weekly predict rumination symptoms. Locus of control and its collaboration with responsibility predicted only rumination symptoms significantly.

The aim of the study conducted by Yorulmaz, Karanci, Bastug, Kisa, and Goka (2008) was to evaluate the exaggerated sense of responsibility, thought suppression and thought action fusion, factors of cognitive model of OCD, in Turkish patients diagnosed with OCD, patients with other anxiety disorders, and a control group. Results of group comparison revealed that patients with OCD were significantly distinguished from group of patients with other anxiety disorders and control group on responsibility base on thought suppression and self-dangerousness. The results further suggested complete support for the international validity and specificity of cognitive factors and model for OCD.

Ono et al. (2011) reviewed the status of cognitive behavior therapy in Japan. Research claimed that in 1980's, this therapy was familiarized in the field of psychiatry in Japan, and became so popular that in 2004, a complete Japanese Association for Cognitive Therapy (JACT) was originated. They also claimed that CBT was found to be

very effective in Japan for depression and anxiety. It was found from the findings that most of the data is composed of case reports or open trials, and in order to prove the effectiveness more well-controlled RCT with larger sample sizes are needed. Researchers mentioned extra ordinarily low quantitative results of RCT in Japan which they attributed to socio-cultural aspects of psychiatric care of Japan. Among different hindrances in effectiveness of CBT, first and foremost hindrance was reported to be language of Japanese people that questioned the effectiveness of psychotherapy as well as the CBT in Japan as compared to the Western culture. The second major barrier was found as the conservative pattern of Japanese society and their interpersonal styles. Overall, this study tried to explore the application of CBT in Japan according to its socio-cultural distinctiveness.

Alizadeh (2012) conducted research in which he used two methods pharmacotherapy and CBT to treat Iranian women with OCD. It was an experimental study in which sample was randomly selected and divided into two groups. Total 100 patients were studied. Each group has 50 participants who were referred to the mental health centers and counseling centers. First group was given psychopharmacological treatment and the other group received the cognitive-behavior therapy. In the end of the treatment, people of first group who took psychopharmacological treatment were unhappy and unwilling to the continuation and extension of treatment and they were afraid of being dependent on the drugs and it was their major complain while repetition in behavior was shown less in this group as compare to the other group. Like CBT, with psychopharmacological treatment depression and anxiety of the participants was decreased but their irrational beliefs were not managed. The second group who received

CBT treatment had predisposition toward the maintenance of the treatment and they were more satisfied with the obtained success as compare to the other group. Results of the study revealed that CBT is more effective for OCD patients as compare to the psychopharmacological treatment.

Being more inclined to religion in its orientation, eastern researchers focused on role of religiosity in OCD occurrence. In this context, Sica, Novara, and Sanavio (2002) examined religiousness and OCD-related symptoms and cognitions in an Italian population. Total 155 participants with different degrees of religiosity, like high, medium and low, completed secretly the Italian versions of well-developed measure of obsessive-compulsive (OC) cognitions and symptoms, anxiety and depression. When depression and anxiety were controlled, religious group with high degree scored higher as compare to the low degree of religiosity on assessment of responsibility, over-importance of thoughts, obsessionality, perfectionism and control of thoughts. Furthermore, measures of over-importance of thoughts and control of thoughts were also linked with obsessive compulsive symptoms only in religious participants. Results of the study also revealed that religion might play a role in the phenomena of OCD.

Siev and Cohen (2007) studied the relationship between religiosity and thought action fusion in Jews and Christians. Evidence suggests that there is a relationship between obsessive cognitions and religiosity in Christian samples but the uncertainty of empirical findings makes it complicated to interpret that literature and to apply that on non-Christian samples. Results indicated a high score of Christians on moral type of TAF as compared to Jews, as predicted by previous literature. The effect was big and was not account for variations in self-reported religious levels. No difference was observed

between the Jewish groups. Moreover, a significant relationship between religiosity and obsessive beliefs was found only in Christian samples. These results matched the supposed relationship between obsessive cognitions and religiosity. No associations were found between general religiosity and obsessive beliefs; rather it depended on religious group.

The study conducted by Yorulmaz (2007) proposed a comprehensive cognitive model for symptoms of OCD, involving many proximal and distal vulnerability factors. The aim of the researcher was to modify three instruments to test the interrelationships between the symptoms of OCD and vulnerability factors in different cultures. Ten appropriate instruments were given to the university students from Canada and Turkey. Analyses revealed that three instruments, when translated into Turkish language, showed appropriate psychometric properties for Turkish students. Cross cultural differences and similarities were also found in OCD symptoms and vulnerability factors. Symptoms of OCD were found to be related to introversion, age, neuroticism, and OCD-related beliefs on likelihood type of TAF, certainty/perfectionism, and threat estimation/responsibility in both Canadian and Turkish samples. In both samples, the relational paths between non-specific, appraisal and control factors, and symptoms of OCD were also found to be significant. However, the only significant factor in symptoms of OCD was religiousness and it contributed to various control and belief factors toward these symptoms, only for Turkish participants. The analyses on differences of religiousness showed that religiosity was more associated to the psychological fusion in morality and in general for Canadian Christians. Moreover, Turkish participants appeared to use worry more for symptoms of OCD, while self-punishment was used by Canadian students.

In short, there is more similarities found altough certain differences in CBT application and thought patterns of eastern population so the need of adaptation in CBT is highlighted by these studies.

CBT in Pakistan. CBT has been proved a widely applicable therapeutic technique in developed countries. It also has been proved an efficient treatment for dealing with several disorders. Despite all these facts, its efficacy and applicability is quite limited in developing countries, like Pakistan (Naeem, Gobbi, Ayub, & Kingdon, 2010). To enhance the applicability of CBT in different cultures, it is required to make cultural adaptations in the method of CBT. This modification is necessary because of the possible effect of various issues on the application of CBT in non-western countries (Iwmasa, 1993; Laungani, 2004). Like other cultures, therapists in Pakistan also alter the therapeutic strategies according to the cultural and religious practices (Naeem et al. 2010). In Pakistan psychologists also use religious practices as part of the therapeutic process (Murray, 2002).

Naeem et al. (2010) pointed number of obsatcles and problems in implementation of CBT with Pakistani patients such the important component of CBT is use of homework assignments, but patients do not give it much importance. This can be due to low illiteracy rate but educated patients are also observed of not showing interest in homework assignment. Moreover, their expectations from the therapy also affect their engagement and compliance with the therapeutic procedure. Most of the times, they do not expect psychological interventions as treatment. The application of CBT also becomes difficult because the concepts of CBT, like cognitive distortions, are difficult to understand for people and their literal translation does not convey the true meaning of the

concept. Overall, their findings indicated that in Pakistan, directive style is used for therapy in Pakistan and it includes many advices, suggestions and support. This can be due to the cultural aspect that patients used to ask for advice and suggestions (Naeem et al. 2010).

As far as the adaptation of CBT according to the culture of Pakistan concerns, no major efforts have been made to modify the therapy at institutional level. Therapists themselves try to tackle the hurdles and to change the therapeutic procedures according to the needs of patients (Naeem et al. 2010). Moreover, only a limited research work has been done to evaluate the efficacy of CBT in Pakistan, mostly based on single case and/or small-n studies. CBT is found to be effective in treating generalized anxiety disorder (Rehman & Mohsin, 2000), panic disorder (Khan & Kausar, 2005), depression (Hassan &Imam, 1994), Bipolar I disorder (Rehman & Sadiq, 1999), and patients of first-episode of schizophrenia with acute onset (Khan & Malik, 2005).

Rationale of the Study

The available literature on CBT effectiveness with OCD indicated its remarkable role in the management of OCD in developed countries (Clark, 2004; Wells, 1997), but its position as an effective module of psychotherapy with patients of developing countries like Pakistan is yet to be explored more (Naeem et al., 2010). In addition, researches conducted on adaptations of CBT in eastern cultures stressed upon the need to adapt CBT according to socio-cultural needs of target population (Frogatt, 2006; Khodayarifard & McClenon, 2011). These facts collectively instigate the author to adapt the CBT for Pakistani OCD patients and to explore its effectiveness with Pakistani patients of OCD. Naeem et al, (2010) has highlighted lots of problems in implementation of westernized

Cognitive Behavior Therapy (CBT) in eastern, religious, and low-literacy rate society of Pakistan. These practical issues are related to (1) conducting formal and in formal assessment, based on standardized tools in English language and Dysfunctional Thought record forms in Urdu, with illiterate and/or individuals not familiar with English language, (2) educating CBT assumptions to illiterate and less educated people, (3) homework assignments (4) implementing westernized CBT on an eastern population where treatment is only considered pharmacology based approach, (5) unavailability of indigenous CBT-based tools and therapeutic material, and (6) scanty literature on efficacy of CBT with Pakistani population. All these issues pursued author of present study to question effectiveness of CBT, an empirical and educational western approach to psychotherapy, with Pakistani population, and made researcher to work on indigenization of CBT according to socio-cultural needs of Pakistani society.

Acknowledging the importance of cultural factors on CBT application, the very purpose of study in hand was to explore the effectiveness of CBT with Pakistani patients suffering from Obsessive Compulsive disorder (OCD), and to devise a therapeutic protocol for target population in Urdu language. To accomplish this aim, certain milestones had to be achieved by planning four interlinked studies. Among those, exploration of CBT status and recent therapeutic trends in Pakistan (Study 1), adapting the required and relevant assessment measures (Study 2), assessing efficacy of Urdu protocol of CBT for OCD (Study 3), and exploring the process of CBT with OCD in Pakistan (Study 4) were included.

Method

The present thesis comprised of four interlinked studies while employing the combined method research design with special focus on between methods approach, in which the researcher combines multiple methods of data collection and analysis across the studies (Creswell, 1994). Among four studies of this thesis, study 1 and 4 were based on qualitative while study 2 and 3 employed quantitative paradigm. Study 2 was comprised of 2 phases, the detail of each study is mentioned below.

Study 1 (Protocol Development)

The present study was based on qualitative paradigm, which best suits the purpose, to explore and discover the experiences and opinions of relevant professionals in using CBT with patients of Obsessive Compulsive Disorder (OCD) in Pakistan (Cresswell, 1994).

Objective

To discover the adaptations opted by Pakistani professionals and problems faced by them in applying Cognitive Behavior Therapy (CBT).

Inquiry Question. Whether there are any adaptations opted by clinical psychologists of Pakistan in using CBT for adult OCD patients?

Secondary Questions.

- Is CBT found to be effective with adult OCD patients of Pakistan?
- What is the variety of techniques commonly used for the purpose?

- Do professionals follow any specific philosophy of life, other than western views, in case conceptualization and using Cognitive Restructuring for Pakistani patients?
- What types of problems and complications are being faced by professionals in applying CBT for the purpose? Are there any solutions to these problems?

Sample

The sample comprised of five professional, trained, working clinical psychologists of Lahore, Pakistan, selected through Convenience sampling of non-probability type, which involves selection of participants on the basis of their willingness and availability (Cresswell, 1994).

Inclusion criteria. The professionally qualified, trained clinical psychologists having minimum qualification of MS in clinical psychology and formal training in CBT with at least five years' work experience in adult psychiatry setting and at least five years' experience of CBT, and willing to participate in this study were taken in sample of current study.

Exclusion criteria. The exclusion criteria was clinical psychologist less qualified than MS in clinical psychology, without any formal training in CBT, work and CBT experience in adult psychiatric setting less than five years, and those who were not willing to participate in this study.

Instrument

The semi-structured in-depth interview was used as data collection method because it gives clear and vivid description of participants' views about research query (Cresswell, 1994). The interview protocol of this study comprised of 10 semi structured main questions and several probing questions based on explored areas related to topic under consideration. The questions were done from general to specific pattern and for that "funneling" technique was used.

The areas explored in interviews were introduction (bio data), personal Experience with CBT, Assessment in CBT, Models of CBT for OCD, Therapeutic trends and approaches and problems faced by professionals in conducting CBT with OCD patients, and their solutions (See Appendix A).

Procedure

Data collection. In current study, the in-depth interview protocol, devised by researcher based on inquiry questions to attain the objective of this study, was conducted on one-on-one basis in exclusive environment with sample after taking consent. The duration of these interviews were 1 and half hour on an average. Whole data were collected in audio recording form. Before taking interviews, the consent was taken by participants after informing them about purpose and procedure of present research. The interviews were conducted at work places of participants to let them feel comfortable.

Data analysis and reporting. For data analysis, the thematic analysis approach was adopted that was appropriate to the objective of this research because in this research it

was needed to identify and analyze common patterns of views and opinions so that inquiry questions could be answered (Braun & Clarke, 2013).

These recorded interviews were primarily listened and important ideas and views were noted down. Then to ensure the credibility of data analysis, each interview was listened repeatedly and notes were taken accordingly. Then this transcribed data of all interviews was analyzed together to extract themes which are common patterns of thoughts, views, opinions related to inquiry questions (Braun & Clarke, 2013). Then, this analysis was shared with supervisor along with original data and analysis was evaluated. After that, data were compiled in thematic pattern and results were reported to make data meaningful. These results were shared with participants (member checking) to improve credibility of findings (Fereday & Muir-Cochrane, 2006). To obtain transferability of results, the thick description of data were used in reporting the results (Braun & Clarke, 2013.). To ensure the confirmability, the triangulation technique was used. For dependability of results, the analysis was sent for peer review to three professionally qualified, trained clinical psychologists having degree of MS in clinical psychology and research experience (Braun & Clarke, 2013). In short, to make this study credible and rigor, different validation strategies were used.

Ethical Considerations

The in-depth interviews conducted in this study were recorded after taking formal written consent of participants after informing them purpose of study. They were ensured that their identities would not be disclosed while the results were discussed focusing on

common themes without mentioning their opinions with their names. Besides that, they were informed about results of study.

Study 2 (Translation & Assessment)

The study 2 was comprised of two phases based on quantitative paradigm purely while the purpose of this study was to translate the required tools of current study and to assess the symptomatic characteristics and belief patterns of sample C of this study. The objective of phase I was to translate the required tools (The Yale –Brown Obsessive Compulsive Checklist & Scale, Obsessive Compulsive Questionnaire -44) of this study to be used in phase II of this study for assessment of sample C. The phase II was aimed to determine the symptomatic characteristics and dysfunctional belief patterns of sample C while this assessment to be used as pre-treatment assessment of study 3 (Outcome).

Objectives

1. To translate the study tools including Y-BOCS-SC, OBQ-44, and CBT related forms.
2. To determine the symptomatic characteristics and beliefs patterns of OCD patients of Study 3.
3. To assess the CBT conceptualization of OCD by determining the correlation of Yale-Brown Obsessive Compulsive Scale (Y-BOCS) and Obsessive Belief Questionnaire-44 (OBQ-44).

Hypothesis

- There will be significant positive correlation between Y-BOCS and OBQ-Urdu-44.

Sample

There were 2 types of samples, B and C gathered in this study. The Sample B consisted of 170 students of colleges of Lahore, was gathered through Convenience sampling, which involves selection of participants on the basis of their willingness and availability (Cresswell, 1994). The Sample C consisted of 24 OCD patients selected through Purposive sampling of non-probabilty type which involves selection of participants on the basis of special characteristics (Dunham, 1988).

Inclusion criteria. For sample B, the inclusion criteria was adult (age 16 or above), student of bachelor and/or equivalent, and willing to participate in phase I of study 2.

For sample C, the inclusion criteria were adult (age 16 or above), diagnosed by one psychiatrist and clinical psychologist based on DSM-IV-TR as suffering from Obsessive Compulsive Disorder, without any co-morbid (Axis I or II) psychiatric disorder at the time of participation in this study, educated at least up to Primary or 5 years of formal education, can read, write and comprehend Urdu language, and willing to participate in Study 2 and 3.

Exclusion criteria.

For Sample B, the exclusion criteria were age less than 16years and/or not willing to participate in phase I of study 2.

The exclusion criteria for sample C was age less than 16 years, diagnosis of co-morbid psychiatric disorder (Axis I and/or II) at the time of participation in this study, educated less than primary or 05 years formal school education, difficulty in reading, writing and comprehending Urdu language, and/or not willing to participate in study phase II of study 2 and in study 3.

Instruments

In study 2, the material consisted of Yale-Brown Obsessive Compulsive Symptom Checklist (YBOCS-SC) ,Yale-Brown Obsessive Compulsive Scale (YBOCS), Obsessive Belief questionnaire -44 (OBQ-44), CBT forms , and a consent form. All tools were translated in this study except consent form which was devised by author for both samples.

The Yale-Brown Obsessive Compulsive Scale (Y-BOCS). The Yale-Brown Obsessive compulsive Scale (Y-BOCS) developed by Goodman and colleagues in 1989 is a clinician administered 10-items scale (full scale score range 0-40) to assess the nature and severity of OCD (Poyurovsky, Faragian, Shabeta, & Kosov, 2008). The severity measure contains 10 core items that assess obsessions and compulsions separately on five dimensions: time, interference, distress, resistance, and control. Each item is rated from 0 (no symptoms) to 4 (severe symptoms); accordingly, the scale yields a total score (range: 0–40) as well as subscale scores for Obsessions and Compulsions (range: 0–20 for each). Six investigational items were also included in the original measure to assess characteristics associated with OCD symptom severity such as avoidance, pathological responsibility, insight (Goodman et al., 1989a, 1989b). However, most studies report

results only from the 10 core items, and the psychometric properties of the investigational items have not been adequately examined (See Appendix C1).

The Yale-Brown Obsessive Compulsive Symptom Checklist (Y-BOCS-SC). The Yale-Brown Obsessive Compulsive Symptom Checklist (Y-BOCS-SC) is a widely used tool to identify the types of obsessive-compulsive symptoms, comprised of of 15 separate categories based on commonly present obsessions and symptoms (Goodman & Rasmussen, 1989).

Obsessive Belief Questionnaire (OBQ-44). The Obsessive Beliefs Questionnaire (OBQ) is a 44-items (7-point) tool used to assess dysfunctional assumptions covering 3 domains (Responsibility and threat estimation, Perfectionism & intolerance for uncertainty, and Importance and control of thoughts) with satisfactory validity and reliability (OCCWG, 2005; See Appendix C2).

Consent form. The consent form was prepared for sample C in which the aim of study, its time duration, responsibilities and rights of subjects and assurance of confidentiality were mentioned (See Appendix D2).

Cognitive Behavior Therapy (CBT) forms.

The different helping forms and other relevant material from books and online sources were translated in Urdu to be used in CBT application with Sample C (See Appendix D 3 –D9).

Procedure

In phase I, the Yale-Brown Obsessive Compulsive Symptom Checklist (Y-BOCS-SC), the Yale-Brown Obsessive Compulsive Scale (YBOCS), the Obsessive Compulsive Questionnaire -44 (OBQ-44) and various CBT based forms were translated by three bilingual psychologists. After selecting appropriately translated items of each scale by a panel including researcher, supervisor and one clinical psychologist, the selected items were sent for back translation to other three bilingual psychologists. The final items of each tool were rated on a 0-10 scale of appropriateness of translation, and for OBQ-44 only, its conceptual relevance with OBQ-44 domains by five clinical psychologists, a mean of at least 8 on each item was taken as criteria of selection of items. After translating all instruments of this study, the tools were administered on 10 OCD diagnosed patients to evaluate tools' appropriateness in terms of understanding of patients and to rule out any possible difficulty in administration of tools in phase II. The YBOCS was administered on 10 OCD patients of to calculate inter rater reliability, rated by 3 clinical psychologists. The English and Urdu versions of OBQ-44 were administered on 50 participants of sample B, with interval of 2 weeks, to assess the accuracy of translation. While for further analysis, Urdu version of OBQ-44 was administered on all remaining participants of sample B. In short, for translation of tools, the standard procedure was followed (Waters et al, 2006).

The translated tools were then administered to sample C to assess symptomatic characteristics and dysfunctional belief patterns. The results of different administrations of these tools were analyzed through appropriate tests of statistical Package for Social Sciences (SPSS 20.0).

Data Analysis

The Descriptive analysis was used to calculate mean ratings of each item of every tool by each rater on 0-10 scale. The Intra-class Correlation coefficient was employed to assess the inter-rater reliability of YBOCS. For validity of translation of OBQ-Urdu-44, the correlation between Urdu and English version was calculated through Pearson Product Moment Correlation while Factor analysis (Principal Component Analysis) and Reliability analysis were conducted for assessment of scale qualities. For assessment of symptomatic characteristics and belief patterns, the Descriptive analysis was employed.

Ethical Considerations

The participants were informed formally through verbal and written form about the rationale of present study and ensured the confidentiality and their integrity during their participation in this study. The written consent form was signed and participants were told that they have all the rights to quit this study on any step. The tools were administered in this study in exclusive environment where participants' confidentiality and privacy were ensured. All the tools adapted in this study were used after taking formal permission from relevant authorities (Appendix B).

Study 3: (Outcome)

Objectives

1. To assess the efficacy of CBT on individual session basis for the management of OCD in psychiatric setting of Pakistan.
2. To assess the role of Cognitive Behavior Therapy (CBT) in relapse prevention after 6-months follow -up.

Hypotheses

- There will be significantly low mean score of CBT group than mean score of Placebo/Waiting group on Mid- and Post-treatment YBOCS.
- There will be significantly low mean scores on YBOCS Mid- CBT level than Pre-CBT YBOCS mean score of combined sample.
- There will be significantly less mean scores on YBOCS Post-CBT levels than Pre-CBT YBOCS mean score of combined sample.
- There will be significant mean difference on Post-CBT and Follow-up mean scores of YBOCS.
- There will be significant mean difference on Post-CBT and Follow-up mean scores of OBQ-Urdu-44.

Sample

The sample C of Study 2 was divided into two groups i.e., Experimental (group 1) and Placebo/control (group 2) of equal number (12 OCD patients in each), by using randomized- control sampling technique (Shaughnessy, Zechmister & Zechmister, 2011). After completing therapy sessions, the sample C was again combined to assess relapse prevention by comparing post –CBT and follow-up scores on both outcome measures.

Research Design

The Study 3 was based on the Mixed Design (Between-Within group) to assess the efficacy of CBT for OCD patients after individual based CBT sessions and after 6-

months follow up. Because it has both the dependent groups design and a repeated measures design (Shaugnessy, Zechmister & Zechmister, 2011).

Instruments

Along with study measures used in previous studies, following instruments were used in this study.

Consent form. A consent form was devised in which whole details of therapeutic process, aim of research, confidentiality statement was mentioned. (See Appendix D3).

Cognitive-Behavior Therapy (CBT) protocol. The Cognitive Behavior therapy (CBT) protocol based on Salkovskis's model of CBT incorporated with the indigenous changes extracted from in-depth interviews of clinical psychologists practicing CBT in Pakistan will be implemented on subjects of Study II to assess its effectiveness for adult OCD patients of Pakistan (See Appendix D1).

Cognitive Therapy Assessment Interview (CTAI). The Cognitive Therapy Assessment Interview is an important assessment semi structured interview upon which the case formulation is based and tailor-made therapeutic program is planned (Wells, 2008).

Therapeutic material. The psycho educational material, Cognitive-behavioral therapy and assessment forms translated in Urdu taken by different sources were used in therapeutic management based on CBT (See Appendix D3-D10).

Procedure

After assigning patients to each group, the assessment conducted in Study 2 was taken as baseline Pre-CBT and Pre-Placebo for CBT and Placebo group, respectively, after which each patient of both groups received individual session (17-19 sessions of 1 hour duration) based on CBT or Placebo therapy. Both groups were assessed on outcome measures twice during this time (mid-treatment and post treatment). After completing Placebo sessions, group 2 has received CBT same as received by group 1 and again group 2 was assessed on mid-treatment and post-treatment levels with taking its post-placebo scores as pre-CBT scores. The double blind technique was used to make sure the objectivity of assessment. The criterion for termination of CBT was falling client's score at least on "12" on YBOCS (Wells, 1997). After that, both groups were compared on each level of assessment to see the efficacy of CBT. In step II, both groups were combined and again assessed on same outcome/study measures after 6 months of termination of CBT. Then post-CBT and 6-months follow up scores were compared to assess effectiveness of CBT in relapse prevention.

Data analysis

Using the SPSS 20.0, the Mixed Design (Between-Within group) ANOVA and One-way Repeated Measure ANOVA were used in step I and II, respectively (Shaugnessy, Zechmister & Zechmister, 2011).

Ethical Considerations

Participants' rights were considered by taking formal written consent for their participation in this study and confidentiality was ensure by hiding their identities and their provided information, whether verbally and/or written, would be confidential. But

delaying of providing CBT to Placebo/control group has been an important ethical issue which was partially compensated by providing CBT after Placebo sessions.

All the translated therapeutic material of this study was used after taking formal permission from relevant authorities to follow the copyright act.

Study 4 (The Case Study)

The aim of this study was to provide an indigenous model of OCD based on CBT theory and devising an indigenous therapeutic protocol for Pakistani society, derived from eight case studies extracted in Study 3.

Objectives

1. To discover and identify the phenomenology of OCD of study sample.
2. To identify an etiological model of OCD applicable of Pakistani society.
3. To extract and identify commonly present dysfunctional thoughts and their types among study sample.
4. To prepare a pilot draft of Obsessive Belief Scale (OBS) based on identified dysfunctional thoughts (See Appendix F).
5. To identify CBT techniques more effective for patients in Pakistan.

Sample

The sample of 8 cases was selected through systematic random sampling from population of 24 complete cases of study 3.

Instruments

The material included in this study was written documents based on sessions notes, homework assignments, and other relevant material to analyze the 8 case studies of study 2.

Research Design

The case study method was used in study 3 to address the inquiry questions mentioned below. The case study method aims to gain a wide in depth picture of the case in which multiple methods of data collection such as documents, archival notes, interview, direct and participant observation are used (Cresswell, 1994).

Research Questions

- What is the phenomenology of OCD of study sample?
- If there is any etiological model of OCD applicable of Pakistani society?
- What are the commonly present dysfunctional thoughts and their types among study sample?
- Which CBT techniques are more effective for patients in Pakistan?
- If there is any cultural differences in model and therapeutic process?

Procedure

The 8 case studies were selected through random sampling of 24 case studies of study 3. The cases were given serial numbers in start of study 2, and every fourth case was selected from both groups as sample of case studies of study 4. After that, the documents based on session notes, assessment forms, homework assignments, and feedback forms were analyzed to address the research questions of this study.

Data analysis

The data were analyzed through thematic analysis first within case and then between cases, transcribing each case, extracting common themes, and discovering the answers of research questions by thorough reading of study material.

Ethical Considerations

During analysis and review of analysis, the identity of participants was kept confidential while consent of participants was taken before sending their cases for review analysis.

Study 1

Results

Table 1

Demographic Characteristics of Sample A

Interviewee	Gender	Age (year)	Qualification	Cliental Type	Setting Public/ Private	Formal Training in CBT	Experience duration with CBT	Average time with CBT/day
1	Female	45	ADCP; PhD	Adult	Both	Yes	12 years	4-5hrs
2	Female	42	ADCP; PhD	Adult	Private	Yes	8 years	3hrs
3	Female	33	ADCP; MS	Adult	Public	Yes	5years	4hrs
4	Female	35	ADCP; MS	Adult	Both	Yes	5 years	4hrs
5	Female	46	ADCP; PhD	Adult	Both	Yes	12 years	4-5hrs

According to Table 1, the sample A was consisted of five professionally qualified, trained female clinical psychologists with age ranges from 33 to 45 years. Among them, three were PhD in clinical psychology and two were M Phil. in Clinical Psychology whereas all had professional training course /degrees in clinical psychology (ADCP) and formal training in CBT. Three professionals had experience of employing their knowledge and skills in public as well as private sector while one was working in public

and one was only in private sector. All had been practically and professionally involved in dealing with adult psychiatric population only, while duration of their experience in conducting CBT ranged from five to 12 years. During their practice, they had been involved with CBT on an average of three to five hours per day.

Analysis

The analysis of interview is based on identifying common themes extracted under areas of in depth interview mentioned in method of Study 1.

Experience with CBT

In this section, the opinion and experience of professionals regarding CBT was explored.

Most preferred and effective therapeutic approach. The interviewees have found CBT the most frequently used and effective therapeutic approach during their clinical practice.

"I think from the day I have started practicing in my clinic, I found CBT to be my first choice and I think if I have this, I don't need any other approach to be used".(Interviewee 3)

"In my experience, CBT has been much used and most effective therapy especially with OCD". (Interviewee 1).

"In start of my practice I did use other therapeutic approaches for OCD but now with experience I think CBT best explains OCD and most effective in its management". (Interviewee 5)

Assessment in CBT

The area of assessment in CBT was explored in this section. The detailed probing was conducted on preferred modes of assessment, problems faced in assessment procedures and their solutions.

Assessment is integral part of CBT practice. Like western trends, the professionals here consider assessment as an integral and fundamental part of therapy and do conduct detailed assessment to proceed in therapy. The overall trend was found to be similar to classic style of CBT in which first two sessions are based on assessment and case formulation.

"I do spend at least initial 2 sessions to collect complete information required to formulate case and plan therapy" (Interviewee 5).

"For me assessment is a must". (Interviewee 1)

Formal tests are not in common practice. The use of formal tests of CBT are not in frequent practice of professionals but they feel more comfortable in using Dysfunctional Thought Record Form (DTR), Behavioral tests, and interview to gain required information regarding symptoms description, cognitive biases and to do the case formulation.

"Frankly speaking I don't use formal tests in CBT but my main assessment tools are interview, DTR, and sometimes behavioral tests". (Interviewee 1)

The reason of not using much formal tests was turned out to be trend of Pakistani patients to be more comfortable and relaxed with interview probing. Besides that, most of patients

in public sector were reported to be less educated while being devised on Western population the formal tests were believed to be providing less information than interview itself.

Interview as main tool. The interview was found to be most preferred and useful tool for assessment purpose by all professionals.

"In my experience I think tests constructed on western population are not much useful for our population. I rather focus on detailed, in depth interview for probing and identifying thoughts, cognitive distortions, schemas and this helps me more in conceptualizing idiosyncratic case formulation of my patients". (Interviewee 4).

Behavioral Tests as substitute of DTR for illiterates. Doing assessment with illiterate patients is found to be a bit more difficult and complicated but professionals resolved this problem by using interview, behavioral experiments, and co-therapist for the purpose. "With illiterate patients, behavioral tests are much useful" (interviewee 4)

CBT Model

Living in an entirely different socio-cultural setup, researcher had a very pertinent question to be raised that if there is any needs to develop new model of CBT for Pakistani population. This question was mainly addressed in this section along with exploring any preferred model of CBT for OCD used by interviewees.

No need to develop indigenous model for Pakistani culture. According to interviewees, there is no natively formulated model of CBT available for Pakistani population neither they feel its need.

“I don’t feel any difficulty using already available western based models like Salkovskis’s model which is my preferred one for OCD patients”. (Interviewee 5)

Even the cognitive distortions, schemas, maladaptive belief patterns were found to be identical so interviewees felt no need to innovate new model.

“If we talk about perfectionism, over responsibility, thought-action fusion, over moralistic attitude, and dichotomous thinking, these all are present in our OCD patient population.” Interviewee 3)

Role of Religion in Belief Pattern. On inquiry about role of social, cultural and religious impact over belief patterns and symptomatic presentation of OCD patients, professionals affirm the role of religion in establishing harsh, strict pattern of thinking but they also think that these ideas do exist in West as well and we can just modify them to fit in our cultural set up.

“If our patients are religious and do follow strict moral standards for cleanliness, etc, so is same for catholic Christians. These “ پاکی ناپاکی ” obsessions and compulsions do exist there too, may be with different terms.”(Interviewee 4)

“They too have certain social cultural, moral and religious beliefs affecting their thinking patterns such as over responsibility, perfectionism, while these kinds of thinking patterns do prevail here”. (Interviewee 2)

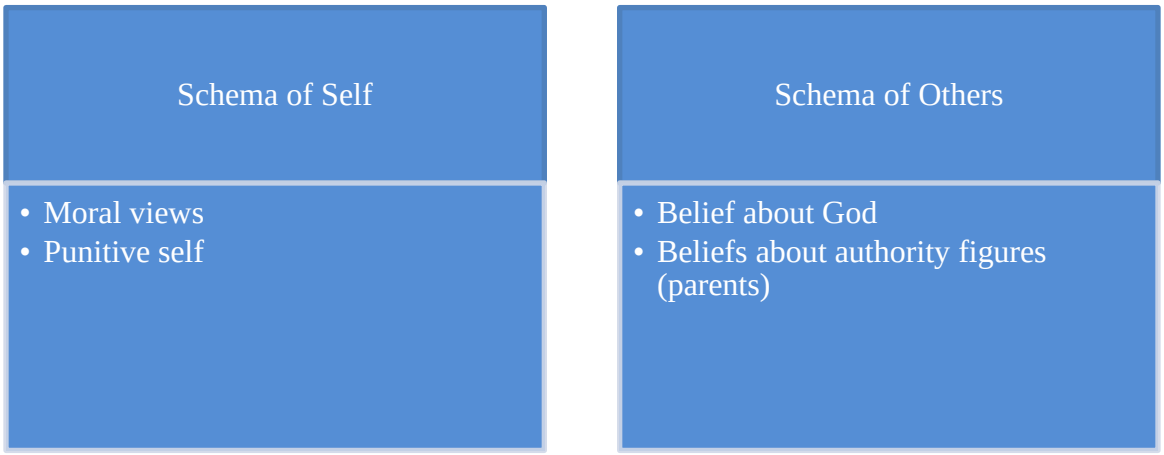
Need to incorporate socio-cultural-religious beliefs in pre-existing CBT models. They also expressed the need to incorporate these belief patterns according to our patients’ experiences and beliefs. They also stressed to consider the patients’ moral

and ethical views, concept of God and authority figures during case formulation. The interviewees have common idea of integrating religious aspects such as concept of God & authority into Schema about others and morality views in schema about self.

“In my experience I think with slight modifications, our patients’ beliefs do fit in already identified cognitive distortions”. (Interviewee 1)

“For me the patients’ overall religious attitude especially concept of God and of parents play important role in developing their moral, perfectionist, over responsibility beliefs”.(Interviewee 4).

Figure 1. Extracted Themes of Schemas



Need to incorporate all pre-existing CBT models. The need to incorporate different already existing CBT model for OCD in to 1 model and selection of appropriate model for each patient has been emerged from interviwees’ ideas.

“I don’t follow only 1 model but do add other models if need. Although my preferred one is David Clark’s model”. (interviewee 1)

"I do use Beck's model quite often but for situation-specific formulation, I do use well's". (Interviewee 4)

On the whole, it can be concluded that no major alterations in pre-existing CBT models of OCD are needed but incorporating schemas related to God and authority figures (parents), can improve case conceptualization for our patients.

Therapeutic Process

The therapeutic process like its stages, session format, effective and ineffective techniques were explored in this section.

Socialisation is must. Professionals in Pakistan do consider psycho-education a very useful tool to engage patient in therapy, to improve patients' compliance and motivation, and a technique to deal with their myths, misperceptions regarding illness and CBT.

They use written, verbal, sometimes recorded material based on list of cognitive distortions with examples, idiosyncratic case conceptualization, ways to do cognitive restructuring, etc.

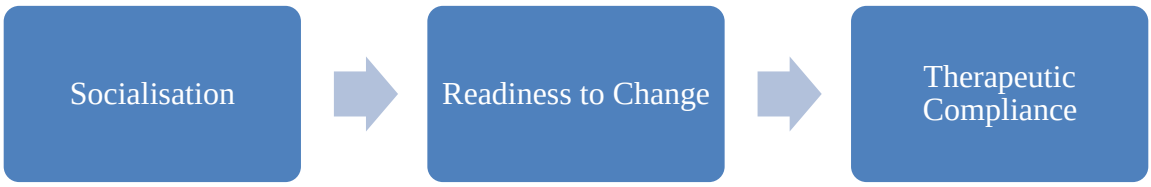
"I focus much on socialization because I believe it is essential for therapeutic prognosis by improving patients' compliance, motivation and comprehension of CBT principles". (Interviewee 1)

"I do give complete case formulation in template form, use patients' self experiences, symptoms, thoughts as examples to give patients' complete understanding of their case". (Interviewee 2)

The significance and importance of socialisation in Pakistani professionals' view and their ways to modify it according to patients' needs can be understood by these words:

"I do always give written material to my patients even if they are illiterate, I do manage their family members to read it for them". (Interviewee 5)

Figure 2. Focusing Importance of Socialisation



Pre-existing socialisation pattern is preferred. All interviewees stressed upon BC connection, CBT's educational, collaborative empirical nature, importance of homework assignments, and role and ways of cognitive restructuring, role of patients' motivation, compliance and readiness to change, in their styles of socialisation. They also use translated material adapted from different books, online articles on the topic for socialisation of their patients on CBT.

یہ ایک ایسا طریقہء علاج ہے جس میں ہم یہ سمجھتے ہیں کہ مریض کی سوچ کا انداز عام لوگوں سے مختلف ہو جاتا ہے جیسے کہ اگر ایک بار کچھ برا ہو جائے تو سوچنا کہ ہمیشہ ایسا ہی ہو گا۔سوچ کا یہ مختلف انداز ہمیں ذہنی پریشانیوں اور بیما ریوں میں مبتلا کرتا ہے۔ ایک ایسا CBT طریقہء علاج ہے جو مختلف طریقوں سے سوچ کے انداز کو زیادہ صحت مند بنا دیتا ہے۔اس طریقے میں ہم آپ کو سوچ کو جانچنا، تبدیل کرنا اور نئی صحت مند سوچ کو اپنانا سیکھاتے ہیں۔

آپ کو مختلف کام سیشن میں اور گھر کے لئے دیئے جائیں گے جو آپ کی بیماری کو ختم کرنے کے لئے ضروری ہیں۔ آپ کا تعاون اور علاج میں مکمل کوشش اس علاج کی کامیابی کے لئے بہت ضروری ہے۔

[1]"This is a treatment technique in which we consider that patient has different pattern of thinking as compared to normal ones for example patient thinks if some bad event happens it will occur always and again and again. This different way of thinking let patient towards mental stress, worries and illnesses. CBT is a treatment technique in which efforts are made to make patients' way of thinking healthier. In this technique, we teach you to evaluate your thinking, to change it into more healthy and helpful patterns. Different tasks will be assigned to you to be done in sessions and at home which are essential to manage your illness. Your cooperation and efforts are very much essential for your treatment".

Importance of readiness to change in compliance. A very important factor in prognosis was identified during interviews and that was "establishing readiness to change" in patients.

"I always focus in my initial sessions to work on addressing patients' myths, misperceptions, fears, apprehension regarding illness and treatment itself. Because in my view, if we become successful in engaging patient in therapy and motivate him for change, we can improve the prognosis a lot." (Interviewee 1)

The professionals stressed upon working on motivation and readiness to change in initial therapeutic sessions because in their view it accelerates prognosis and prevents drop outs

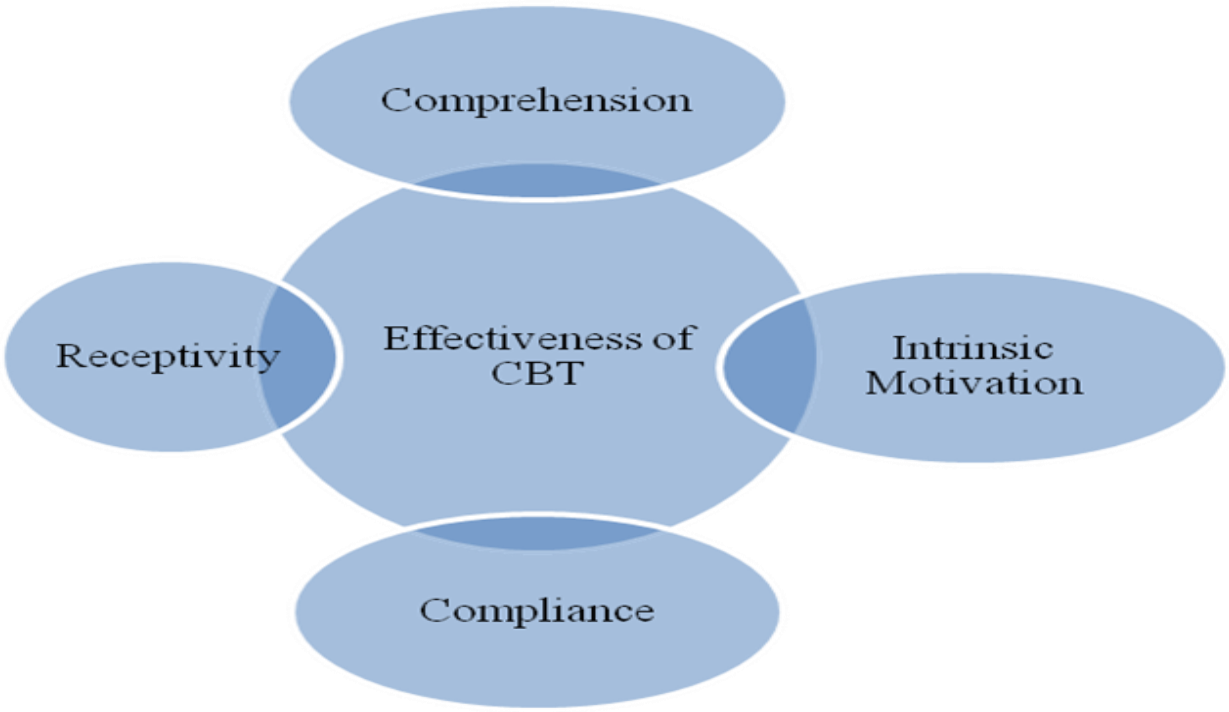
[1] English translation of above given Urdu paragraph.

as well as relapse.

“If we don’t work on motivating patients to engage in therapy they don’t work on changing their beliefs enthusiastically, even not share these beliefs, and chances of poor prognosis, relapse or even drop outs increase”. (Interviewee 4)

“Intrinsic motivation is necessary for prognosis and working on it through addressing patients myths.”(Interviewee 1)

Figure 3. Indicating Extracted Factors of Effectiveness of CBT



Simultaneous implementation of cognitive and behavioral reattribution techniques. The majority opines that it is more effective if we do start cognitive as well as behavioral techniques simultaneously but focus of behavioral techniques should

be strictly changing maladaptive beliefs.

“I found it more effective when I use cognitive restructuring and behavioral techniques simultaneously and for that I divide my session into two parts”. (Interviewee 2)

“For severe intensity of OCD or prominent compulsions, I do prefer behavioral attribution techniques first and then cognitive or verbal reattribution, but if severity is moderate, I use cognitive techniques first. Actually it all depends upon illness severity, patients’ comprehension level and clinical insight”. (Interviewee 5)

Use of religious philosophy in cognitive restructuring. Admitting the role of religion in belief formation, professionals affirmed the use of religious philosophy and teachings in process of cognitive restructuring.

“ yes, I do use hadith, aayat as examples to restructure dysfunctional beliefs especially associated with perfectionism, contamination and blasphemy” (Interviewee 2)

Western pattern of session duration and number is followed. A consensus was present in duration of sessions (one hour) and average number of sessions (14-16) as commonly practiced in west (Wells, 1997).

“My therapeutic sessions are of around one hour duration in my opinion, as far as my experience concern, around 14-16 therapeutic sessions we do achieve around 75% improvement”. (Interviewee 3)

Termination criterion is 70% improvement. The termination of therapy was considered to be based on patient’s response and his family feedback, his functionality

level, and clinician's assessment. Roughly professionals think that around 70% improvement is enough to terminate therapy and go for booster and follow up sessions.

"On an average 70% improvement is satisfactory, after that I focus on follow up sessions." (Interviewee 1)

Therapy termination is based on multiple factors. In deciding termination of therapy, not only clinician's opinion but patient's and his family feedback and response are considered.

"Termination of therapy is based on patient's functioning level and patient's as well as his family feedback, and obviously my own judgment too." (Interviewee 2)

Relapse prevention & booster sessions are in practice. All professionals have acknowledged the importance of relapse prevention and booster sessions in long term efficacy of CBT. Their responses indicated that they do focus on conducting relapse prevention sessions, do give therapy blue prints, relevant session notes and reading material before terminating the therapy.

"Personally I do like the CBT concept of relapse prevention and therapy blue print. I always give my patients therapy blue print in written form and I feel they become more confidants of their learned skills in therapy". (Interviewee 1)

"I do conduct booster sessions and also the last two or three sessions of my therapy always based on relapse prevention". (Interviewee 3)

"For me relapse prevention sessions should be focused a lot. I use different techniques based on educational style, Socratic dialogue. I do ask them to make management plan of

some hypothetical OCD case, I ask them to advise so imaginary friend having same OCD symptoms or having relapse signs, etc, to maintain cognitive change occurred in effect of CBT". (Interviewee 4)

Perceived Effective & Ineffective Techniques

The opinion of sample about effectiveness of different CBT techniques with OCD patients of Pakistan was identified. Professionals stressed upon certain techniques they have found more effective for their OCD patients than others.

Behavioral Reattribution is much effective. The Behavioral reattribution techniques were found much effective for majority of OCD patients as they told:

"I do conduct behavioral exposures, obviously focusing on challenging cognitive distortions by using behavioral methods such as Exposure, Survey, and Modeling."(Interviewee 1)

"For my resistant, defensive, less educated or with predominant compulsive symptoms, behavioral experiment technique of CBT has been better in terms of effectiveness". (Interviewee 4)

Detached mindfulness is for obsessions. To deal with obsessions, professionals found detached mindfulness as quite an effective technique.

"Detached mindfulness is a good enough technique, and better substitute of thought stopping and distractions, to manage obsessions, at least before starting cognitive restructuring, to give patient immediate relief from obsessions". (Interviewee 4)

Cognitive restructuring is most effective technique of cbt. Western CBT professionals consider cognitive restructuring as most effective technique of CBT (Clark, 2004), and same is the opinion of Pakistani professionals. They also stressed upon extensive focus on using cognitive restructuring as main technique to deal with core beliefs, interpretations of obsessive thoughts, images, impulses, and compulsions, and maladaptive assumptions.

"As far as my most preferred technique of CBT for OCD, my choice will always be cognitive restructuring because it enables our patients to finally face, challenge and change maladaptive interpretations of obsessions and compulsions. Without it I can't even think of CBT." "Yes definitely I consider it the most effective technique to manage OCD". (Interviewee 1)

"Most effective technique is cognitive restructuring and I do use it as in CBT books like DTR, double, triple columns, defense attorney, role reversal, distancing, and even humor". (Interviewee 3)

Imagery is limited to the management of obsessional images. Imagery techniques such as "Turn off imagery", "Finish out imagery", "Mastery imagery", etc are used by cognitive behavior therapist to deal with obsessional images (Beck, 1985. On question regarding its effectiveness for Pakistani OCD patients there was a mixed opinion by professionals.

"I think imagery techniques have no value at all in OCD management. In my practice of so many years I have never used them". (Interviewee 3)

"Yes off course, I use "finish out imagery,"turn off imagery" and other forms to deal with images in OCD, and I found it effective to some extent. But even using it, I focus more on altering patients' interpretations of those impulses". (Interviewee 1)

Relaxation and distraction techniques are contraindicated. Relaxation, meditation, deep breathing was not much approved by CBT practitioners of Pakistan. They acknowledged the role of deep breathing and relaxation as immediate but temporary relief to intense anxiety and distress associated with OCS, but rejected its role on long term basis because of their possible use as safety behaviors.

"I do not consider deep breathing, relaxation in CBT because patient may use them as safety behaviors which obviously hinder our therapeutic goals. But yes with very anxious, distressed patients I sometimes advice deep breathing temporarily". (Interviewee 1)

"I never used deep breathing or relaxation or any distraction methods. I think these are against basic assumptions of CBT and even adversely affect prognosis". (Interviewee 3)

"I always suggest my patients to avoid using deep breathing because it may become a safety behavior". (Interviewee 2)

Effectiveness of CBT with uneducated patients

According to United Nations Educational, Scientific, and Cultural Organization (UNESCO) Institute for Statistics, the overall literacy rate of Pakistan in 2009 was found to be 54.89% ("Pakistan-Literacy Rate", 2013). This low rate of literacy demands the modification of CBT accordingly, which is a therapy of logic, reasoning and education,

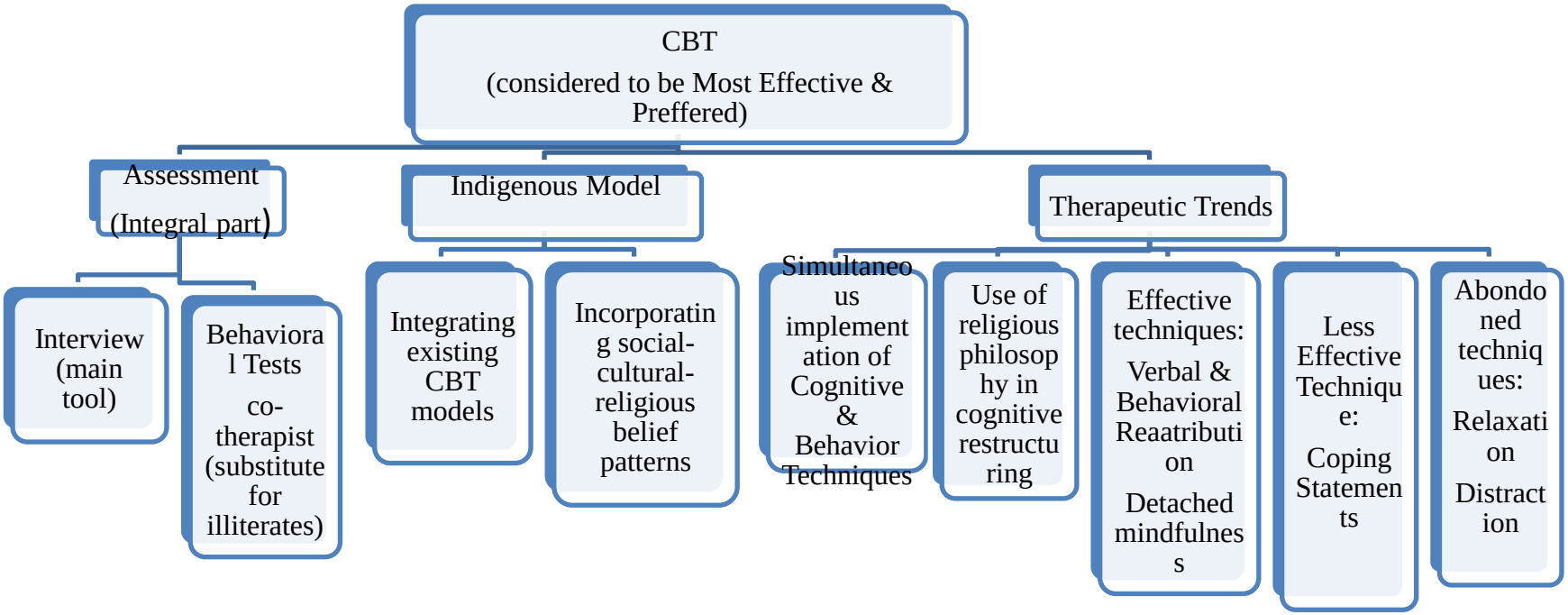
for OCD patients of Pakistan. Considering this a very pertinent query, this study has focused on inquiring whether CBT professionals of Pakistan have felt this need, and if yes, how they have modified CBT for their illiterate OCD patients.

CBT is effective for illiterates with slight modifications. The consensus was found among all interviewees that CBT can be used with illiterate patients with slight modifications such as use of simple, specific, lay man terms, and translated materials from CBT resources and more preliminary forms of techniques. They also stressed upon presence of experiential wisdom is enough for effectiveness of CBT with illiterates.“I use CBT tests and other written material in translated form” (interviewee 1).“ We have to use simple, very concrete examples and methods of CBT to deal with illiterate patients”. (Interviewee 3) “I often do try to be more guiding in

cognitive restructuring of dysfunctional thoughts of illiterate patients”. (Interviewee 4) “It is better to use simple, specific techniques, and avoid bombardment of lots of techniques with illiterate patients” (Interviewee 5) “ You can use more behavioral reattribution techniques than cognitive ones with illiterates and if using cognitive, then its better to use very simple and brief way” (Interviewee 1)

“With illiterates, I often prefer co-therapist and do try giving examples from their background and to their comprehension level, sometimes I used pictures rather than words to explain CBT concepts”. (Interviewee 2)

Figure 4. Depicting the Process of CBT with OCD in Pakistan


CBT
(considered to be Most Effective & Preffered)
Assessment
(Integral part)
Interview (main tool)
Behavioral Tests
co-therapist (substitute for illiterates)
Indigenous Model
Integrating existing CBT models
Incorporating social-cultural-religious belief patterns
Therapeutic Trends
Simultaneous implementation of Cognitive & Behavior Techniques
Use of religious philosophy in cognitive restructuring
Effective techniques:
Verbal & Behavioral Reaatribution
Detached mindfulness
Less Effective Technique:
Coping Statements
Abondoned techniques:
Relaxation
Distraction

Recommendations for Protocol

On the basis of analysis of interview, certain recommendations were incorporated in pre-existing therapeutic protocols of CBT for OCD patients, in order to devise indigenous therapeutic protocol of this study.

- Being considered, by sample, as most effective therapy for OCD patients of Pakistan, it can be recommended to researcher to implement CBT on study III sample quite confidently.
- Assessment should be completed in first two sessions of 60-90 minutes duration each.
- The Cognitive Therapy Assessment Interview (CTAI) will be used as main assessment tool.
- Other preferred assessment tools will be behavioral tests and Dysfunctional Thought Record (DTR) form along with research tools.
- For illiterates and less educated patients, behavioral tests and co-therapist will be used as assessment modes.
- During case formulation of patients, the beliefs about God and authority figures and about moral values and punitive self will be focused.
- The development of an indigenous model of CBT for OCD patients of Pakistan will be focused in Study IV.
- Imagery techniques of CBT will only be used while relaxation, deep breathing, other imagery and distraction techniques contradictory with CBT assumptions will not be part of therapeutic protocol.

- The religious teachings and philosophy can be used in cognitive restructuring.

Discussion

In study 1, it was tried to explore each and every area related to application of CBT for OCD patients of Pakistan so that on the basis of professionals' responses not only the CBT status could be explored but an indigenous and effectively applicable therapeutic protocol of CBT for OCD patients of Pakistan can be planned. The information provided by professionals was very fruitful in achieving the goals of study. The themes identified in this study indicated many similarities in trends of CBT in Pakistan with western trends but certain differences were also found which indicate the cultural adaptations made by CBT professionals here in their CBT practice.

Like its popularity in western countries for OCD (Clark, 2000), CBT here in Pakistan became successful in becoming therapy of choice for professionals when all professionals rated it as most effective, preferred, suitable and treatment of choice for OCD patients of Pakistan.

According to study findings, the assessment is considered by professionals here as an integral part of CBT with OCD patients. It is an established fact through researches and responses of CBT professionals all over the world that ongoing assessment has been an essential element of CBT but also strength of CBT as evidence-based approach (Overholser, 1999). But a major finding of this study was that formal tests are not in common practice of professionals here in Pakistan which is quite different than traditional practice in west. The possible reasons of this trend are behind the fact that there is lack of adapted and devised CBT-based formal tests in Pakistan, and also the lack of familiarity and comfort level of Pakistani population with questionnaires, and then the main reason of lack of education in our population. According to

study findings, as a substitute to formal tests, CBT professionals here do rely on interview as main mode of assessment, and behavioral tests as an additional tool as a substitute of dysfunctional thought record (DTR) forms.

Pakistani society is an eastern society having religion as very prominent aspect of culture. Dealing with such kind of society where eastern culture is colored with religion, the application of westernized models of CBT without any amendments is questionable. Because it has been found in various studies that cultural and religious aspects of client's life should be focused in planning any therapy including CBT for that specific individual (Abramowitz, 2006; Good, 2010; Huppert & Sieve, 2010; Waller, Trepka, Collerton & Hawkins, 2010). Answering to this question, study found an essential need to incorporate social, cultural and religious beliefs and practices in preexisting western models of CBT so that an indigenous CBT based model for OCD patients of Pakistani population can be devised. The most important factor in case conceptualization of CBT with OCD patients was found to be their beliefs regarding strict moral and religious values, their punitive, critical self and most importantly their schema of God and authority figures as being harsh, critical and punitive. In the light of certain research findings in which scrupulosity has been found not only a symptom but factor of OCD (Nelson , Abramowitz , Whiteside & Deacon, 2006), and perfectionism as a cognitive distortion commonly present in OCD patients (OCCWG, 2005), this finding of present study is justifiable. In a religious society, the philosophy of life being followed is usually based on religious values, practices and beliefs which made religion, GOD and authority figures (parents) as schema source. These schemas combined with perfectionist attitudes may compel individuals to develop obsessions and compulsions of scrupulosity, cleaning, washing, and so forth., and let individual to adopt certain dysfunctional thoughts related to perfectionism, over responsibility and need to control thoughts,

the common obsessive beliefs of OCD (Abramowitz,Deacon ,Woods, Tolin, 2006; Cosgrove, 2011). Participants of this study stressed upon incorporating these schemas in case formulation and also to address these schemas and beliefs in cognitive restructuring, as it is suggested to include religious aspects in formulation and therapy of CBT (Huppert & Siev, 2010). Professionals' recommendations to use relevant religious literature in cognitive restructuring of these schemas and beliefs which have their roots in religion is also in line with available literature on CBT which stressed upon incorporating cultural and religious aspects to tailor the therapeutic plans of patients (Caberara, 2013; Cosgrove, 2011).

The literacy rate in Pakistan is quite low as compare to western societies ("Pakistan-literacy rate, 2013) which creates problems in implementation of CBT which is an educational approach to psychotherapy (Beck, 1985). Dealing with this problem, professionals suggested certain modifications in the implementation of techniques like use of simple language and concrete examples as it was suggested by Hays (1995) to tailor the therapy according to individuals' level of comprehension and language.

Despite these slight differences between CBT practices of west and Pakistan, there is a general consensus on majority areas such ways of socialisation, session duration and format, choice of effective and ineffective techniques, and so forth. In short, study reveals that CBT professionals of Pakistan are trying to implement CBT in systematic and evidence-based way while also being culture-sensitive professionals they not only acknowledged need to modify CBT according to Pakistani culture but also made attempts on individual levels. However there is still a need to make joint efforts to work on this aspect of CBT so that CBT can be applied more effectively in our society.

The study 1 has focused on a relatively neglected aspect of research in Pakistan because except one study (Naeem et al, 201), no study could be found on CBT status and its application in Pakistan. The study 1 has provided guidelines in planning indigenous CBT therapeutic protocol for OCD patients of Study 3.

Study 2

Results

Phase I

Table 2

The Inter-Rater Correlation Coefficient (ICC) of YBOCS

Item No.	ICC	Item No.	ICC
1	.97*	10	.94*
2	.98*	11	.95*
2b	.98*	12	.96*
3	.96*	13	.96*
4	.97*	14	.96*
5	.98*	15	.96*
6	.96*	16	.93*
6b	.95*	17	.95*
7	.97*	18	.95*
8	.96*	19	.96*
9	.94*	[a]Total	.92*

Note: Three raters rated YBOCS audio interviews of ten OCD patients.
* $p < 0.01$. [a]Total score on YBOCS.

Table 2 is indicating the inter-rater reliability of Yale-Brown obsessive Compulsive Scale (YBOCS) which was found significantly high ($p<.01$). These results depict excellent reliability

of YBOCS indicative of YBOCS Urdu version a reliable tool to assess severity of Obsessive Compulsive Disorder (OCD) among Urdu speaking population.

Table 3

Descriptive Analysis of Sample B

Variables	*f*	*%*
Gender	170	100
Male	85	50
Female	85	50
Age (years)	170	100
18	55	32.0
19	46	26.7
20	22	14.8
21	33	19.4
22	14	8.1
Education	170	100
Intermediate	62	36.0
Graduation	76	46.4
Post-graduation	32	18.6
[a]SES	170	100
Middle Class	133	78.4
Upper middle	31	15.2
Lower middle	6	3.5

Note:[a]*SES= Socioeconomic status*

The descriptive analysis of demographical information of sample A is given in table 3, (n=170), mentioned that sample B was comprised of 50% male and 50% females college students ,with mean age 19.4 among those mostly students of intermediate and graduation (36.0% & 46.4%) and only 18.6% are students of post-graduation level. The majority of sample

was representative of middle class (78.4%) although slight representation of upper and lower middle socioeconomic class was also present.

Table 4

Inter-Correlations of OBQ-44 and OBQ-Urdu-44 (N=50)

Measures	1	2	3	4	5	6	7	8	*M*	*SD*
1. (U)PC	-	**.68***	**.74***	**.85***	.64*	.66*	**.91***	.77*	69.64	17.53
2. (U)ICT		-	**.70***	.67*	**.70***	.75*	**.86***	.75*	40.64	13.68
3. (U)RT			-	.75*	.75*	**.85***	**.91***	.83*	63.96	17.56
4. (E)PC				-	.78*	.81*	.85*	**.92***	66.78	19.72
5. (E)ICT					-	.88*	.86*	**.75***	37.62	15.56
6. (E)RT						-	.83*	**.95***	59.82	19.30
7. OBQ-Urdu							-	**.87***	174.24	43.91
8. OBQ-44									160.20	50.22

Note: (*U)* = .Urdu OBQ subscales; (E) = English/Original OBQ subscales; PC= Perfectionism & intolerance for uncertainty; ICT= Importance and control of thoughts; RT= Responsibility and

threat estimation; OBQ- Urdu = Urdu OBQ total; OBQ-44= Original OBQ-44 total; Important correlations are bold face. *$p < 0.01$.

The accuracy of Urdu translation of OBQ-44 was assessed by calculating the inter-correlations among English and Urdu total and subscales score of sample C, as indicated in Table 4. The total score of adapted version of OBQ-44 (Urdu version) was found to be significantly correlated with the original OBQ-44 (English version) total score (r=.87). The Urdu and English versions of each subscales were also found to be highly correlated with their counterparts, ranging from r= 0. 70 to 0.92. The Inter correlation among subscales of OBQ-Urdu and with its total score was also satisfactory. Overall the translation of OBQ (OBQ-Urdu) was found to be satisfactory.

Table 5

Reliability analysis of OBQ-Urdu-44 (N=170)

Measures	1	2	3	4	α	*M*	*SD*
1. RT	-	.81*	.80*	.94*	.85	77.95	16.94
2. PC		-	.79*	.93*	.87	85.38	16.06
3. ICT			-	.91*	.81	47.39	12.92
4. OBQ-Urdu				-	.85	216.90	43.56

Note: RT= . Responsibility and threat estimation,; PC= Perfectionism & intolerance for uncertainty,; ICT = Importance and control of thoughts; OBQ-Urdu = OBQ-Urdu-total;. α= Cronbach's Alpha. *$p < 0.01$.

The Urdu version of OBQ-44 was found to have good internal consistency with α= .85 for total scale and for subscales RT, ICT, and PC (α= .85, .87, and .81, respectively) as mentioned in Table 5. The subscales were exhibiting significantly high correlation with OBQ-total, all are .91 and above. The subscales were showing significantly high inter-correlations ranging from r=.79 (inter-correlation between subscales of Perfectionism and Intolerance for Uncertainty-PC and Importance and Control of Thoughts-ICT) to r= .81, (inter-correlation between subscales of Responsibility and Threat Estimation –RT and Perfectionism and Intolerance for Uncertainty -PC).

Table 6

Factor Loadings for Exploratory Factor Analysis with Varimax Rotation of Obsessive Belief Questionnaire-Urdu (N=170)

Item No.	Obsessive Belief-General(OB-G)	Cautious/Vigilant (CV)	Perfectionism (PC)
1	**.41**	.10	.18
3	**.47**	.05	.34
9	**.50**	-.08	.24
12	**.48**	.26	.14
13	**.62**	-.15	.17
16	**.40**	.35	.29
17	**.40**	.29	.29
18	**.46**	.25	.25
20	**.58**	.16	.32

21	**.76**	.18	-.13
25	**.63**	.13	.13
29	**.53**	-.46	.24
30	**.66**	.05	-.08
32	**.40**	-.36	.25
33	**.45**	.38	.22
34	**.56**	.27	-.09
35	**.42**	.30	.17
38	**.47**	.29	.31
39	**.63**	.21	.05
40	**.74**	.10	.05
41	**.60**	.31	.08
42	**.63**	.15	.05
43	**.56**	.10	.25
44	**.44**	.28	.23
5	.01	**.63**	.06
6	-.06	**.60**	.17
19	-.10	**.62**	.17
22	.50	**.52**	.10
23	.18	**.64**	.11
24	.20	**.49**	.37
26	.36	**.56**	.26
27	.41	**.53**	.51

28	.05	**.52**	.51
36	.30	**.55**	-.02
[a]31	.19	**.52**	**.51**
[a]37	.22	**.58**	**.40**
4	.23	.26	**.60**
10	.15	.08	**.70**
11	.08	.12	**.75**
14	.02	.20	**.61**
2	.25	.33	.13
7	.29	.33	.27
8	.30	.32	.36
15	.34	.30	.16
Eigenvalues	12.98	3.50	1.97
% Variance	29.38	7.96	4.49
Cum. %	29.38	37.34	41.83

Note. Factor loadings >.40 are in boldface. [a]Item # 31 & 37 were included in factor 3 (PC) based on its presence in PC domain of OBQ-44.

The Table 6 is depicting the factor loadings of each item of Urdu translated OBQ-44 calculated by employing the Exploratory Factor Analysis (EFA) with Varimax rotation method, on the sample of 170 subjects (Sample B). The KMO measure of sampling adequacy was .81 suggesting the suitability of data for factor analysis (Hutcheson & Sofroniou, 1999). The Bartlett's test of sphericity was also found to be significant ($p<.001$), which further confirmed the adequacy of sampling. The criterion for selection of items in factors was > .40 factor loading.

Only for item #31 and37 the selection was based on their classification in original OBQ-44 so these two items were kept in factor 3 rather in factor 2. On the basis of selection criteria (factor loading >.40), 40 items were selected while 4 items (item # 2, 7, 8, 15) were excluded.

The new scale emerged as the result of EFA was labeled OBQ-Urdu-40 as it was consisted of 40 items.

The belief domains (Obsessive Belief-General [OB-G], Cautious/Vigilant –CV, and Perfectionism-PC) explained 42% of OBQ-Urdu-40 scores. The first belief category OB-G was comprised of 24 items among which 7 items of RT, 8 of PC, and 9 from ICT belief domains of original OBQ-44 were included. The second factor was named Cautious/Vigilant (CV) having 10 items (RT=6, Pc=1, ICT= 3). The third belief domain had 6 items of PC domain of OBQ-44. The three factors of OBQ-Urdu-40, OB-G, CV, and PC explained 19%, 13%, and 9% of total variance, respectively.

Table 7

Reliability analysis of OBQ-Urdu-40 (N=170)

Measures	1	2	3	4	*α*	*M*	*SD*
1.OB-G	-	.59*	.52*	.95*	.91	104.56	28.13
2. CV		-	.62*	.80*	.86	61.87	12.11
3.PC			-	.68*	.78	31.01	5.07
4.OBQ-Urdu-total				-	.80*	197.44	39.87

Note: OB-G= Obsessive Belief-General factor; CV= Cautious/Vigilant; *PC* = Perfectionism & intolerance of uncertainty; OBQ-Urdu-40 = OBQ-Urdu shortened version (40 items); *α* =Cronbach's Alpha; *$p < 0.01$.

The reliability analysis of Obsessive Belief Questionnaire in Urdu (OBQ-Urdu-40), based on 40 items of OBQ-44, given in Table 7, is depicting good internal consistency for total and subscales OR, CV, PC(*α*=.80, .91, .86, .78, respectively). There were significant inter - correlations among three factors (OBQ-G, OR, and PC) and also with OBQ-Urdu-total. The moderate correlations, although significant, among factors (r=.59, .52, .68) also indicate that these are interrelated but distinctive constructs. The analysis also indicates that Cronbach's Alpha can be improved from .80 to .85 in case of deletion of the third subscale (PC), whereas

exclusion of OB-G and CV from OBQ-Urdu-40 will be resulted in a decrease in Cronbach's alpha (.59 & .77, respectively).

Phase II

Table 8

The Correlation between YBOCS & OBQ-Urdu-44 (N=24)

Measure	YBOCS	*M*	*SD*
OBQ-Urdu-44	$.20^{ns}$	234.25	29.92
YBOCS		29.71	2.14

*Note:*ns=non-significant.

The Pearson Product Moment Correlation between Yale-Brown Obsessive Compulsive Scale (YBOCS) and Obsessive Belief Questionnaire (OBQ-Urdu-44) given in Table 8 was found to be not significant which rejects the hypothesis of Study 2 Phase II.

Table 9

Descriptive Analysis of Symptomatic Characteristics of Sample C on [a]YBOCS-SC (N=24)

Symptom Category	*M*	*SD*
Contamination Obsessions	14.79	1.67
Aggression Obsessions	9.29	.90
Washing Compulsions	8.63	.98
Scrupulosity Obsessions	7.58	1.18
Sexual Obsessions	5.04	.80
Checking Compulsions	4.67	1.18
Repeating Compulsions	3.58	.75
Ordering Obsessions	2.17	.62
Somatic Obsessions	2.04	.60
Miscellaneous Obsessions	1.92	.35
Miscellaneous Compulsions	1.75	.37
Organizing Compulsions	1.13	.34
Hoarding Compulsions	.63	.27
Hoarding Obsessions	.46	.25
Counting Compulsions	.33	.23

Note: M= Mean score on each category. [a]YBOCS-SC= Yale-Brown Symptom Checklist

In Table 9, the means and standard deviations of each symptom category of Yale-Brown Obsessive Compulsive Symptom Checklist (YBOCS-SC) based on scores of sample C (24 OCD patients) are given in descending order.

The most prominent symptoms found in sample C were contamination and aggression obsessions, washing compulsions and scrupulosity obsessions whereas sexual obsessions, checking compulsions and repeating compulsions are worth mentioning. The hoarding compulsions, hoarding obsessions and counting compulsions were found to be less in sample C.

Table 10

Descriptive Analysis of OBQ-Urdu-44 Scores of Sample C (N=24)

Scale	*M*	*SD*
RT	89.54	2.3
PC	85.25	2.5
ICT	58.58	2.5
OBQ-Urdu-44	234.25	6.1

Note: RT= Responsibility and threat estimation,; PC= Perfectionism & intolerance for uncertainty; ICT = Importance and control of thoughts; OBQ-Urdu-44 = OBQ-Urdu-total.

The mean and standard deviations of OBQ-Urdu-44 (total and subscales) based on scores of sample C are given in Table 10 which indicated that the sample has more cognitive distortions Responsibility and Threat estimation (RT) and Perfectionism and Certainty (PC) as compare to Importance of and need to control thoughts (ICT).

Discussion

The Study 2 was planned primarily to assess the severity of OCD and belief patterns of patients of OCD of Study 3 (Sample B). For that purpose, the Study 2 was divided into two phases. First phase was "Translation phase" in which Yale-Brown Obsessive Compulsive Scale-Checklist (YBOCS-SC) and Obsessive Belief Questionnaire (OBQ-44) were translated into Urdu and their psychometric properties were determined so that both tools could be used in Study 3 confidently. The phase II was "Assessment phase" in which the symptomatic characteristics and belief patterns of Sample B (24 OCD patients) were explored.

Phase I

In phase I, the YBOCS-SC and OBQ were translated into Urdu by following the standardized procedure of translation and back translation and it was then administered to 10 OCD patients to assess its comprehensibility in Urdu. The aim was to prepare Urdu drafts of both measures by following the standardized guidelines of translation procedure (Beaton, Bombardier, Guillemin, Ferraz, 2000).

The YBOCS-SC is considered most reliable and widely used assessment tool for OCD (Frost, Steketee, Krause, &Trepanier, 1995; Hiranyatheb, Saipanish & Lotrakul, 2014) and has good validity and reliability and sensitivity to change (Goodman et al. 1989a; 1989b; Moritz et al. 2002). That is the reason it was chosen for this doctoral work to be used for evaluating the effectiveness of CBT for symptom reduction of OCD among subjects of Sample B. The YBOCS-SC has two parts, one comprised of symptom checklist of OCD whereas second is scale to assess symptom severity and other associated features such as "pathological doubting" and "pervasive slowness", etc. For translation, both parts were dealt differently based on their nature

and purpose of use. As Yale-Brown Symptom checklist is for identifying symptoms of OCD, it does not require raters agreement but it needs patients' comprehensibility of items (symptom presentations), so checklist was administered on 10 OCD patients to assess if they could understand its meaning. Among those patients five were uneducated and for them test administrator recited each symptom in front of patient and filled the form based on their responses. Whereas educated patients were let to read checklist and to fill according to their responses. The changes were made accordingly based on this trial administration and thus Urdu draft of Yale-Brown Obsessive Compulsive Symptom Checklist was prepared.

The YBOCS is a clinician rating scale and considering the nature of this scale the inter-rater reliability was found to be most appropriate reliability type (Barrett, 2000). The reliability is psychometric property of test that refers to its consistency and dependability whereas inter-rater reliability is a test's consistency among two or more raters (Muchinsky, 2006).This scale was aimed to be used as change index for Study 3 where patients' responses on this scale would be rated by different psychologists so it was crucial to determine its inter-rater reliability to avoid pitfalls in evaluating efficacy of CBT in Study 3. The other reason to choose inter-rater reliability as an important psychometric property of YBOCS to be determined is the fact that the authors of YBOCS preferred inter-rater reliability index (Goodman et al. 1989a).

The method to calculate inter-rater reliability coefficient (ICC) was cautiously planned in which recorded responses on YBOCS were rated separately by 3 raters who were qualified clinical psychologists. It was tried to first get them familiar with whole YBOCS (Urdu translation) and its administration and rating procedures. The raters rated each interview separately and they were blind to other raters' ratings. In short, every mean was adopted to make

sure that the inter-rater reliability of Urdu version of YBOCS could not be questioned otherwise results of Study 3 could not be valid.

The table 2 of Results was showing the highly significant inter-rater reliability among three raters, ranging from Cronbach's Alpha .92 to .96, of Urdu translated YBOCS which is consistent with original research findings (Goodman et al. 1989a) and reliability index of its revised version (Stroch et al. 2010). On the basis of these results it can be concluded that Urdu version of YBOCS is reliable measure to assess the symptom severity of OCD among Urdu speaking population.

The objective of this phase was to provide researcher Urdu YBOCS-SC for Study 3 so further psychometric assessment was postponed for future plans. Therefore, on the basis of this phase author admit that Urdu translation of YBOCS-SC needs to be evaluated on different dimensions of psychometric properties such as different types of validity, reliability and factor structure based on Pakistani population as it has been adapted and evaluated for its original as well as cross cultural versions (Anholt et al. 2010; Arrindell , Eisenhardt, van Berkum, & Kwee, 2002; Deacon & Abramowitz ,2005; Ólafsson, Snorrason, & Smári, 2010)

As next step to Phase I, the Obsessive belief Questionnaire-44(OBQ-44) was translated in Urdu language and its psychometric properties were explored, so as to provide a valid and reliable self-report measure to assess dysfunctional beliefs of OCD patients of Sample B and to detect any change in belief patterns as effect of CBT. Because OBQ has been claimed a valid and reliable tool to assess obsessional beliefs of OCD patients (Wu & Carter, 2008) and has been reported a change-sensitive tool in response to CBT (Anholt, et al. 2010) therefore it was chosen to be used as an outcome measure of Study 3. As OBQ-44 is in English language whereas

majority population of Pakistan is uneducated, among patient population very small percentage of those who could read English (‘Pakistan-Literacy Rate’, 2013).Therefore it was thought better to administer a self report tool in first/preferred language of population which is Urdu for target population of Study 3. Therefore it was planned to translate OBQ-44 into Urdu. For the purpose, to attain linguistically appropriate scale, multiple methods were adopted such as the standard procedure of translation and back translation, experts’ opinion and ratings, assessment of comprehensibility target population (OCD patients of Pakistan) as it was done in adaptation of OBQ-44 for Brazilians (Bortoncello, Braga, Vivan, Gomes, & Cordioli, 2012). The Arabic translation of OBQ-44 was evaluated by calculating the correlation between original and Arabic OBQ-44, whereas both OBQs were administered with 4 weeks interval (Rahat, Rahimi, & Mohamadi, 2012). In current study, same method was used to determine the accuracy of translation that is after administering both versions of OBQ-44 with one month interval the inter-correlations between original and translated versions of OBQ-44 was calculated. Results mentioned in Table 3indicated significantly high correlation (r=.87) between total scores of both versions. Combining this with the high inter correlations between subscales of English and translated version (OBQ-Urdu-44) ranging from (.70 to .92) was in line with previous researches and indicated satisfactory standard of translation (Shams et al. 2014).

To determine the psychometric properties of OBQ-Urdu-44 , the internal consistency was assessed on a non-clinical sample (Sample A)of 170 students of slightly more females (56.3%)than males (43.7%), majority (58.7%) in age range of 18-19 years (32% and 26.7%, respectively) and whereas 4/5 (80.4%) were educated up to intermediate and graduation (36% and 46.4%, respectively) as compared to subjects educated up to post-graduation (18.6 %), and sample mainly belonged to middle socioeconomic class (78.4%) as compared to upper middle

(15.2%) and lower middle (5.4%) class. The internal consistency of OBQ-Urdu-44 was found to be satisfactorily high as depicted by reliability coefficients for OBQ-Urdu-total (α=.87) and subscales RT, PC, and ICT (α=.81, .85, .87, respectively). This result, in consistent with original OBQ-44 results (OCCWG,2005) and its other adapted versions across the world (Bortoncello et al., 2011; Cagin & Dag, 2009; Julien et al., 2008; Myers, Fisher, & Wells., 2008; Rahat et al., 2012; Sica et al., 2004), made OBQ-Urdu-44 a reliable self-report tool to assess obsessional dysfunctional beliefs found in OCD patients as OBQ-87 & 44 were claimed to be in OCCWG researches (OCCWG, 2001,2003 & 2005). The subscales (RT, PC, and ICT) were also found to be highly correlated with each other (ranging from .79 to .81) as well as with OBQ-total (.91 to .94). This pattern is relatively different from findings of original (OCCWG, 2005) as well as French version (Julien et al, 2007) because in both studies they found moderately high correlation among factors. This high correlation is indicative of overlap of constructs. Another possible reason is that these three factors depict obsessional dysfunctional beliefs so may occur simultaneously in one individual.

To further explore the psychometric properties of OBQ-Urdu-44, the Exploratory Factor Analysis (EFA) with Varimax rotation was conducted on 44 Urdu translated items administered on Sample A (n=170). EFA failed to replicate the original three factor structure (OCCWG, 2005) and factor structure found in majority of the studies of adapted versions (Bortoncello et al., 2011; Julien et al., 2008; Rahat et al., 2012). Present study, came up with different factor structure from original one, comprised of three factors in which first factor contained majority of OBQ-44 (24 items), second factor has total 11 whereas third factor has only 6 items. This different dimensionality of factors from original one were also found in few other researches (Cagin & Dag, 2009; Myers, Fisher & Wells, 2008; Shams et al. 2014;Woods et al. 2004).

The first factor Obsessive Belief-General (OB-G) has 24 items from three subscales (RT= 7 ,ICT= 9 , PC= 8) of OBQ-44 and it can be attributed as general obsessional beliefs because this factor has diverse type of items like having perfectionist and high moral standards, need to control thoughts and over-responsibility. The presence of general factor is identical with POBQ factor structure (Shams et el. 2014) and Woods et el. (2004) findings. This general factor has may be less specific bliefs related to OCD as compared to other belief domains (Shams et al. 2014), and more related to anxiety which is an associated feature of OCD and this general factor is may be associated with other anxiety disorders (Woods et al. 2004).

The second factor Cautious/ Vigilant (CV) has 11 items among those 6 items are from RT, 3 from ICT and 2 items from PC factor of OBQ-44. This factor attributed a tendency to be careful, cautious to avoid harm and negative consequences, and to be heedful.

The third factor comprised of five items of PC factor of OBQ-44 and consequently labeled as Perfectionist (PC) factor in OBQ-Urdu-40. This factor reflects the patients' need to be perfect in every task (even in their thought contents and behaviors), inability to tolerate imperfections and mistakes, and need to avoid ambiguity and uncertainty.

The EFA conducted in this study resulted in elimination of 4 items due to low factor loading (<.40) which made OBQ-Urdu a 40 item scale (OBQ-Urdu-40).

The reliability analysis conducted on OBQ-Urdu-40 depicted good internal consistency of scale (α=.80), whereas all three subscales (OR, CV, and PC) were satisfactorily reliable in terms of Cronbach's coefficient (α=.91, .86, and .78, respectively). The subscales were found to be significantly inter-correlated with each other and with full scale as well. The moderate correlations, although significant, among factors (r=.59, .52, .68) also indicate that these are

interrelated but distinctive constructs. This pattern is identical to original and French versions (Julien et al, 2008; OCCWG, 2005)

The OBQ-Urdu-40 can be more shortened by excluding Factor 3 PC on the basis of a reasonable number of items in Factor 1 and 2, and diversity of items type in both factors, and foremost, improvement of reliability coefficient of OBQ-Urdu-44 after deletion of PC factor (α= .80 to .85). This shortened version will be more feasible and convenient in terms of time saving.

Conclusively, Urdu adaptation of OBQ-44 has shown satisfactory psychometric properties hence making it a reliable tool to assess obsessional beliefs among Pakistani population. In addition; this study has provided a shortened version which is less time consuming.

Phase II

The Phase II of Study 2 was aimed to assess the symptom characteristics and dysfunctional beliefs of Sample B (24 OCD patients) of Study 3. To assess the symptom patterns, the YBOC-SC was administered on patients on individual setting and then by using descriptive analysis, means and standard deviations on each category of YBOC-SC were calculated to determine phenomenology of obsessive compulsive symptoms of Sample B. According to Table 7, the most prevalent symptoms were of contamination and aggression obsessions, washing compulsions and scrupulosity obsessions came next to them and after that, sexual obsessions, checking and repeating compulsions were scored high. These findings are partially consistent with study findings on phenomenology of OCS among Turkish OCD patients in which contamination and aggression obsessions were most common ones as found in Phase II of Study 2 but contrary to Turkish sample in this study sample somatic obsessions and symmetry

compulsions were found to be less (Karadağ, Oguzhanoglu, Ozdel, Ateşci&Amuk, 2006). The similarity of both studies' results can be attributed to cultural similarities between both target populations. But these findings are not consistent with previous research findings on phenomenology of OCD available on Pakistani population (Saleem& Mahmood, 2009). The possible reason of this difference is different of measuring tool. Saleem and Mahmood (2009) used their indigenous tool whereas this study had administered YBOCS-SC Urdu translation which on one side has superiority over their checklist because YBOC-SC is more standardized and valid tool but on the other hand its weak aspect was that it was a translated version without having a determined validity and reliability for our population.

The dysfunctional belief profile of Sample B was identified through descriptive analysis of their scores on OBQ-Urdu-44 total and on its subscales. The results mentioned in Table 8 were indicated that these patients had more obsessional beliefs related to Responsibility-Threat overestimation (RT) and Perfectionism-certainty (PC) domains of OBQ-Urdu-44 whereas they scored less on Importance and control of thoughts (ICT) as indicated by mean scores on RT, PC and ICT (89.54, 85.25 & 58.58, respectively).These findings are in line with researches conducted on French and Persian OBQs where Julien et al. (2007) and Shams et al. (2014) respectively, found same sequence of OBQ subscales in terms of mean scores. The reason of this similarity with French version can be attributed to similar sample (clinical sample) of both studies whereas similarity of cultural contexts might have led the identical results with Persion OBQ (POBQ). Contrary to this, for its Arabic counterpart, the lowest mean score was calculated for PC domain which is different from current findings which can be attributed to different sample for Arabic OBQ as they used student population for sample selection.

The total mean score (234.25) on this study measure was also quite high which is indicative of high level of obsession related dysfunctional beliefs because maximum score on this scale can be 308. This high mean score is not consistent with previous researches on original OBQ-44 and its cross cultural versions where total mean scores was found to be around 135 to 175 (Julien et al. 2007; OCCWG, 2005; Rahat, Rahimi, &Mohamadi, 2012; Shams et al. 2004). The possible reason to this difference is that the sample B of present study was purely a clinical sample which was selected from patient population consulting to psychiatric settings. Therefore their symptoms were so high in intensity that they considered need for treatment. This symptom severity may be a cause of high score on OBQ as in many researches association between OCS and OBQ scores was found (Moulding et al. 2011; Myers, Fisher, & Wells, 2008;Wu & Cater, 2008).

As last step of Phase II of Study 2, the correlation between YBOCS and OBQ-Urdu-44 was calculated in order to test the hypothesis of study 1. The researches available on OBQ-44 found association between dysfunctional beliefs with OCS (Abramowitz, Lackay, and Wheaton, 2009) and with severity of OCD as well (Faull, Joseph, Meaden, & Lawrence, 2004; Rahat et al. 2012), whereas they claimed predictive validity (Taylor et al. 2010) and discriminant validity of obsessional beliefs (Cagin & Dag, 2009; Izadi, Asgari, Neshatdust, & Abedi, 2014; Shams et al. 2014). On the basis of these findings author of current study hypothesized that there would be significant positive correlation between OBQ-Urdu-44 and YBOCS total scores. But the correlation between these two measures found not significant which rejected the Study 2 hypothesis. These findings are inconsistent with available literature on the topic because majority researches found good convergent validity of OBQ with symptom-severity tools of OCD (Cagin & Dag, 2009; Myers, Fisher, & Wells, 2008; Sica et al. 2004). This inconsistent finding is

actually in line with a research finding by OCCWG (2001) in which OBQ was found to be highly significantly correlated with Padua Inventory but its correlation with a self report YBOCS was weaker (ranging from .38 to .63 for total and subscales) than with Padua Inventory and authors attributed this with the difference of measurement strategies of YBOCS and Padua. Keeping this in view, the current findings can be argued that the YBOCS used in this study is much more different from Padua than YBOCS self report version, in measuring OCD severity. So it can be argued that if a self report version of YBOCS had weaker correlation with OBQ-44 may be because of different administration and measuring strategies than a very weak correlation of clinician administered YBOCS is understanable. Above all, not significant positive correlation between YBOCS and OBQ-Urdu-44 may be seen as an effect of different strategies of administration of both tools because first tool is clinician administered whereas second is a self report tool in its nature.

Conclusively, Study 2 has provided satisfactory Urdu translations of YBOCS-SC and OBQ-Urdu-44 for their use as outcome measures in study 3. But extensive psychometric properties of both scales are recommended to be explored in future so that these tools may be used not only in clinical practice but research purposes in Pakistan for Urdu speaking population.

The Study 2 has provided Urdu versions of two very important tools for assessment of OCD severity with its symptomatic patterns and severity and patterns of obsessional beliefs (YBOCS-SC and OBQ-44, respectively) for participants of Study 3.

Study 3

Results

Table 11

Two Way Mixed ANOVA for Placebo/waiting and CBT groups on YBOCS (n=12)

Source	*MS*	*df*	*F*	η^2	*p*
Between groups	475.35	1	44.21	.67	.001
Within groups	362.23	[a]1.63	124.01	.85	.001

Note: [a] Hyunh-Feldt Correction

The Table 11 is mentioning the Mixed ANOVA between-within subjects to compare scores of Placebo/waiting and CBT groups on YBOCS at pre-,mid-, and post-treatment (placebo and CBT, respectively) levels. The Within groups ANOVA, using Hyunh-Feldt correction, mentioning significant mean difference across three levels (Pre-,mid-, and post-CBT) of YBOCS scores $F(1, 1.63)= 124.01$, $p= .001$, $\eta^2 = .85$ which indicated that there is significant change among three levels of mean scores of YBOCS with highly significant effect size. The ANOVA comparing both groups across the time is indicating significant mean difference between both groups on YBOCS scores $F\ (1, 22) = 44.21$, $p=.001$, $\eta^2=.67$which revealed that both groups scored significantly different on mid and post treatment levels of YBOCS administration.

Table 11.1

Means and Standard Deviations of Attention-Control and CBT groups for YBOCS on Pre-, Mid-, and Post-Treatment (n=12)

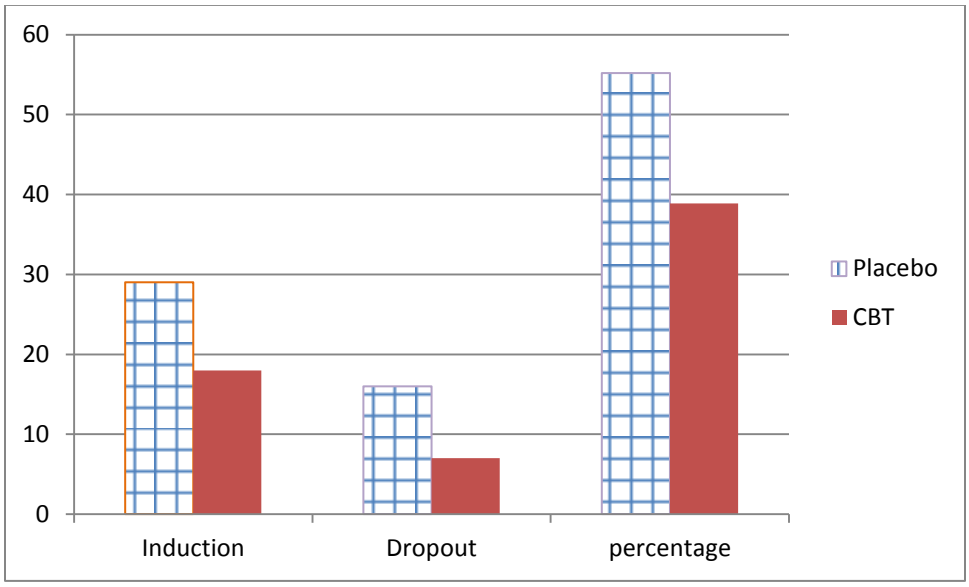
[a.] Level	Group	*M*	*SD*
[b]Pre-Treatment	Placebo/waiting	27.42	2.15
	CBT	27.58	1.24
	Total	27.50	1.72
Mid-Treatment	Placebo/waiting	26.83	2.72
	CBT	24.33	1.92
	Total	25.58	2.64
Post-Treatment	Placebo/waiting	26.55	3.58
	CBT	10.47	.95
	Total	18.51	7.16

Note: [a]Level of assessment. [b]Pre, Mid and Post-Placebo and CBT group scores on YBOCS.

The means and standard deviations based on Placebo/Waiting and CBT groups scores on YBOCS pre-, mid-, and post-treatment (Placebo or CBT) are mentioned in Table 11.1. Initially both groups' mean scores on pre- treatment level were almost equal which indicates that severity of OCD of patients of both groups was almost equal. There is a trend of slight decrease in means of Placebo/waiting group from pre-treatment to post-treatment level whereas CBT group showed slight decrease from pre to mid treatment level but rapid decrease in means from mid to post

treatment level of YBOCS administration which showed that CBT group has marked decrease in severity of symptoms as compared to Placebo/Waiting group. Combining Table 11 and 11.1 results, it can be concluded that CBT had been much effective in treating symptoms of OCD and reducing severity of OCD as compared to placebo which confirmed the first hypothesis of Study 3.

Figure 5 showing the difference of CBT and control groups on patient inductions and dropouts



The figure 5 is indicating more inductions in Placebo group (29) than in CBT group (18) which was the result of more drop outs from Placebo group as compared to CBT group (16 and 7, respectively) which indicates that high percentage of patients (55%) inducted in Placebo group have left therapy prematurely as compared to patients (39%) inducted in CBT group. Conclusively, figure 5 is indicating more dropouts from Placebo group than CBT group.

Table 12

*One Way Repeated Measures ANOVA for YBOCS (*N= 24)

Source	*df*	*MS*	^{a}F	η^2	*p*
Within groups	2.9	1483.144	194.61	.89	.001

Note :[a]Greenhouse-Geisser correction.

The effectiveness of CBT on 24 patients of OCD was evaluated, by using Repeated Measures ANOVA withGreenhouse-Geisser correction, on their scores of YBOCS at Pre-, Mid-, Post-, and Follow up-CBT levels. According to Table 12, ANOVA results indicated that there was significant effectiveness of CBT F (2.9, 66.64) =194.61, $p=.001$, $\eta^2=.89$, on sample of Study 3.

The Post hoc tests using Bonferroni correction given in Appendix E indicated that CBT had significantly reduced the severity of OCD as measured on YBOCS from pre-treatment to mid- and post-treatment levels (27.46 ± 3.08 vs 25.50 ± 2.96 and 11.79 ± 1.50), respectively. Whereas CBT could not work effectively on relapse prevention level as indicated by significantly high mean score (p>.005) at Follow-up level as compared to Post-treatment (11.79 ± 1.50 vs 14.92 ± 4.14). Table 12 and post hoc test has rejected the second hypothesis but confirmed the third and fourth hypotheses of Study 3.

Table 12.1

*Means and Standard Deviations of Sample C on Pre-, Mid-, Post-, and Follow up-CBT for YBOCS (*N= 24)

[a.] Level	*M*	*SD*
[b]Pre-CBT	27.46	3.08
Mid-CBT	25.50	2.96
Post-CBT	11.79	1.50
Follow-up	14.92	4.14

Note: [a]Level of assessment. [b]scores on YBOCS on Pre, Mid, Post CBT and Follow-up levels.

The means and standard deviations of 24 OCD patients' scores on YBOCS at Pre-, Mid-, Post-, and Follow up-CBT levels given in Table 12.1 are indicating a trend of rapid decrease in scores from Pre-CBT to Mid- and Post-CBT levels which got reversed on Follow up level.

Table 13

One Way Repeated Measures *ANOVA for OBQ-Urdu-44 (N=24)*

Source	*df*	*MS*	[a]*F*	η^2	*p*
Within groups	1.68	406.990	5.91	.25	.020

Note: [a]Huynh-Feldt correction.

The results of Repeated Measures ANOVA has been given in Table 13 which indicates that there was not significant mean difference {$F(1.68, 38.57)=5.91, p=.020, \eta^2=.25$}among the three times (i.e. Pre-, Post- and Follow up-CBT) administration of OBQ-Urd-44 on 24 patients of OCD in Study 3. Briefly results indicated that CBT could not affect the obsessive beliefs of OCD patients significantly. On the basis of these results it can be concluded that fifth hypothesis of study 3 was rejected.

Table 13.1

Means and Standard Deviations of Sample C for OBQ-Urdu-44 on Pre-, Post-, and Follow up-CBT Levels (N= 24)

[a.] Level	*M*	SD
[b]Pre-CBT	234.25	29.93
Post-CBT	226.71	27.73
Follow-up	230.54	28.19

Note: n= 24. [a]Level of assessment. [b]scores on OBQ on Pre, Mid and Post CBT levels.

In Table 13.1, the mean scores of sample C (24 OCD patients), on OBQ-Urdu-44 at Pre-, Post-, and Follow up-CBT levels, were given which indicated noticeable decrease in mean score on Post-CBT level but again mean score raised slightly on Follow up-CBT level.

Discussion

The CBT has been claimed an efficacious therapy for OCD in western world (Hofmann & Rees, 2008; Overholser, 1999) and its efficacy has been established in RCTs (Rufer et al.

2005; Warren and Thomas,2001) but very limited evidence is available for CBT effectiveness with Pakistani population (Naeem et al. 2010). The Study 3 was designed to assess the efficacy of indigenous therapeutic protocol of CBT based on amalgamation of western models of CBT and proposed amendments recommended in Study 1 results. For this purpose, a randomized-control double blind trial was conducted to make sure the objectivity of results. The efficacy of CBT was evaluated in several ways on two outcome tools i.e. YBOCS and OBQ-Urdu-44. In first step, the comparison of CBT and Placebo-Waiting group was determined by using Mixed ANOVA (Between-Within Groups) and a comparison of both groups on number of dropouts. In second step, the combined group (N=24) was assessed on One Way Repeated Measures ANOVA by comparing mean sores on YBOCS (Pre, Mid, Post and Follow up) and OBQ –Urdu-44(Pre, Post, and Follow up) separately.

The comparison of CBT and Placebo groups' scores on YBOCS was done by using Mixed ANOVA to test the hypothesis 1 of Study 3. On the basis of available literature on supremacy of CBT over Placebo and/or control groups (Hoffman & Smits, 2008) the researcher hypothesized that the CBT group's mean scores would be significantly less than mean scores of placebo group on mid and post levels of YBOCS administration. The results indicated significant mean difference ($p>.001$) between both groups on both levels of assessment in favor of CBT and on the basis of these results it can be claimed that CBT has been proven significantly effective in reducing symptom severity of OCD as compared to Placebo/waiting group. The effect size of CBT found to be highly significant. These findings are in line with previous research findings conducted (McLean et al. 2001; Rufer et al. 2005; Tolin, Frost, & Steketee, 2007; Watson & Rees, 2008).

The comparison of both groups on number of drop out patients was done assuming that the dropout rate would be low in CBT group as compared to other group because patients would feel more satisfied with their progress in CBT (Whittal & McLean, 1999). The results confirmed the assumption as there were 57% dropouts from Placebo/waiting as compared to 39% of CBT group dropouts. Considering the nature of this trial, the possible reason of this difference is nature of intervention applied in both groups. In Placebo group, there were no efforts to establish rapport which is considered a significant predictor of improvement (Vogel, Hansen, Stiles, & Götestam, 2006), no discussions on symptoms, and patients had been just involved in doing diverse activities such as knitting, stitching, gardening, painting, etc, which had no direct effect on their symptoms and belief patterns. Opposite to Placebo group, the CBT sessions were planned on protocol devised in Study 1 and were targeted towards symptom reduction by working on changing dysfunctional thoughts.

In order to keep research ethics intact, the Placebo/waiting patients also received complete CBT sessions which were terminated when they achieved the criteria as it was followed for CBT group. The overall efficacy of CBT was established by employing One way repeated measures ANOVA on pre-, mid-, post-CBT, and 6-months follow up. The results indicated highly significant efficacy of CBT with quite high effect size (.89) which are consistent with western findings on CBT efficacy (Butler, Chapman, Forman, & Beck, 2006). On the basis of these findings it can be concluded that CBT protocol devised in Study 1 had been proved much effective in dealing with OCS of Sample C. On the other side, quite high dropout rate (38%) of CBT-receiving patients is indicating need to improve the quality of CBT. Although there are multiple reasons of patient dropouts from psychotherapy and its rate has been reported 30% to 55% in psychotherapy (Hamilton, Moore, Crane, & Payne, 2011) but comparatively low

dropout rate of CBT (20%) as reported by Clark (2004) again alarmed the author to work over quality of CBT protocol of current study.

In addition, the significant mean difference between post-CBT and follow up scores on YBOCS where follow up mean scores were reported to be higher than post-CBT is questioning effect of CBT on relapse prevention. These findings are not consistent with popular findings on CBT ability to prevent relapse (Storch et al. 2008; Valderhaug, etal. 2007). Although Podea, et al. (2009) reported lack of stability in improvement by CBT over time as in case of present study CBT failed to prevent relapse.

The effect of CBT on obsessional beliefs was assessed by comparing mean scores of combined group (N=24) on OBQ-Urdu-44 on pre- and post-CBT, and 6-month follow up levels by employing One way repeated measures ANOVA which rejected the hypothesis 5 by accepting the null hypothesis. These findings are quite surprising as these are inconsistent with previous researches and claims of CBT experts that CBT significantly change the dysfunctional thoughts (Dalfen, 2004) and that there is an association between symptom severity and scores on beliefs measures (Anholt, vanOppen, Cath, Emmelkamp et al. 2010; Coradeschi et al, 2012). There can be several reasons of these inconsistent results. There might be more need to work on rigid, fix, deep rooted schematic beliefs of our population. Viewing these results in light of increase in mean scores on YBOCS on follow up assessment, it can be concluded that there was not satisfactory work done on cognitive restructuring of obsessional beliefs during therapy. Which in return might become cause of relapse in Sample C. Secondly, the techniques of cognitive restructuring might not be focused much as required to be. Thirdly, the mean score of non-clinical sample of Study 2 on OBQ-Urdu-44 was quite high (Table 4) and close to clinical sample score. This may indicate the speculation that these beliefs are not specific to OCD for

Pakistani population and may be prevalent in general population. Therefore, may have reinforcement from society and considered normal. Moreover, the non significant correlation between YBOCS and OBQ-Urdu-44 and non significant belief change in Study 3 collectively reflects the need to use measures other than OBQ-like self-report to assess obsessional beliefs.

Conclusively, the Study 3 has successfully evaluated the efficacy of indigenous CBT manual and findings are partially consistent with western researches although the need to improve protocol by focusing more on cognitive change and relapse prevention is highlighted.

The Study 3 has not only provided research evidence for effectiveness of Urdu protocol of CBT for OCD patients of Pakistan but also provided case studies to be analyzed in Study 4 for in depth exploration of CBT process for OCD patients of Pakistan.

Study 4

Results

The study 4 aimed to analyze eight case studies of Study 3 to probe the answers of inquiry questions raised in Study 4. The areas focused in this analysis were common symptoms (phenomenology), case conceptualization (critical events, personality, beliefs, etc.), therapeutic process (effective and ineffective techniques, modifications) and problems in implementation of therapy.

Common Symptoms (Phenomenology)

The most common symptom categories among obsessions present in sample of Study 4 were contamination (being clean as per religious rules) پاکی ناپاکی religious, sexual and aggression obsessions mostly thoughts but very few images and impulses. Among compulsions washing, checking and repeating compulsions were prominent mostly in religious context such as reciting Qura'anic verses repeatedly, washing, bathing according to religious rules and for prayes (غسل ,پاک کرنا ,وضو). The overt and yielding compulsions were more than covert and controlling ones, respectively. A unique prominent type of compulsions was found in present study sample which has strong religious context (i.e. reciting religious verses repeatedly). This type was kept under repeating compulsions.

Case Conceptualization

Developmental History. The common possible predisposing factors identified in longitudinal analysis of patients were subjective perception of harsh, critical, punitive, over religious parenting especially father, family history of OCD, strict and perfectionist view of

religion, strict moral and religious patterns of life practiced in family, and obsessive compulsive personality traits.

Critical Incidents. The critical events identified in longitudinal analysis of patients were psycho-social stressors e.g. divorce, breakup, financial and educational problems, etc.

Pre-morbid personality. The common personality traits found in sample were being organized, punctual, meticulous, critical, cautious, careful, moralistic, perfectionist and introvert.

The case histories indicated poor stress management whereas anxiety and avoidance were common reactions to stress.

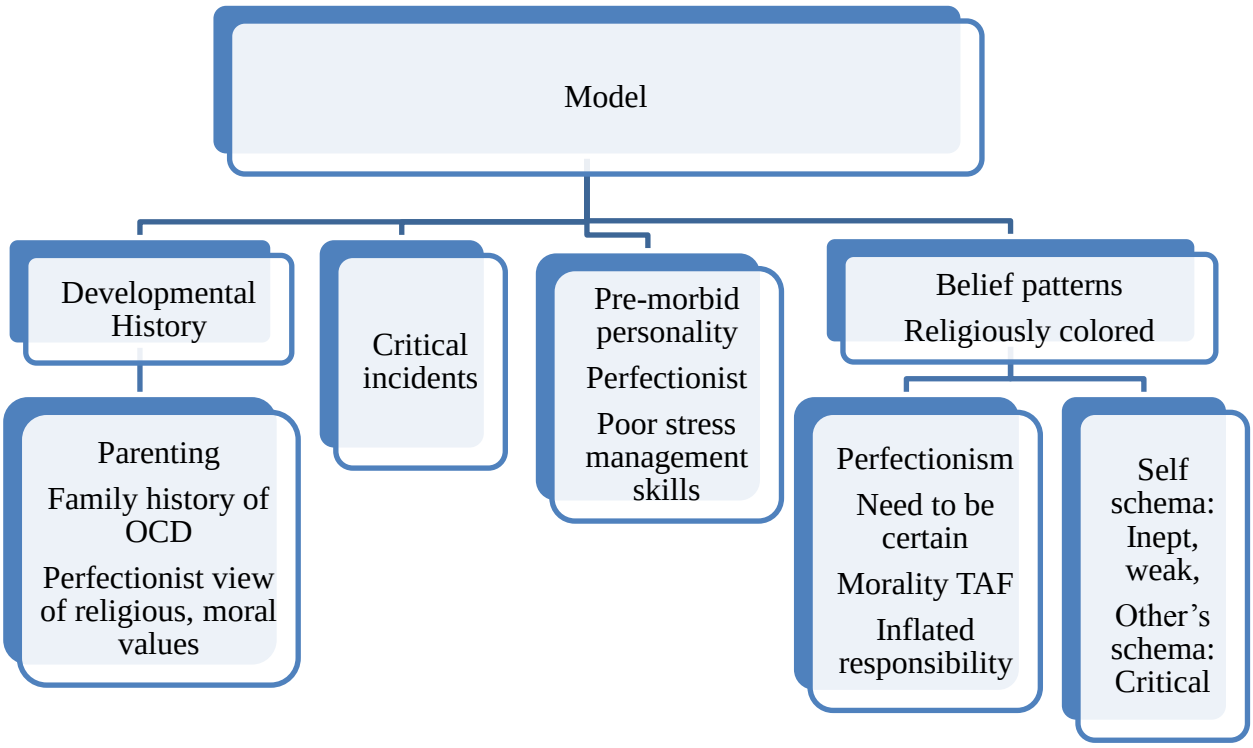
Belief patterns. The most common logical errors identified from case histories were perfectionism and need to be certain whereas morality thought action fusion, over responsibility and intolerance of anxiety were also commonly found cognitive distortions. A unique logical error found among sample was pessimistic view of self in religious context which might have its roots in perceptual biases regarding God and religion. As one patient said "I am having these thoughts because I am sinful **میں گناہگار ہوں اس لئے مجھے یہ سوچیں آتی ہی.** ". The schema of self was weak, inept, sinful, and bad, whereas schema of others (world and God) was of being punitive, harsh, demanding and critical. The schema of God and, as its result, perception of religion was found to be governing forces of majority of patients' belief patterns. Additionally, the Negative Automatic Thoughts (NATs), beliefs and interpretations of patients were religiously colored, such as, **میں اپنی ہر سوچ کے لئے اللہ کو جوابدہ ہوں اور کوئی بھی غلط سوچ مجھے جہنم میں پہنچا دے گی. وضو مکمل طور پر صحیح نہ ہو تو نماز قبول نہیں ہوگی. اللہ مجھے ان گندی سوچوں کے لئے کبھی معاف نہیں کرے گا.**

[2]"I am answerable to Allah for my each and every thinking, and one bad thought will lead to me to the Hell. "If I do not clean myself for prayers/ ablution perfectly, my prayers will not be accepted. "Allah will never forgive me for these nasty thoughts".

(See Appendix F for Obsessional Belief Scale—Pilot draft)

The beliefs regarding nature and etiology of disorder depicted patients' religious and cultural background as they view illness as punishment of their sins and/or effect of some magic or omen (buri nazar). That may be a possible reason that majority had consulted for treatment to faith healers first.

Figure 6. Etiological model of OCD



[2]English translation of dysfunctional beliefs given in previous page.

Therapeutic Process

Effective techniques. The effective techniques for readiness to change were found to be "cost-benefit analysis" and coping statements whereas it was observed that promoting readiness to change had been followed throughout the therapeutic process especially before behavioral exposures (behavioral experiments).

For psycho-education and socializing CBT, "Normalization", ABC of CBT by using idiosyncratic Dysfunctional Thought Record (DTR) form, and "Suppression experiment" were found to be most effective ways.

For managing obsessions initially "the detached mindfulness" had been reported to be much effective by majority of clients.

Among much effective ways to challenge logical errors and dysfunctional thought patterns the "Behavioral Experiments" were prominent.

Socratic dialogue and different verbal reattribution techniques were rated as more persuasive methods for changing dysfunctional thought patterns.

Less effective techniques. Patients considered written cognitive restructuring bit difficult, not appealing and less effective.

The use of family member as co-therapist was not found effective and difficult to implement probably because of high expressed emotions of family.

Figure 7. Effective techniques of CBT with sample C

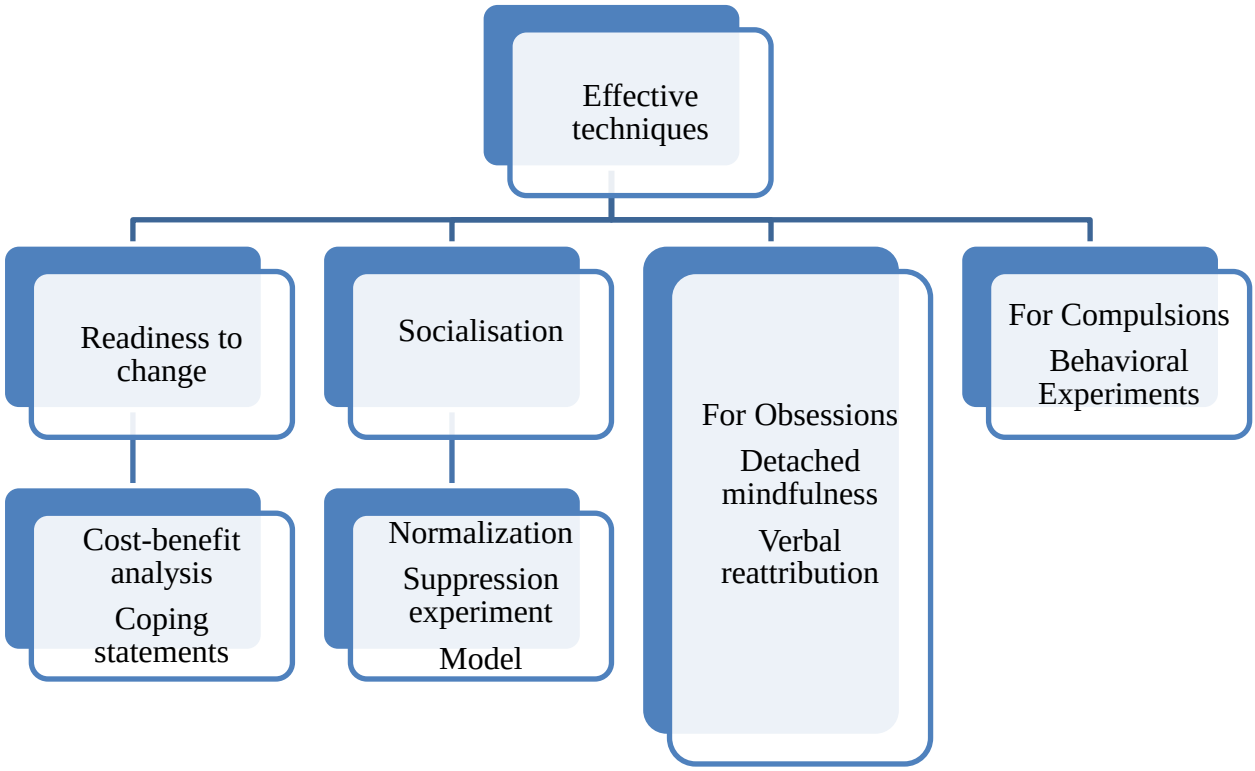
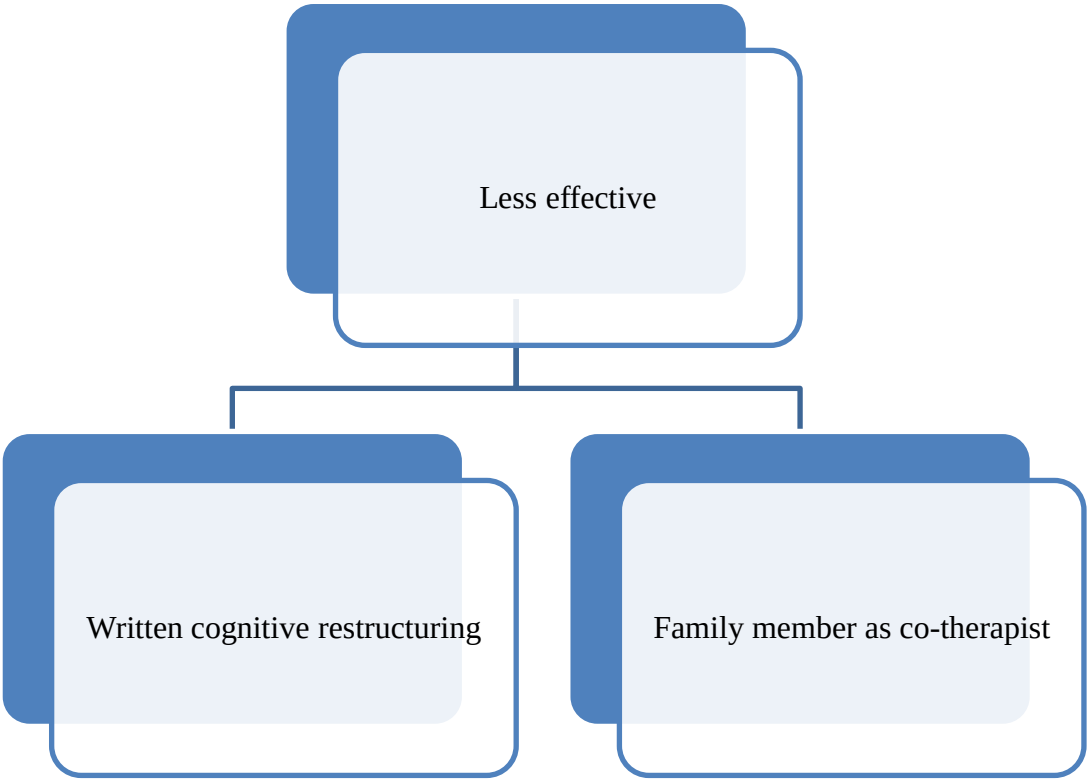


Figure 8. Less effective techniques of CBT with sample C



Cultural modifications. On the level of psycho-education, the Islamic concept of ارادی اور غیر ارادی سوچیں (intentionally and unintentionally) produced thoughts and their relation with consequences were found to be much effective in managing patients' anxiety, guilt and shame associated with obsessions and need to control obsessions. The psycho educational material based on relevant religious literature was also given to read again and again along with other elements of bibliotherapy. That material was found to be an effective home work.

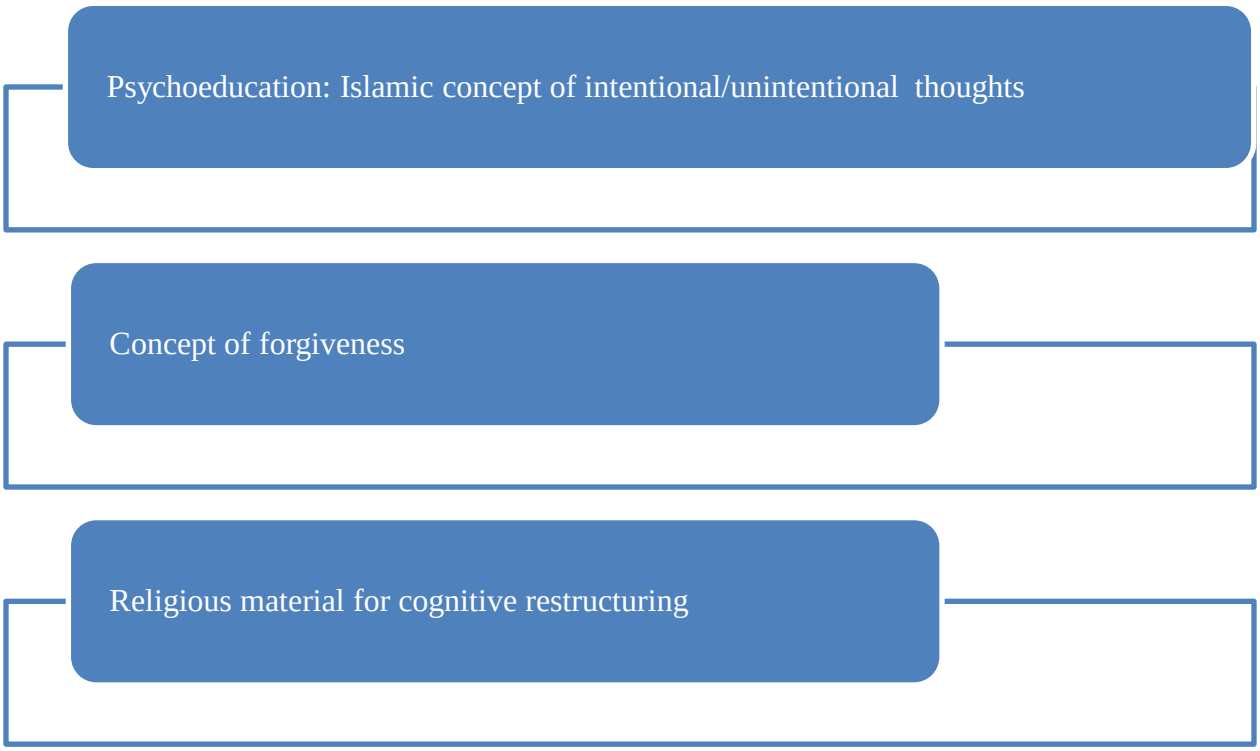
The concept of forgiveness in Islam, forgiving oneself and forgiveness as a major characteristic of God was much focused in dealing with

The use of Qura'anic Aya'at (verses) and Hadiths in cognitive restructuring were rated very much effective and supportive methods to change faulty appraisals.

To deal with washing and repeating rituals associated with religious acts were satisfactorily dealt with use of relevant religious literature in cognitive restructuring and psycho-education.

The concept of God and religion was focused in cognitive restructuring which was reported to be good way to change perfectionist thinking and self-blaming and downing.

Figure 9. Cultural modifications adopted in CBT process



Conclusion

Over all from phenomenology to case conceptualization and therapeutic process the cultural and religious context was prominent and has colored the symptoms presentation and belief interpretations. As its result, the use of relevant religious material for psycho education and cognitive restructuring found to be effective for sample of study 4.

Discussion

As an extension of Study 3, Study 4 intended to probe the CBT role in OCD management in cultural context of Pakistan by analyzing eight case studies randomly selected from Sample C. The aim was to see common symptoms prevalent in Sample E, to explore the therapeutic process with special emphasis on effective techniques for Sample C, and identify cultural differences of therapeutic process.

The common symptoms found in sample C confirmed the Study 2 quantitative results of phenomenology of Sample C as assessed on YBOC-SC in terms of their categories. For example, Study 4, like Study 2, indicated most common symptoms among Sample C were contamination, aggression, scrupulosity and sexual obsessions (mainly thoughts type), and cleaning, repeating and checking compulsions (overt and mental types).This is consistent with findings of Nelson et al. (2006) where scrupulosity has been found to be associated with sexual and aggression obsessions. Being qualitative in nature, Study 4 viewed the content of OCS qualitatively which has given these findings a different path on which author could learn more about religious-cultural impact on OCS. For example, the repeating mental compulsions were associated with recitation of qura'anic verses (again and again) in order to let oneself clean in religious terms "being clean from sins" as described by one patient. Another example is contamination

obsessions which had religious content **نا پاک** (unclean in terms of religion) more than germs contamination as it has been seen in western data (Rachman, 2004). These patients with contamination obsessions felt themselves being in danger to get punishment of "hell" from God, being rejected by God, and a constant threat to others related to them by contaminating them with **ناپاکی** (being dirty / unclean in religious terms). These findings are in line with Rachman (2004) where he defined contamination obsession as fear of being polluted and a danger for others as source of contamination. But the difference here is a religious content found in current study sample.

The contamination fear found in Sample C can be associated with threat-full information based on religion prevail in Pakistani society which might have let patients develop a sense of over responsibility to be "clean from bad doings", etc, (Rachman, 2004).This type of information and early experiences with authority figures (parents) can also be a source of self and God's schema. Because case histories indicated towards a negative (punitive, harsh, critical, unforgiving) schema of God and self was perceived as week (more vulnerable to do bad things, inability to prevent danger) which can be attributed to learning dysfunctional beliefs of RT and extremely strict moral standards domain through early experiences and religious information (Conway-Williams, 2011; Salkovskis, Shafran, Rcahmna,&Freeston,1999).

The coping mechanism adopted by patients of this study were reciting repeatedly the qura'anic verses covertly in order to let them clean from "sin" they thought they have committed by having"bad thoughts". This recitation can be considered a religious symbolic way of being clean as western patients do wash themselves after having contamination obsessions (Rachman, 2004). Interestingly, the choice of compulsions and safety behaviors were related to basis of

obsessions for example, they choose recitation of verses (compulsions), reassurance from religious scholars, and avoiding religious stimuli.

The Study 4 findings related to prevailing dysfunctional beliefs of morality thought-action fusion, perfectionism, intolerance of uncertainty and inflated responsibility are consistent with available data in which it was found that religious people have more of thought-action fusion (Williams, Lau, & Grishum, 2012;Yorulmaz, Gençöz,& Woody, 2009), and perfectionism and RT as most common types of cognitive errors found among OCD patients (Bouchard, Rhéaume, &Ladouceur, 1999; Shams & Milosevic, 2013). The common belief mentioned by patients of this study was their concern whether God would forgive them showed that they want to be certain about their end at Day of Judgment which showed a deep down need of certainty as Fergus and Rowatt (2014) found that intolerance of uncertainty has its association with individuals'' beliefs regarding God's perception as being punitive and critical. The findings of Study 4 are confirming Scrupulosity model posit by Abramowtiz and Jacoby (2014).

The religious and cultural impact on this illness is evident from commonly shared myth among Sample C that OCD is their punishment of sins and/or some magic as result of which majority had consulted faith healers before coming for psychiatric help. This kind of perception regarding etiology and management of OCD has been rejected in progressed countries (Dein, 2010) but it is still to be addressed in developing countries.

On the level of cognitive restructuring, the religious literature was used to challenge and modify scrupulosity-related beliefs and beliefs related to contamination compulsions because CBT advocates the use of relevant empirical information related to patients' philosophy of life (Osgood-Hynes, n.d.). So that a more factual information based on religious do and don'ts and a

normative comparison could be provided (Huppert & Siev, 2010), because literature advocates that scrupulosity has not its basis in religious teachings but ones' own need to be perfect and certain, and beliefs related to inflated responsibility to avoid bad doings (Krauth, n.d..).

The concept of unforgiving God and guilt were seen central to patients' beliefs which were similar to western research findings (Conway-Williams, 2011), and these beliefs and thinking patterns were main focus of attention during cognitive restructuring especially patients with scrupulosity symptoms.

Study 4 has presented academically stimulating findings regarding role of religious and cultural norms and values on phenomenology, dysfunctional beliefs and management of OCD patients of Pakistan whereas majority of findings were consistent with CBT conceptualization of OCD. This study has also provided a list of dysfunctional beliefs which could be used as obsessional beliefs scale by adopting scale construction procedures.

General Discussion

The mental health of human beings has been considered as much important as physical health for wellbeing and, as its result, the progress of individuals. The growing mental health problem has been the focus of attention of health professionals and researchers because a nation's prosperity, progress and bright future depend a lot on its mental and emotional stability. People, who suffer from mental problems or issues, cannot exert their potentials in wellbeing of their family, society and country to their full potential. Presence of mentally ill persons in any society is a threat to the integrity of that society and its values. That is the reason, all over the world the treatment of mental health problems and illnesses are major focus of attention.

Among a number of psychiatric disorders, OCD has been considered a very distressful and crippling mental illness (Kring, Davison, Neale, & Johnson, 2007). In Pakistan although no epidemiological studies are available on OCD, yet anyone can speculate that being a part of this planet Earth, Pakistan is not an exception regarding OCD prevalence. As a mental health professional, the author deals with two to three patients per day of OCD in OPDs of psychiatry which indicates, to some extent, its occurrence among psychiatric population of Pakistan.

In western world, OCD completed its journey from demon's influenced condition to a distinct psychiatric disorder (APA, 2013), in terms of its nature and etiological explanations, and from a psychodynamic and behavioral perspective of its management to cognitive restructuring of faulty thinking patterns (Clark, 2004). Research data on role of CBT in OCD management reveal empirically established efficacy of CBT and validity of its theoretical assumptions for OCD phenomenon (Overholser, 1999). Even CBT claimed to have most rich research evidences for management of OCD. Not only in western world, but CBT has been evaluated as an effective

treatment modality in eastern countries too. But unfortunately, very little work has been done on this very topic in Pakistan whereas it is a fact that, like rest of the world, CBT is now becoming the most applied psychotherapy in Pakistan too.

As a professional clinical psychologist of a third-world country, the author has concerns regarding her role in management of psychiatric illnesses in Pakistan. Therefore this study was planned to address the effectiveness of CBT with OCD patients of Pakistan specifically. The present study aimed to cover as much aspects of this topic as can be in short period of PhD program. As almost no research data available on this topic regarding Pakistani patients so study focused first to probe the process of CBT application in Pakistani patients of OCD by working clinical psychologists here so that a first hand knowledge of CBT status could be gained in order to devise an applicable treatment protocol suitable to Pakistani cultural context.

Culture is a set of guiding principles of members of a social group or society which influence their views about world and self, and their emotional and behavioral responses and ways to relate with world (Bhui & Morgan, 2007). The impact of culture is thus evident from the fact that it affects individuals' values, beliefs and behaviors and that is the reason of differences in values and thinking patterns of persons with different cultural background (Kuneman, 2010). So to understand and deal with humans their cultural background must be focused. The psychotherapy deals with humans therefore an effective psychotherapy should be culturally adapted (Griner & Smith, 2006).

Cultural adaptation means a process of changing and adapting goals, content, process and language of psychotherapy according to the culture of population under consideration, thus ensuring the efficacy and relevance of therapy (Papas et. al., 2010). The culturally adapted

therapeutic models are needed because specific therapies are originated in western culture and their across culture application without adaptation will question their credibility and will threat efficacy.

The CBT is an empirically strong module of psychotherapy which assumes a bio-psycho-social theory of human thinking, feeling and behaving patterns (Frogatt, 2006) but because of its western origin and influence, its application without adaptation in eastern world is debatable. The mental health professionals of eastern world question the capacity of westernized CBT to be generalized in their religious and collectivist cultures (Khodayarifard & McClenon, 2011).

In some societies, religious beliefs, principles and practices sometimes become so dominating over culture that religion colors their culture and cultural values. Pakistan is among those societies where amalgamation of culture and religion influenced the way of thinking and behaving. The impact of religion speaks louder in form of patients' beliefs regarding etiology of mental illness (evil eye, Satan's influence, and magic, or curse) and their health beliefs in which they take healer as source through whom Allah (God) bestows them health. That is the reason that they want active directive therapy because they like authoritative style in healing (Tseng, 1999). In this context, CBT can be considered best suitable approach for Muslim societies. Considering the importance of adaptation in improving CBT's efficacy for specific society, CBT has been adapted for different religious and ethnic societies such as for jewism, Christianity and Taoism, and integration of these religious perspectives in CBT case formulation has also been considered (Waller, Trepka, Collerton & Hawkins, 2010). The religious groups were considered because in some societies culture is so much colored with religion that value systems and thinking patterns become more influenced by religion (Agorastos, Demiralay & Huber, 2014).

Pakistan is among those countries where religion has great impact over culture. Therefore individuals here have more religiously influenced thoughts and beliefs. In country like Pakistan, the efficacy of CBT cannot be established objectively without adaptation by integrating religious and cultural values, norms, and beliefs. Especially in case of OCD, in which the scrupulosity, sexual, contamination, and aggression obsessions and compulsions exist, the need to adapt CBT accordingly becomes more intense.

In order to address the role of CBT for OCD patients of Pakistan, it was planned to adapt a CBT –based therapeutic protocol for OCD patients keeping their religious and cultural needs. There was high need to translate and create CBT material in Urdu language so that CBT could be provided effectively in first language of target population. This process of adapting CBT according to cultural and religious needs, values, and belief system of OCD patients belonged to Pakistan consisted of devising a therapeutic protocol based on CBT models in which the professionals' suggestions and amendments according to religious-cultural background of target population were integrated and CBT assessment and therapeutic tools (forms, biblio, and scales) were translated into Urdu so that patients' needs could be met. Then the effectiveness of this protocol was evaluated in Study 3 and in Study 4, the cases were analyzed qualitatively to refine this protocol more in order to make it more effective. It was made sure during this process of adaptation that basic principles of CBT should remain the base of this protocol and religious and cultural beliefs and values should only be considered in light of CBT. Because the aim was to first to understand formulation of their cases in terms of their religious and cultural backgrounds and then integrate those formulations in models of CBT, and secondly to modify their maladaptive thinking patterns and faulty interpretations with help of religious and cultural relevant materials. In short, the basic goal of that protocol was to modify dysfunctional beliefs by

using CBT principles and techniques in which religious values were integrated. It is not first time in the world that religious and cultural values of patients were integrated in CBT application but previous studies mentioned these efforts. For example, Huppert and sieve (2010) discussed CBT with religious individuals in which they have adapted E/RP according to their patients' religious values whereas Good (2010) studied the integration of CBT and spirituality for management of depression, Kuneman (2010) adapted group CBT according to cultural values of Hispanic/Latino depressives, and Papas et al. (2010) tried to make cultural adaptation of CBT for HIV patients.

The major purpose of this research was provision of an indigenous therapeutic protocol based on CBT for patients of OCD from Pakistan. For accomplishment of this, a main study was planned entitled "Development of a therapeutic protocol of CBT for OCD patients of Pakistan". The mixed approach (qualitative and quantitative) of research design was employed in conducting four interlinked studies which can be taken as four steps leaing to one destination---the main purpose.

In Study 1 (Devising therapy Protocol), the main objective was to devise CBT protocol integrated with cultural needs of patients. For this purpose, to identify and discover the experiences and opinions of professionally qualified clinical psychologist regarding their practice with CBT, in depth semi structured interviews were conducted so that their valuable experience could be integrated in pre-existing CBT models to devise therapeutic protocol of this study. The data were further analyzed qualitatively to address the issue in consideration. This study was quite helpful in planning therapy protocol because author had gathered information from those who had been experiencing the process of CBT application as therapist and knew the difficulties in implementation of CBT in Pakistani culture. Their knowledge of different aspects of assessment and therapy of CBT with our target population made it easy for author to plan a

protocol of CBT to meet target population need. The strength of Study 1 is its relevance in term of its method and results on the basis of which fruitful recommendations were made for adaptation of CBT for OCD management in Pakistan.

The Study 2 (Translation and Assessment) phase I was basically conducted to prepare required tools for assessment and therapy of OCD patients whereas in phase II, the baseline assessment of 24 OCD patients was conducted before implementation of CBT. In Phase I, the YBOCS-SC and OBQ-44 (assessment measures) were translated and their psychometric properties were explored. The CBT forms and worksheets such as Dysfunctional Thought Record (DTR), Cognitive Distortions form, Behavioral experiment worksheet were translated by following standard procedures to make them comprehensible for Sample C. This study provided two important tools of assessment in Urdu and several CBT based forms and socialisation material in Urdu which can be used by professionals in their practice and research purposes. This study has also discussed the phenomenology and belief patterns of OCD patients of Sample C. This proved to be partially resembled in their pattern with western clinical population's symptoms and dysfunctional beliefs but more similar with eastern and Islamic culture of Iran. This similarity again confirms the impact of culture and religion on ones thinking patterns. The study 2 also maintained the cultural perspective of current research in its journey to explore CBT role in OCD in Pakistani context.

Linked with Study 2, Study 3 (Outcome) was purely a quantitative approach based on RCT in which OCD patients of Sample C received CBT sessions, based on protocol devised in Study 1 and 2, individually and were analyzed using Mixed ANOVA (Between-Within Groups) and One Way Repeated Measures ANOVA for two outcome measures. These results were partially consistent with efficacy studies of CBT for OCD in west as there was significant mean

scores reduction of CBT group on YBOCS as compared to control patients and CBT overall proved to be significantly effective in treating OCS but results failed to prove CBT role in relapse prevention and managing dysfunctional thoughts. These findings on one side confirmed the efficacious role of CBT with Pakistani patients of OCD but on other side demand to improve quality of treatment protocol with more focus on cognitive restructuring and relapse prevention.

The last study (case study) was conducted to complete the gestalt of this picture of CBT with OCD in Pakistan. Author considered it necessary to take a qualitative view of process of CBT application done in Study 3. Because Study 3 had just discussed efficacy of CBT in quantitative term but to get in depth view of the process of therapy, the qualitative approach of study 4 was necessary. This Study has provided the different aspects of OCD and CBT in cultural context of Pakistan such as prevalent symptoms and their content, common dysfunctional belief patterns, beliefs and myths related to etiology and management of OCD, and effective techniques for sample C. The results of study 4 has provided detailed picture of topic in hand which helped much more in refining therapy protocol of this study which was the main purpose of present research study. A pilot draft of Dysfunctional Attitude Scale was also extracted in study 4 from patients' beliefs identified and probed during Study 3. In short, Study 4 has given the pragmatic view of CBT application within Pakistani culture.

Conclusively, all four studies guided systematically towards main goal of this doctoral work and not only provided a treatment protocol with relevant CBT based material in Urdu (the main purpose) but also provided useful tools and findings to be used by professionals in clinical work.

Limitations

- The sample A did not consist of any male psychologist, because no male clinical psychologist in Lahore fulfilled the inclusion criterion, which neglected their view point.
- The sample A was taken from Lahore city only so the opinion of psychologists of other areas of Pakistan was lacking in results.
- The opinion of OCD patients was not taken on topic.
- The validity of tools was not adequately established.
- The sample is small for Randomized Control Trials (RCTs).
- The comparison of demographic variables and their impact on efficacy was not explored.
- The medication effect could not be excluded.
- The sample had no treatment resistant case.
- The case studies were not primarily written and prepared for qualitative analysis.

Significance of Study

Being first study of its kind in Pakistan, this doctoral work has opened the pathway towards more empirical indigenous work in clinical psychology in Pakistan. The tools translated in this research work will be important addition to Urdu assessment measures available here. This research work has provided a treatment manual of CBT for OCD in Urdu which has its vast application in clinical practice and research in Pakistan. This study has been successful in providing indigenous information regarding OCD phenomenology and CBT process which can be helpful in improving understanding of this disorder and therapy in cultural context of Pakistan

that may be helpful in improvement of CBT practice standard in Pakistan. From its method to results, this study has tried to cover almost all aspects of this topic so that a comprehensive and pragmatic picture of CBT with OCD in Pakistani cultural context could be gained to improve the standard of clinical psychology research and practice in Pakistan.

Future Implications

This study can be replicated in reference to other psychiatric disorders so that overall standard of practice of clinical psychology in Pakistan can be improved and efficacy of CBT can be established with other disorders too. Moreover, the findings of this study will be useful in understanding OCD with reference to CBT in cultural context of Pakistan. The research will be helpful in improving CBT application for OCD patients in mental health settings here in Pakistan.

Overall, this doctoral work has lot of future implications in fields of research and clinical practice.

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Appendix A

Introduction:

This interview aims to probe the experience of professional clinical psychologists with Cognitive Behavior Therapy (CBT) for Anxiety Disorders especially OCD. Kindly frame your answers with special focus on adult OCD patients of our population and your personal experience and opinion as well rather than popular views.

Interview

Area: Introduction & Personal Experience in CBT

Name (optional): ----------

Gender: Male/Female Age:--------- yrs

Clinical Qualification:----------

Type of Cliental: Adult/Child/Both Average time/day in each ----------

Setting: Govt /Private/Both Average time/day in each ----------

Training in CBT: ----------

Duration of Experience with CBT: ----------

Type of clients dealt with CBT: ----------

1. Would you like to tell your basic qualification in

clinical psychology?

2. Please tell me in detail about your professional experience in clinical psychology?

3. If you have done any professional course/diploma/workshop in CBT, kindly describe your experience in detail?

4. You are practicing CBT in Pakistan; please relate your experience with this therapy here. From how much time you have been practicing it? On average, how many sessions do you conduct daily based on CBT?

5. Have you conducted any research based on CBT? Will you please share its details?

Area: Assessment in CBT

1. What in your opinion is the role of psychological assessment in CBT in dealing with OCD patients of our population?

2. What type of assessment do you conduct in your CBT sessions?

3. What are the pros & cons of these methods?

4. Which one is more effective for our population, in your opinion?

5. On what basis you plan & format your assessment sessions?

6. What is the duration & number of your CBT assessment sessions generally?

7. What is your pattern of mid-treatment assessment?

8. What is your experience regarding clients' response towards homework-base baseline charts, and formal tests?

9. If you ever did use any assessment method other than contemporary ones, would you please share those methods & your experience?

(i) Why did you feel need to adapt contemporary methods?

10. What is your experience with use of Behavioral tests as assessment methods for our population?

11. How many sessions do you take to formulate case?

12. Which model do you focus generally for case formulation? (i) What is the criterion of your choice for this specific model?

13. What developmental factors you focus more for case formulation? (i) What is the criterion of your choice for these specific factors?

Area: Model

1. Do you follow any specific model of CBT in dealing with patients of OCD? (i) Which one & why? (ii)Is it necessary to follow one model or we can integrate two or more?

2. Have you ever tried to develop or adapt your own CBT based model for your patient population? (i) Kindly share its details and your experience with it?(iii) Why did you feel need to develop your own model?

3. What is your opinion in implementation of western-based models on our clinical population?

4. What is CBT in your opinion? How would you define CBT? Is it one therapy or different brands of therapies under one generic name?

Area: Therapy

1. What methods do you use to provide psycho-education/ socialisation? What method is more effective and why?

2. In which words do you explain CBT for your clients for socialisation?

2. What ii your experience is the effectiveness of CBT with uneducated and less educated ones? (i) Is there any need to modify it for them?

3. How therapy can be modified with uneducated and less educated ones?(i) Have you modified it? (ii) Please share your experience in this context?

3. Some professionals think that OCD patients do follow religious & moralistic philosophy of life; What is your opinion in use of religious philosophy of life in conducting cognitive restructuring sessions of OCD patients? (i) How much you think religious knowledge, coping statements based on Aya'a & Hadith, etc are useful in dealing with OCD patients' cognitive errors and dysfunctional beliefs?

4. On what basis you structure your treatment plan for OCD patients? (i) What is the number, duration & format of sessions?

5. What is your experience in effectiveness of behavioral techniques? (i)Which techniques do you often use for OCD patients & why? (iii) if patient denies to verbalize or express the content of obsessive thoughts, what would be your (a) plan of action (b) choice of treatment techniques in this case?

6. What is the importance of Imagery techniques in the management of OCD in your opinion?(i) What type & Imagery techniques you use generally? (ii) For which symptoms you use Imagery generally?

7. What methods of Cognitive restructuring you use for OCD patients? (i) Do you consider any innovations in it?

8. Do you focus on Symptoms or Schemas in dealing with OCD patients? (i)What is your experience with it? (ii) What are the criteria of your choice?

9. Do you focus on all cognitive distortions or only address to selected ones for a specific case? (i) What is the basis of your selection?

10. How much effective you have found the use of coping statements in management of OCD?

11. Do you use co-therapist? (i) What is your experience in this context?

12. How many relapse-prevention sessions you conduct with OCD patients? (i) What is the content & format of these sessions?

13. How many follow up sessions do you conduct with OCD patients? (i) What is the content & format of these sessions?

14. What are your criteria of termination of therapy?(i) On what basis you have set these?

Area: Problems:

1. What problems do you have to face in implementation of CBT for OCD patients of our population?

2. How do you manage to overcome these problems?

3. Do you think these problems are specific to our cultural background and circumstances?

4. Are these problems specific to CBT or for other therapies too?

Appendix B

RE: permission to adapt Yale-Brown OCS (YBOCS)

Thursday, March 12, 2009 9:14 AM

From:

"Goodman, Wayne (NIH/NIMH) [E]" <goodmanw@mail.nih.gov>
View contact details

To:

kirenashfaq@yahoo.com

Kiran:

Thank you for your interest in the YBOCS. You have my permission to translate the YBOCS & checklist into Urdu. You anticipated some of the conditions: 1) you cannot use for commercial purposes; 2) this permission does not constitute a transfer or copyright: this is retained by Wayne Goodman, MD; 3) and please acknowledge of the original Archives of Gen Psychiatry publications from 1989 on the YBOCS. I look forward to seeing a copy of the translated scale. Were you planning to conduc t an independent back translation? Obviously, the latter would help me assess the fidelity of the translation.

Best of luck and regards,

Wayne

Wayne K. Goodman, M.D.
Director, Division of Adult Translational Research and Treatment Development (DATR)
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From: kiran ishfaq [mailto:kirenashfaq@yahoo.com]
Sent: Tuesday, March 10, 2009 5:45 AM
To: Goodman, Wayne (NIH/NIMH) [E]
Subject: permission to adapt Yale-Brown OCS (YBOCS)

Hi, I am a practicing clinical psychologist in a government hospital in Pakistan. I am doing my PhD thesis on CBT & its efficacy for OCD in Pakistan from Government CollegeUniversity,Lahore,Pakistan. I want to adapt YBOCS & Checklist in Urdu (national language of Pakistan), kindly grant me permission to do so With its original version in English. I

assure you that it will not be used for any financial purpose but only for my research. I will follow proper standardized procedures of adaptation and it will be an urdu version of YBOCS for people in Pakistan. I may also send you the adapted version with its research article when i will complete my work. Kindly do me favor. I will be thankful to you. Pls your scale is very useful for my thesis and if i adapt it in Urdu it will also be helpful to use for our clinical population. I will be highly obliged if you can send me efficacy studies of CBT for OCD. Your kind gesture will promote research culture in Pakistan as mine research is its first kind of research study in Paksitan. Pls reply soon positively. Thanx

Kiran Ishfaq

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RE: Need Obsessive Belief Questionniare (OBQ)

Monday, May 26, 2008 4:15 PM

From:

"Steketee, Gail S" <steketee@bu.edu>
Add sender to Contacts

To:
"kiran ishfaq" <kirenashfaq@yahoo.com>

Message contains attachments
2 Files (75KB) | Download All

- OBQ-44.doc
- OBQ-44 score key.doc

Dear Kiran Ishfaq,

I am attaching the OBQ-44 questionnaire for you to translate and another form that shows how to score it according to the English version factor scales. I ask that you use the translation and back-translation method with another colleague who speaks English very well in order to be sure that your translation is accurate according to the original meaning. When you have completed this and tested the translated measure, I would appreciate having your translation for my electronic files in case anyone else should ask for this version. Please put your name and contact information at the bottom of your translation so anyone who asks can locate you to discuss your work.

Best wishes,

Gail Steketee, PhD
Professor, Dean
Boston University School of Social Work
264 Bay State Rd.
Boston , MA 02215
steketee@bu.edu
617-353-3760
Fax 617-353-3913

From: kiran ishfaq [mailto:kirenashfaq@yahoo.com]
Sent: Monday, May 26, 2008 5:18 AM
To: Steketee, Gail S
Subject: Need Obsessive Belief Questionniare (OBQ)

Hi, I am practising clinical psychologsit in a psychiatry department in Pakistan . I am doing PhD on OCD & CBT from Govt. College University , Lahore Pakistan , and i want to adapt OBQ in Urdu (National language of my country) so i want english version of OBQ and your permision to do it. Kindly send me OBQ and grant permision to translate and adapt it in urdu.

Kiran Ishfaq

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Appendix D

CBT Protocol

Session No. 1 & 2:

Duration: 90 minutes each

Objective:

To complete psychological assessment for CBT case conceptualization and OCD symptom severity.

Tools:

- Cognitive Therapy Assessment Interview (CTAI)
- Y-BOCS-SC
- OBQ-Urdu-44
- Consent Form (See Appendix D2)

Procedure:

The assessment will begin with CTAI in which below mentioned steps will be followed:

- Provision of information regarding structure and goal of assessment
- Probing complete information regarding presenting complaints
- Determining cross-sectional analysis of the problem; DTR will be given to determine ABC of problem
- Determining longitudinal analysis including complete personal and family history, vulnerability factors and critical events

After that, assessment tools will be administered:

- Administering Y-BOCS-SC and OBQ-Urdu-44
- Preparing patient for next session (first therapeutic session)

Home work (H.W):

- DTR
- Psycho-education material (See appendix D3)

Session No. 3-5

Duration: 60 minutes each

Objective:

- To provide complete psycho-education, and socialization of idiosyncratic CBT based case conceptualization (Salkovskis' model)
- To provide more clear understanding of CBT conceptualization of CBT and to manage obsessional thoughts.
- To make a priority list of symptoms to be managed.
- To get patient ready to change

Tools/ Techniques:

- Psycho-education material
- CBT model (See Appendix D4)
- Advantages-Disadvantages to change (See Appendix D5)
- Normalization and Externalizing OCD
- Cognitive distortions list (See Appendix D6)
- Thought Suppression Experiment
- Ban Suppression
- Detached mindfulness

Procedure:

The psycho-education material given to patient in last session will be discussed with patient and myths, misperceptions will be addressed.

The Socialisation of CBT model (idiosyncratic case formulation based on Salkovskis' model) will be conducted by using educational style and Socratic dialogue with pictorial presentation of model.

A priority list of OCD symptoms to be managed in hierarchy will be made with mutual consensus of patient and therapist.

The normalization of problem will be done by using list of obsessional thoughts occur in normal population (Clark, 2004) and by arranging a mini survey on collecting information regarding occurrence of obsessional thoughts among normal population.

The appraisal model will be discussed with patient with help of his/her own examples using Socratic dialogue.

The thought suppression experiment will be conducted to give patient clear understanding of adverse effect of suppression on obsessions.

The cognitive distortions list with examples will be discussed with patient by fitting patient's thought examples in each type.

H.W.:

- Reviewing psycho education material, idiosyncratic model, and cognitive distortions
- Filling DTR by identifying patient's own cognitive distortions (See Appendix D7)
- Practicing Detached mindfulness

Session No. 6-12

Duration: 60 minutes each

Objective:

- To manage compulsions
- To conduct Mid-CBT assessment

Tools/Techniques:

- Readiness to change
- Behavioral Experiments/Reattribution (See Appendix D8)
- Cognitive Restructuring (See Appendix D9)
- Y-BOCS

Procedure:

The compulsions will be managed through cognitive restructuring of thoughts beneath fears, avoidances, and apprehensions in facing anxiety provoking situations and objects.

The Behavioral experiments will be planned to manage compulsions.

The cognitive restructuring techniques will be employed to change obsessional beliefs and cognitive distortions beneath the OCS.

H.W.:

- Behavioral Experiments
- DTR

Session No. 14-16

Duration: 60 minutes

Objective:

- To manage residual beliefs, appraisals and avoidances/safety behaviors.
- To manage related symptoms of OCD such as pathological doubt, slowness, poor insight, and so forth.

Tools/Techniques:

- Behavioral Experiments/Reattribution
- Cognitive Restructuring

Procedure:

The residual beliefs and safety behaviors along with related OCD features will be identified through probing and analyzing patient's daily routine and DTR. The Behavioral experiments will be planned to manage associated symptoms and safety behaviors along with readiness to change.

The cognitive restructuring techniques will be employed to manage residual beliefs and appraisals.

H.W.:

- Behavioral Experiments
- Advantages-Disadvantages to change
- DTR

Session No. 17-19

Duration: 60 minutes

Objective:

- To prevent relapse.
- To conduct Post CBT assessment

Tools/Techniques:

- Therapy Blue Print (See Appendix C9)
- Role Reversal

Procedure:

The Therapy blue print will be made in session and it will be explained to patient. The possible signs and symptoms of relapse and a realistic, research-based probability of relapse will be counseled to patient. The effective ways to prevent relapse will be counseled too.

The role reversal technique will be used in order to check patient's understanding of whole therapeutic process especially cognitive restructuring and relapse prevention.

H.W.:

- Therapy Blue Print
- Other written material given during CBT process

Note:

Each session will be started with review of home-work and difficulties and/or failures in completing home- work assignments will be addressed.

Appendix D1

Placebo Protocol

Session 1

Duration: 60 minutes

Objective:

- To conduct Pre-Placebo assessment.

Tools:

- Y-BOCS-SC

Procedure:

The Y-BOCS-SC will be administered in session to assess severity and nature of symptom.

H.W.:

None

Session No. 2-15

Duration: 60 minutes

- Objective:
- To provide Placebo treatment.

Activities:

- Embroidery
- Stitching
- Envelop making
- Paper bags making

Procedure:

The placebo sessions will be based on monotonous activities, it means that from above activities, for one patient one activity will be chosen and that will be continued till end of Placebo sessions. Anything related to OCD and its treatment will be prohibited and during sessions therapist will not be present but will leave room after letting patient to start activity and will end it in time.

H.W.:

None

Note:

The mid- and post-treatment assessment will be conducted on session 8 and last session.

Appendix C1

ییل براؤن ۔ پیمانہ ء وہم و جبر

89)/ (9 Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

عمومی ہدایات

کے مریضوں (Obsesive-Compulsive disorder-OCD) یہ پیمانہء درجہ بندی وہمی جبری بیماری میں پائی جانے والی علاما ت کی اقسام اور شدت کی درجہ بندی کے لیے بنایا گیا ہے۔ عام طور پر درجہ بندی کا انحصار مریض کے بیانات پر ہوتا ہے مگر حتمی درجہ بندی کا فیصلہ سوالات کرنے والے کے نفسیاتی بیماریوں کے متعلق علم اور رائے پر ہوتا ہے ۔ ہر سوال کے متعلق مریض کے بیان کو مریض کے انٹر ویو والے دن سے لے کر پچھلے ایک ہفتے کے دوران مریض کی اوسط حالت کو مد نظر رکھتے ہوئے درجہ بندی کریں۔ ہر سوال یا علامت پر مریض کاحاصل کردہ سکور اس علامت کی پچھلے ایک ہفتے کے دوران اوسط شدت کو ظاہر کرتا ہے۔

کی صورت میں کیا جاتا ہے۔ (Semistructured interview) اس پیمانہء درجہ بندی کو نیم منظم سوالات اس پیمانے کو استعمال کرنے والے کوتمام سوالات کو دی گئی ترتیب اور الفاظ کے مطابق کرنا چاہیے۔ تاہم مزید وضاحت کے لیے اضافی سوالا ت کرنے کی اجازت ہے۔ اگر مریض سوالات کے دوران کسی بھی موقع پر کوئی اضافی معلومات مہیا کرنا چاہیے تو ان معلومات کو بھی توجہ دینی چاہیے۔ بنیادی طور پر اس پیمانے میں درجہ بندی کا انحصار مریض کے دوران انٹر ویو بیانات اور آپ کے مشاہدے پر ہوتاہے۔ اگر آپ کا یہ خیال ہو کہ دی گئی معلومات بہت زیادہ غلط ہیں تو مریض کی معلومات کے قابل بھروسہ ہونے پر یقین کرنا مشکل ہو جائے گا اور ایسی صورت میں آپ کو شق نمبر19پر اس کو معلومات کے مطابق درج کرنا چاہیے۔

مریض کے علاوہ دوسرے لوگوں (مثلاً شوہر ، بیوی یا والدین) کی طرف سے مہیا کی گئی اضافی معلومات کی درجہ بندی کا تعین کرنے کے لیے صرف اس صورت میں معلومات میں استعمال کریں اگر آپ یہ فیصلہ کریں کہ:

1- یہ معلومات علاما ت کی شدت کا تعین اور درجہ بندی کرنے کے لیے ضروری ہیں۔

2 ۔ ایک قابل بھروسہ اور متوازن ہفتہ وار درجہ بندی اس آگاہ کنندہ سے ہر دفعہ حاصل کی جا سکتی ہے۔ سوالات کو شروع کرنے سے پہلے مریض کو سمجھانے کے لیے ''وہم '' اور ''جبری افعال'' کی تعریف بیان کر دیجیے۔ ['وہم '' وہ ان چاہے اور تکلیف دینے والے خیالات ، تصورات ، یا تحریکات (یعنی سوچ پر عمل کرنے کی شدید اور فوری خواہش) ہیں جو بار بار آپ کے ذہن میں آتے رہتے ہیں۔ یہ آپ کی خواہش اور مرضی کے بغیر آپ کے ذہن میں آتے رہتے ہیں۔ آپ کو ان سے نفرت یا گھن محسوس ہو سکتی ہے۔ آپ کویہ فضول محسوس ہو سکتے ہیں۔ اور یہ آپ کی اصل سوچوں، عادات ، رویوں اور شخصیت کے الٹ ہو سکتے ہیں۔]

دوسری طر ف['' جبر ی افعال وہ کام یا رویے ہیں جو آپ یہ جانتے ہوئے بھی کہ وہ فضول یا حد سے ' بڑھے ہوئے ہیں ، مجبوراً کرتے ہیں بعض اوقات ، آپ خود کو ان کاموں کو کرنے سے روکنے کی کوشش کرتے ہیں مگر ایسا کرناآپ کے لیے مشکل ہوتا ہے۔ جب تک یہ کام مکمل نہ ہوں آپ بے چینی محسوس کرتے رہتے ہیں]''۔

اب میں آپ کو وہم او ر جبری افعال کی کچھ مثالیں د یتی ہوں ،وہم کی ایک مثال ہے۔ '' اپنے بچوں کو نقصان پہنچانے کی باربار آنے والی سوچ یا اس سوچ پر فوری عمل کرنے کی شدید خواہش، اگر چہ آپ

''نے اصل میں کبھی ، اس پر عمل نہ کیا ہو۔
ایک جبری فعل کی مثال ہے استعمال کی چیزوں کا باربار معائنہ کرنا مثلاً گھر سے نکلنے سے پہلے '' ''چولہے ، تالے ، پانی کی ٹونٹی کو چیک کرنا۔
اگرچہ زیادہ ترجبری افعال کو دوسرے دیکھ سکتے ہیں مگر کچھ جبری افعال ذہنی طور پر بھی کئے '' جاتے ہیں مثلاً چپکے چپکے یا دل دل میں چیزوں کامعائنہ کرنا، یا کوئی برا خیال آنے پر دل میں کوئی جملہ (یاآیت) دہرانا ''۔
''اب اگر آپ ''وہم '' اور ''جبری افعال '' کے متعلق کچھ اور سوال پوچھنا چاہیں تو پوچھ سکتے ہیں۔ '' اگر یہ واضح ہو گیاہو کہ مریض ان الفاظ کا مطلب اچھی طرح سمجھ چکا ہے تو متواتر آزمائش کی صورت میں ہربار، ان الفاظ کی تعریف اور مثالیں بیان کرنا ضروری نہیں ۔صرف اتنا ہی کافی ہو سکتا ہے کہ مریض کو مختصراً ' یہ یا د کروا دیاجائے کہ وہم خیالات یا فکر ہوتی ہے جبکہ جبری افعال وہ رویے یا کام ہوتے ہیں جوہم ظاہری طور پر یا دل میں کرنے پر مجبور ہوتے ہیں ۔
مریض کی مطلوبہ یا اہم علامات کی فہرست بنانے کے لیے مریض کواس کے تمام موجودہ وہم اور جبری افعال کو ایک ایک کر کے لکھنے یا بیان کرنے کو کہیں۔
موجودہ علامات کی نشاندہی کے لئے ییل براؤن علامات کی فہرست کو استعمال کریں ۔ یہ ماضی کی علامات کی نشاندہی اور ان سے خبردار رہنے کے لیے بھی مدد گار ثابت ہوتی ہے اس لیے کہ ماضی کی علامات حالیہ درجہ بندی کے دوران دوبارہ سے نمودار ہو سکتی ہیں۔
ایک دفعہ موجودہ وہم اورجبری افعال کی اقسام کی نشاندہی ہو جائے تو انہیں مطلوبہ / اہم علامات فارم پر آسان اقسام میں ترتیب دے کر ایک فہرست کی صورت میں لکھ لیں۔ (مثلاً مطلوبہ جبری افعال کو '' معائنہ و پڑتال'' اور '' دھلائی و صفائی '' میں تقسیم کر لیجئے۔)
علامات کے نمایاں پہلوؤں کو وضاحت سے بیان کریں تاکہ ان کو اچھے طریقے سے سمجھا جا سکے (مثلاً '' معائنہ و پڑتا ل'' کے جبری افعال کی فہرست کے ساتھ ساتھ یہ بھی واضح کریں کہ مریض کس لئے معائنہ و پڑتال کرتا ہے) یہ بھی ضرور واضح کریں کہ کون سی معلومات اتنی اہم ہیں کہ جن پر جانچ اور تشخیص کے اس عمل میں زیادہ توجہ دی جائے گی۔
نوٹ: تاہم ہر مشق کے لیے حتمی سکور کو مریض کو تما م خبط یا جبری افعال کی مجموعی درجہ بندی کو ظاہر کرنا چاہیے۔
درجہ بندی کو کرنے والے کو اس با ت کو یقینی بنا لینا چاہیے کہ بیان کیے گئے رویے یا علامات وہمی کی حقیقی علامات ہیں نہ کہ کسی اور (Obsessive-Compulsive Disorder---OCD) جبری بیماری کی علامات کو ظاہر کرتے ہیں۔Paraphilia یا(Specific Phobia) ذہنی بیماری مثلاً بے جا خوف سے الگ کرنا (Complex Moter tics)جبری افعال کی تشخیص کو پیچیدہ ، حرکی ، عضلاتی رعشہ بعض اوقات مشکل حتیٰ کہ ناممکن بھی ہو سکتا ہے ۔ ایسی صورت میں مطلوبہ معلومات کا غیر مبہم اور واضح نقشہ بیان کرنا اور بعد میں کی جانے والی درجہ بندیوں میں تسلسل کا ہونا بے حد ضروری ہے۔
کے لیے الگ درجہ بندی کے پیمانے کاہونا بھی ضروری ہے ۔ tics ایسی صورت میں
Impulse ییل براؤن وہم و جبری علامات کی فہرست میں دی گئیں کچھ علامات ایسی ہیں جو کہ اب اگرچہ ییل براؤن وہمی جبری Trichtillomania کی علامات میں شامل ہیں مثلاًContral Disorder۔
کی بیماریوں کی تشخیص کے لیے موزونیت کا DSM-IV-R اورDSM-III-R کی(Y-BOCS) پیمانہ ابھی تحقیق سے پتہ چلانا باقی ہے۔ تاہم جب ییل براؤن وہمی جبری پیمانہ کو وہمی جبری بیماری کے

مریض کی ایسی علامات کی شدت کی درجہ بندی کے لیے استعمال کیا جا رہا ہو جو کہ وہمی جبری تو وہمی جبری بیماری (Trichotillomaniaبیماری کے مرض کی نمایاں اور اصل علامات نہ ہوں (مثلاً کی علامات شدت کے لیے الگ سے اور ان علامات کی Y-BOCS)کو ییل براؤن وہمی جبری پیمانہ شدت کے لئے، کہ جن کا وہمی جبری بیماری سے تعلق ابھی واضح نہیں، الگ سے کیا جائے گا۔

دوبارہ درجہ بندی کرنے کی صورت میں ، مطلوبہ وہمی علامات پر ایک بار پھر سے غور کریں اور اگر ضرورت ہو توشق نمبر 1کو شروع کرنے سے پہلے ردو بدل کر لیں۔ یہی عمل مشق نمبر6کی درجہ بندی کرنے سے پہلے مطلوبہ جبری افعال کے لیے دہرائیے۔

تمام19شقوں کی درجہ بندی کی جاتی ہے مگر شق1سے10(شق 1ب اور6ب کو نکال کر) کل سکور کا تعین کیا جاتا ہے۔

کا کل سکو ر شق نمبر1-10کا مجوعہ (شق نمبر1ب اور شق Y-BOCS ییل براؤن وہمی جبری پیمانہ نمبر6ب کے سکو رکا نکال کر) جبکہ خبط اور اجباری افعال کا جزوی سکور بالترتیب شق نمبر1-5کا مجموعہ (منفی شق 1ب)اور شق نمبر6-10کا کل مجموعہ سکور(منفی شق 6ب) ہے۔

بیل براؤن ۔ پیمانہ ء وہم و جبر

اب میں آپ سے آپ کے وہم کے بارے میں بہت سے سوالات پوچھوں گی'' [مریض کے مطلوبہ /اہم '' ''وہم''کا یہاں خصوصی طورپر ذکر کیجیے]۔

1۔وہم پرصرف شدہ وقت:

سوال: '' آپ کے کتنے وقت پر ا ن وہمی سوچوں کا قبضہ رہتا ہے ''؟ [اگر مریض نہ سمجھے تو]''آپکا کا کتنا وقت ان وہمی سوچوں پر خرچ ہوجاتا ہے ''؟

جب وہم مختصر ، وقفے وقفے سے مداخلت کرتے ہو ں تو گھنٹوں میں ان پر صرف ہونے والے وقت کا] تعین کرنا مشکل ہوجاتا ہے۔ اسطرح کی صور تحال میں وقت کا تعین اس بات سے کیجئے کہ وہم کتنی بار وقت کے ایک مخصوص وقفے کے دوران آتے ہیں۔ ایسی صورت میں ، وہم کی بار بار مداخلت کرنے کی تعداد اور ایک دن میں وہم سے کل متاثر ہ گھنٹوں کی تعداد کو مد نظررکھتے ہوئے پوچھئے]۔

سوال:'' وہم کی سوچیں کتنی بار آتی ہیں ؟'' [روز مرہ کی ادھر ادھر کی سوچیں اور فکر، جو کہ وہم سے اس لحاظ سے مختلف ہوتی ہیں کہ یہ مریض کی شخصیت کے مطابق اور منطقی ہوتی ہیں(اگرچہ حد سے بڑھی ہوتی ہیں)، پر صرف شدہ وقت کو اس میں شمار نہ کیاجائے]۔

0 ۔ بالکل نہیں

1 ۔ معمولی ، ایک گھنٹے یومیہ سے کم یا کبھی کبھار کی مداخلت۔

2 ۔ درمیانہ ایک سے تین گھنٹے یومیہ یا بار بار مداخلت۔

3 ۔ شدید ، تین سے آٹھ یا بہت زیادہ مداخلت۔

4 ۔ حد سے زیادہ شدید 8گھنٹے یومیہ سے زیادہ یا تقریباً مسلسل مداخلت۔

1 (ب۔وہم سے آزاد وقفہ: (مجموعی سکور میں شامل نہیں

سوال:''آپکے جاگنے کے دوران اوسطاً ایک دن میں زیادہ سے زیادہ مسلسل کتنے گھنٹے آپ وہم سے مکمل آزاد گزارتے ہیں''؟[مریض اگر نہ سمجھے تو] سوال: ''آپ کے اندازے کے مطابق جب آپ جاگ رہے /رہی ہوں تو ایک دن میں زیادہ سے زیادہ مسلسل کتنے گھنٹے آپ وہم کی مداخلت سے مکمل طورپر آزاد گزارتے / گزارتی ہیں''؟[اگر ضرورت ہو تو پوچھیے] سوال:''وقت کا سب سے لمبا وقفہ کتنا ہوتا ہے جب وہم بالکل ذہن میں نہیں آتے؟''۔

0 ۔کوئی علامت نہیں

1 ۔ وہم کی علامت سے آزادطویل وقفے ، مسلسل 8گھنٹے یومیہ سے زیادہ خبط سے آزاد وقت۔

2 ۔ وہم کی علامات سے آزاد مختصر وقفے، مسلسل 1سے 3گھنٹے یومیہ خبط سے آزاد وقت۔

3 ۔وہم کی علامات سے آزاد درمیانے وقفے ،مسلسل 3سے 8 گھنٹے یومیہ خبط سے آزاد وقت۔

4 ۔ وہم کی علامات سے آزاد انتہائی مختصر وقفے،مسلسل 1 یومیہ سے کم خبطسے آزاد وقت

2 :۔ وہم کی وجہ سے ہونے والی مداخلت

سوال:''آپکے وہم آپ کے سماجی میل جول (ملنا جُلنا ، دوستی ، رشتہ داری) یا کام کاج ، نوکری کی صلاحیت میں کس حد تک مداخلت کرتے ہیں۔؟'' سوال: ''کیا کوئی ایسے کام ہیں جو آپ ان وہم کی وجہ سے نہیں کر سکتے/سکتی؟''

اگر مریض حالیہ دنوں میں کوئی کام نہیں کررہا تو اس بات کا تعین کیجیے کہ اگر وہ نوکری پیشہ ہوتا] تو اسکی کارکردگی وہم کی وجہ سے کتنی متاثر ہو سکتی تھی ؟[

0 ۔بالکل نہیں
1 ۔ معمولی ، سماجی میل جول یا پیشہ وارانہ کارکردگی میں تھوڑی سی مداخلت مگر مجموعی طورپر کارکردگی نہیں بگڑی ۔
2 ۔ درمیانی ، سماجی میل جول یا پیشہ وارانہ کارکردگی میں واضح مداخلت مگر ابھی بھی صورتحال قابو میں ہے۔
3 ۔ شدید مداخلت ، جوسماجی میل جول یا پیشہ وارانہ کارکردگی میں بگاڑ اور کمزوری کی وجہ بن رہی ہے۔
4 ۔ حد سے زیادہ مداخلت ، ناکارہ بنا دینے والی

3 ۔ وہم سے ہونے والی اذیت:

سوال:''آپکو وہم کی وجہ سے کتنی تکلیف محسوس ہوتی ہے ''؟

[زیادہ تر مریضوں میں وہم کی وجہ سے ہونے والی اذیت کو تشویش کے ساتھ ملا دیا جاتا ہے تاہم مریض یہ بیان کر سکتا ہے کہ وہم پریشان کن ہیں مگر وہ تشویش کے احساس سے انکار کر سکتا ہے ، صرف اس تشویش کی درجہ بندی کریں جووہم کی وجہ سے پیدا ہوتی ہو اور عمومی تشویش یا دوسرے حالات سے منسلک تشویش کو نظر انداز کردیں ۔ (Generalized Anxiety)

0 ۔بالکل نہیں
1 ۔ معمولی اذیت، زیادہ پریشان کن نہیں۔
2 ۔درمیانی اذیت، پریشان کن مگر قابو میں رہنے والی۔
3 ۔شدید اذیت، بہت زیادہ پریشان کن
4 ۔حد سے زیادہ اذیت، تقریباً مسلسل اور ناکارہ بنا ڈالنے والی اذیت و تکلیف۔

4 ۔وہم کے خلاف مزاحمت:

سوال:''آپ ان وہم کی سوچوں کو روکنے کے لیے کتنی کوشش کرتی/کرتے ہیں ؟ جب وہم کی یہ سوچیں آپ کے ذہن میں آتی ہیں تو آپ کتنی مرتبہ ان سوچوں کو جھٹکنے ، انہیں فضول سمجھ کر ذہن سے نکالنے یا اپنی توجہ کو ان سے ہٹانے کی کوشش کرتے /کرتی ہیں ''؟۔

[وہم کو روکنے میں حاصل ہونے والی حتمی کامیابی یا ناکامی کی بجائے صرف مریض کی وہم کے خلاف مزاحمت کی کوشش کا تخمینہ /اندازہ لگائیں اور صرف مریض کی مزاحمت کی کوشش کی درجہ بندی کر یں۔ مریض کی وہم کے خلاف مزاحمت کی قوت کا تعلق اسکی ا ن خبط پر قابو پانے کی صلاحیت سے ہو بھی سکتا ہے او ر نہیں بھی ہو سکتا ہے ۔ اس بات کو دھیان میں رکھیے کہ یہ سوال وہم کی شدت کو براہ راست نہیں ناپتا بلکہ اسکے برخلاف یہ صحت کی علامت کو جانچتا ہے یعنی وہ کوشش جو مریض گریز کرنے یا جبری افعال کرنے کی بجائے کسی اور طریقے سے وہم کے خلاف کرے ۔اسطرح جس قدر مریض مزاحمت کی کوشش کرتا ہے اتنی ہی کہ کم اسکی کارکردگی متاثر ہوتی ہے ۔ مزاحمت کے براہ راست / افعالی اور بالواسطہ / انفعالی طریقے ہوتے ہیں ۔ کرداری طریقہ علاج میں مریض کی حوصہ افزائی کی جاتی ہے کہ وہ خبط کی علامات کا توڑ کرنے کے لیے ان کے خلاف کوشش نہ کریں(مثلاً ''سوچ کو ذہن میں آنے دیں'' انفعالی مزاحمت ہے) یا پریشان کرنے والے خیالات کو ارادتاً ذہن میں لائے۔ اس شق کے لیے کرداری طریقہ علاج کے ان مختلف طریقوں کو مزاحمت کی اقسام کے طور پر ذہن میں رکھیئے۔ اگروہم بہت کم ہیں تو شاید مریض انہیں روکنے کی ضرورت ہی محسوس کرتا ہو۔ایسی صورت میں ''o'' نہ] پر نشان لگانا چاہیے۔

0 ۔ ہمیشہ مزاحمت کی کوشش کرتا ہے، یا علامات اتنی کم ہیں کہ بہت براہ راست اور موثر مزاحمت کی ضرورت محسوس نہیں کرتا۔
1۔ مزاحمت کی اکثر اوقات کوشش کرتا ہے۔
2۔مزاحمت کی کسی حد تک کوشش کرتا ہے۔
3 ۔معمولی ہچکچاہٹ کے ساتھ وہم کی سوچوں کے آگے، قابو پانے کی کوشش کے بغیر، ہتھیار ڈال دیتا ہے۔
4۔اپنی تمام تر رضامندی کے ساتھ وہم کی تمام سوچوں کے آگے ہتھیار ڈال دیتاہے۔
5۔وہم پر اختیار کا درجہ:
سوال''آپکو اپنیوہم پر کتنا قابو ہے ''؟ ''آپ اپنی وہمی سوچوں کو روکنے یا ان کا رخ موڑنے میں یا اپنا دھیان بدلنے میں کس حد تک کامیاب ہوتے /ہوتی ہیں ''؟
[مزاحمت سے متعلق پچھلے سوال کے برخلاف، مریض کی وہم پر قابو پانے کی صلاحیت وہم کی شدت سے زیادہ تعلق رکھتی ہے]
0۔مکمل اختیار
1 ۔کافی اختیار، تھوڑی سی کوشش اور توجہ کی مدد سے وہم کے سلسلے کو روکنے یا منتشر کرنے کے قابل ہونا۔
2۔درمیانی اختیارکبھی کبھار وہم کو روکنے یا منتشر کرنے میں کامیاب ہو پانا۔
3 ۔ معمولی اختیار،بہت ہی کم بار وہم کو روکنے یا منتشر کرنے میں کامیاب ہو پانا، اپنی توجہ کوبے حد مشکل کے ساتھ ہٹا پانا۔
4 ۔کوئی اختیار نہیں،وہم کو مکمل طور پر بے غیر اختیاری عمل/تجربہ سمجھنا، بہت ہی کم اس قابل ہو پانا کہ کسی بھی لمحہ کے لئے بھی خبط کو بدل پانا۔
[اگلے کئی سوالات آپ کے جبری اعمال کے بارے میں ہیں مریض کے اہم /مطلوبہ جبری افعال کا یہاں خصوصی ذکر کیجیے]
6۔جبری افعال پر صرف ہونے والا وقت:
سوال : ''آپ جبری افعا ل کو کرنے میں کتنا وقت خرچ کرتے ہیں''؟ [جب جبری افعا ل کا تعلق زیادہ تر روزہ مرہ کی سرگرمیوں سے ہو تو پوچھیے]
'' ان جبری افعال کی وجہ سے روزانہ کے معمول کے کاموں کو مکمل کرنے میں آپکا دوسرے لوگوں کی نسبت کتنا زیادہ وقت لگ جاتا ہے۔''
[جب جبری افعال مختصر وقت کے لیے اور وقفے وقفے سے کئے جاتے ہوں تو ان پر لگنے والے وقت کا اندازہ کل گھنٹوں میں مشکل ہو سکتا ہے۔ ایسی صورت میں کل وقت کا اندازہ اس بات سے کیجئے کہ یہ افعال کتنی کثرت سے(یعنی کتنی بار) کئے جاتے ہیں ۔ جبری افعال کو کرنے کی تعداد اور ان سے متاثرہ گھنٹے فی دن، دونوں کو مدنظر رکھیئے۔ جبری افعال کے وقت کے الگ الگ دنوں میں کئے جانے کو گنئیے، نہ کہ ایک وقت میں متواتر دہرائے جانیوالے جبری فعل کو مثلاً ایک مریض جو ایک دن میں 20بار ہاتھ دھونے کا جبری فعل کرنے کے لیے واش روم جاتا ہے اور ہر بار 5بار تیزی سے ہاتھ دھوتا ہے تو وہ ہاتھ دھونے کے جبری فعل کو 20بار یومیہ کرتا ہے نہ کہ=100) 20235 (5 100بار یومیہ ۔ پوچھیے:]
سوال:' 'آپ کتنی بار جبری افعال ادا کرتے ہیں ''؟ '

زیادہ تر مریضوں میں جبری افعال ایسے کاموں پر مشتمل ہوتے ہیں جن کا مشاہدہ کیا جا سکتا ہے(مثلاً]
ہاتھ دھونا مگر کچھ جبری افعال ایسے بھی ہوتے ہیں جو دل میں /اندرونی طور پر کئے جاتے ہیں جن کا
مشاہدہ دوسرے نہیں کر سکتے (مثلاً خاموشی سے معائنہ و پڑتال کرنا، دل میں آیات دہرانا)۔
0۔بالکل نہیں
1۔معمولی(1گھنٹہ یومیہ سے کم جبری افعال پر صرف کرنا)یا کبھی کبھارجبری افعال کی ادائیگی
2۔درمیانہ،(1سے 3گھنٹہ یومیہ جبری افعال پر صرف کرنا)یااکثر جبری افعال کی ادائیگی
شدید،(3سے 8گھنٹے یومیہ جبری افعال پر صرف کرنا) یا بہت زیادہ کثرت سے جبری افعال کی ادائیگی۔
حد سے زیادہ شدید،(8گھنٹے یومیہ سے زیادہ وقت جبری افعال کی ادائیگی میں لگنے رہنا(اتنی کثرت
(سے کہ گننا مشکل ہو جائے
6(ب ۔جبری افعال سے آزاد وقت: (کل شمار میں شامل نہیں
سوال: '' آپ کے اندازے کے مطابق، جاگنے کے دوران آپ ایک دن میں مسلسل کتنے گھنٹے اوسطاً
جبری افعال سے مکمل طور پر آزاد وقت گزارتے / گزارتے/گزارتی ہیں ''؟ [اگر ضروری ہو تو
پوچھئے] '' وقت کا سب سے لمبا وقفہ کو ن سا ہوتا ہے جب آپ بالکل بھی جبری افعال نہیں کررہے
ہوتے /ہوتی'' ؟
0۔ کوئی علامات نہیں
1۔ علامات سے آزاد طویل و قفہ ، مسلسل 8گھنٹے یومیہ سے زیادہ علامات سے آزاد وقفہ
2۔ علامات سے آزاد درمیانی وقفہ ، مسلسل 3سے8گھنٹے یومیہ علامات سے آزاد قفہ
3۔ علامات سے آزاد مختصر وقفہ ، مسلسل 1سے 3گھنٹے یومیہ علامات سے آزاد وقفہ
4۔ علامات سے آزاد بے حد مختصروقفہ ، مسلسل 1گھنٹہ یومیہ سے کم علامات سے آزاد وقفہ
7:۔جبری افعال کی وجہ سے ہونے والی مداخلت
سوال:''آپکے جبری افعال آپ کے سماجی میل جول (ملنا جُلنا ، دوستی ، رشتہ داری) یا کام کاج ، نوکری
کی صلاحیت میں کس حد تک مداخلت کرتے ہیں۔؟'' سوال: ''کیا کوئی ایسے کام ہیں جو آپ ان جبری
''افعال کی وجہ سے نہیں کر سکتے/سکتی؟
اگر مریض حالیہ دنوں میں کوئی کام نہیں کررہا تو اس بات کا تعین کیجیے کہ اگر وہ نوکری پیشہ ہوتا]
[تو اسکی کارکردگی جبری افعال کی وجہ سے کتنی متاثر ہو سکتی تھی ؟
0۔بالکل نہیں
1 ۔ معمولی ، سماجی میل جول یا پیشہ وارانہ کارکردگی میں تھوڑی سی مداخلت مگر مجموعی طورپر
کارکردگی نہیں بگڑی ۔
2 ۔ درمیانی ، سماجی میل جول یا پیشہ وارانہ کارکردگی میں واضح مداخلت مگر ابھی بھی صورتحال قابو
میں ہے۔
3 ۔ شدید مداخلت جوسماجی میل جول یا پیشہ وارانہ کارکردگی میں بگاڑ اور کمزوری کی وجہ بن رہی
ہے۔
4۔ حد سے زیادہ مداخلت ، ناکارہ بنا دینے والی
8:۔ جبری افعال سے ہونے والی اذیت
سوال: '' اگر آپ کو جبری فعل یا افعال کو اداکرنے سے روکا جائے توآپ کیسا محسوس کریں گے /گی
''؟ [وقفہ] '' آپ کتنے بے چین ہو جائیں گے /گی ''؟ [اس اذیت کی شدت کی درجہ بندی کیجئے جو مریض

کو جبری افعال کی ادائیگی کی کو مکمل ہونے سے روکنے پر ، بغیر تسلی کی فراہمی کے محسوس ہوتی ہے۔ تمام نہیں مگر زیادہ تر مریضوں میں جبری افعال کی ادائیگی کے بعد تشویش و بے چینی میں کمی ہوجاتی ہے۔ اگر انٹرویو کرنے والے کی را ئے میں اوپربیان کئے گئے طریقے کے مطابق جبری افعال کو روکنے سے تشویش میں واقعی کمی ہو جاتی ہو تو پوچھئے :]

سوال:'' آپ جبری افعال کو کرتے ہوئے تب تک کتنے بے چین ہوتے / ہوتی ہیں جب تک کہ آپ کو تسلی نہ ہوجا ئے کہ وہ مکمل ہو گئے ہیں''؟۔

0۔ بالکل نہیں

1۔ معمولی ،جبری افعال کو ر وکنے پریاجبری افعال کی ادائیگی کے وقت معمولی تشویش۔

2۔ درمیانی ، مریض بیان کرتا ہے کہ تشویش جبری افعال کو روکنے سے شدت اختیار کر تی ہے مگر قابو میں رہتی ہے ، یا یہ کہ جبری افعال کی ادائیگی کے دوران تشویش بڑھتی ہے مگر قابو میں رہتی ہے۔

3۔ شدید نمایاں اور بے حد پریشان کرنے والی تشویش اگرجبری افعال کی ادائیگی سے روکا جائے تو،یاجبری افعال کی ادائیگی کے دوران نمایاں اور بے حد پریشان کر دینے والی تشویش۔

4۔ انتہائی شدید، ناکارہ بنا ڈالنے والی تشویش محسوس ہوتی اگر جبری فعل کو کرنے کے طریقہ میں ذرا سی بھی تبدیلی لانے کی کوشش کی جائے، یا جبری افعال کی ادائیگی کے وقت ناکارہ بنا ڈالنے والی تشویش محسوس ہونا۔

9جبری افعال کے خلاف مزاحمت:۔

سوال:'' جب ان جبری افعال کو کرنے کا خیال آتا ہے تو خود کو ان جبری افعال کو کرنے سے روکنے کے لیے کتنی کوشش کرتی/کرتے ہیں ؟''

[جبری افعال کو روکنے میں حاصل ہونے والی حتمی کامیابی یا ناکامی کی بجائے صرف مریض کی جبری افعال کے خلاف مزاحمت کی کوشش کا تخمینہ /اندازہ لگائیں اور صرف مریض کی مزاحمت کی کوشش کی درجہ بندی کر یں۔ مریض کی خبط کے خلاف مزاحمت کی قوت کا تعلق اسکی ا ن خبط پر قابو پانے کی صلاحیت سے ہو بھی سکتا ہے او ر نہیں بھی ہو سکتا ہے ۔ اس بات کو دھیان میں رکھیے کہ یہ سوا ل جبر ی افعال کی شدت کو براہ راست نہیں ناپتا بلکہ اسکے برخلاف یہ صحت کی علامت کو جانچتا ہے یعنی وہ کوشش جو مریض جبری افعال کے خلاف کرے ۔اسطرح جس قدر مریض مزاحمت کی کوشش کرتا ہے اتنی ہی کم اسکی کارکردگی متاثر ہوتی ہے ۔اگر جبری افعال بہت کم ہیں تو شاید مریض انہیں روکنے کی ضرورت ہی محسوس نہ کرتا ہو۔ایسی صورت میں ' o ' پر نشان لگانا چاہیے۔]

0۔ ہمیشہ مزاحمت کی کوشش کرتا ہے، یا علامات اتنی کم ہیں کہ بہت براہ راست اور موثر مزاحمت کی ضرورت محسوس نہیں کرتا۔

1۔ مزاحمت کی اکثر اوقات کوشش کرتا ہے۔

2۔ مزاحمت کی کسی حد تک کوشش کرتا ہے۔

3۔ معمولی ہچکچاہٹ کے ساتھ جبری افعال کے آگے، قابو پانے کی کوشش کے بغیر، ہتھیار ڈال دیتا ہے۔

4۔ اپنی تمام تر رضامندی کے ساتھ جبری افعال کے آگے ہتھیار ڈال دیتاہے۔

10جبری افعال پر اختیار کا درجہ:۔

سوال:'' آپ کوجبری افعال کو ادا کرنے کی کتنی شدید خواہش محسوس ہوتی ہے؟'' [وقفہ] ''آپ کوجبری افعال پر کتنا قابو ہے''؟

0- مکمل اختیار:

1- کافی اختیار،جبری فعل کی ادائیگی کا دباؤ محسوس کرتا ہے مگر عموماً اس پر قابو پا لیتا ہے۔

2 درمیانی حد تک اختیار،جبری فعل کی ادائیگی کا شدید دباؤ محسوس کرتا ہے۔ مگر تھوڑی سی مشکل کا سامنا کرتے ہوئے جبری افعال پر قابوپالیتا ہے۔

3 معمولی اختیار،جبری افعال کی ادائیگی کے لیے بہت شدید تحریک محسوس کرتا ہے۔ انہیں لازماً مکمل کرنے میں بہت مشکل سے معمولی تاخیر برداشت کرپاتا ہے ۔

4 بالکل اختیا رنہیں،جبری افعال کی ادائیگی کے لیے مریض بے اختیار انہ اور بے بس کر دینے والے تحریک محسوس کرتا ہے، بہت کم ہی اس قابل ہو پاتا ہے کہ جبری افعال کی ادائیگی میں کبھی ایک لمحے کی تاخیر کو برادشت کر پائے۔

باقی کے سوالات وہم اورجبری افعال دونو ں کے بارے میں ہیں ۔ کچھ سوالات ان سے تعلق رکھنے '' والے مسائل کے بارے میں ہیں۔''

[یہ تفتیشی شقیں ہیں اور وہمی جبری پیمانہ (Y-BOCS) کے مجموعی سکور میں شامل نہیں۔ مگر یہ ان علامات کو مزید جانچنے میں مدد گار ہو سکتی ہیں۔]

11- وہم اورجبری افعا ل کی فہم:

سوال: '' کیا آپ اپنے وہم یا جبری افعال کو مناسب اور معقول سمجھتے / سمجھتی ہیں '' [وقفہ] '' آپ کا کیا خیال ہے کہ اگر آپ جبری افعال ادا نہیں کریں گے/گی تو کیا ہوجائے گا ؟'' '' کیاآپ یہ یقین رکھتے ہیں کہ جبری افعال کو نہ کرنے کی صورت میں کچھ ضرور ہوجائے گا؟ رکھتی/''

[مریض کے وہم و جبر ی افعال کی فہم کی درجہ بندی کا تعین انٹر ویو کے دوران بیان کردہ خیالات ، جو کہ وہ وہم و جبری ا فعال کی نا معقولیت اور زیادتی کے متعلق رکھتا ہے، کی بنیاد پر کریں]۔

0- شاندار فہم، مکمل منطقی و معقول ۔

1 اچھی فہم، وہم و جبری ا فعال کے بے معنی ہونے یا حد سے بڑھے ہونے کو تسلیم کرنا،لیکن پوری طرح اس بات کا قائل نہ ہونا کہ تشویش کے علاوہ بھی فکر مند ہونے کے لیے کچھ اور موجود نہیں ہے (یعنی شکوک میں مبتلا ہونا)۔

2 بہتر فہم، ہچکچاہٹ کے ساتھ وہم و جبری ا فعال کے بے معنی یا حد سے بڑھے ہوئے ہونے کا اقرار کرتا ہے، لیکن مترلزل رہتا ہے۔ کچھ بے معنی خوف محسوس کرسکتا ہے مگر ان پر یقین نہیں۔

3 بری فہم ، وہم و جبری ا فعال کے بے معنی و حد سے بڑھے ہونے کا انکار کرنا، مگر ان کے مخالف ثبوت کی سچائی کو تسلیم کرنا (یعنی ضرورت سے زیادہ اہمیت دیئے جانے والے خیالات کی موجودگی)-Overvalued ideas]

4 مکمل طور پر پریقین ہونا کہ وہم و Delunional Thought) (۔ فہم کی عدم موجودگی ، وہمی سوچ جبری ا فعال با لکل معقول و مناسب ہیں اور مخالف ثبوت کو نظر انداز کردینا۔

12- : ۔ گریز و اجتناب

سوال:''کیا آپ اپنے وہم و جبری افعال کو کرنے کی فکر کی وجہ سے کچھ کام کرنے، کہیں آنے جانے، یا کسی کے ساتھ ملنے سے بچنے کی کوشش کرتے رہتے ہیں؟''[اگر ہاں ، تو پوچھیئے:]''آپ کس حد تک ان کاموں کو کرنے سے بچتے رہتے ہیں''؟[مریض کے جان بوجھ کر چیزوں یا کاموں سے گریز کرنے کی عادت کی درجہ بندی کریں۔ بعض اوقات جبری افعال کی ایسے منصوبہ بندی کی جاتی ہے کہ وہ کسی ایسی صورتحال جس سے انسان خوفزدہ ہو، سے گریز کرنے میں مدد دے سکے۔ مثلاً '' کپڑے

دھونے کا بار بار کیا جانے والا کام ''جبری فعل ہے نہ کہ گریز پر مبنی رویہ۔اگر مریض اس جبری فعل کی وجہ سے کپڑے دھونا چھوڑ دے ، تو یہ گریز کہلائے گا۔]

0۔ بالکل کوئی قصداً گریز نہیں۔

1۔معمولی، بہت کم گریز۔

2۔درمیانہ،کسی حد تک گریز،صاف طور پر موجود۔

3۔شدید،،کافی حد تک گریز، نمایاں طور پر موجود۔

4 ۔حد سے زیادہ شدید، بہت وسیع پیمانے مر گریز، مریض علامات کو ابھارنے والی ہر چیز سے گریز کرنے کے لئے تقریباً ہر کوشش کرتا ہے۔

13۔ فیصلے کرنے میں دشواری کا درجہ:

سوال: '' کیا آپ کو ان چھوٹی چھوٹی باتوں کے متعلق بھی فیصلے کرنے میں مشکل پیش آتی ہے جن کے بارے میں فیصلہ کرتے ہوئے شاید لوگ دوسری بار سوچنے کی ضرورت بھی محسوس نہ کریں(مثلاً صبح کونسے کپڑے پہنوں، چائے کی کونسی پتی خریدوں، گھی کس کمپنی کا لیناچاہئے)؟''[مریض کی ہر وقت مختلف سوچوں میں گھرے رہنے کی عادت، یا ادھیڑبن کی سوچوں کی وجہ سے فیصلوں میں دشواری کو اس میں سے نکال دیجئے۔ متضاد سوچیں جو کہ منطقی اور مشکل فیصلے کرتے ہوئے آتی ہیں انہیں بھی اس شق کی درجہ بندی کرتے ہوئے شامل نہ کریں]۔

0۔ بالکل نہیں۔

1۔معمولی،چھوٹی چھوٹی چیزوں سے متعلق فیصلہ کرتے ہوئے تھوڑی سی مشکل محسوس کرنا۔

2 ۔ درمیانی،ایسی چیزوں سے متعلق فیصلہ کرتے ہوئے بھی خاصی مشکل محسوس کرنا جن کے بارے میں فیصلہ کرتے ہوئے شاید لوگوں کو د وسری بار سوچنا بھی نہ پڑے۔

3 ۔شدید، غیر ضروری طور پر چیزوں کے مثبت /منفی پہلوؤں (فائدے/نقصان) کا مسلسل تجزیہ کرتے رہنا۔

4۔ حد سے زیادہ، فیصلے کرنے میں ناکام رہنا، ، فیصلے کرنے میں لاچاری

14۔ حد سے بڑھا ہوا احساس ذمہ داری:

سوال:'' کیا آپ اپنے کئے گئے کاموں کے نتائج کے لئے خود کو بہت زیادہ ذمہ دار سمجھتے /سمجھتی ہیں؟ کیا آپ ان واقعا ت کے نتائج کے لئے بھی خود کو ذمہ دار سمجھتے /سمجھتی ہیں جو کہ آپ کے مکمل اختیار میں نہیں ہوتے؟''[عام احساس ذمہ داری، احساس بے وقعتی،مریضانہ احساس جرم و گناہ کو اس حد سے بڑھے ہوئے احساس ذمہ داری سے الگ رکھتے ہوئے اس شق کی درجہ بندی کریں۔ ایک پچھتاوے کا شکار انسان اپنے اعمال کو یا خود کو شیطانی سمجھتا ہے]۔

0۔ بالکل نہیں۔

1 ۔ معمولی، صرف پوچھنے پر ظاہر کرنا، حد سے بڑھے ہوئے احساس ذمہ داری کی معمولی حد تک موجودگی۔

2 ۔درمیانہ، خیالات کا برملا اظہار، واضح موجودگی،مریض میں اپنے اختیار سے باہر واقعات کے لئے بھی حد سے زیادہ احساس ذمہ داری کا پایا جانا۔

3 ۔شدید ، خیالات کی نمایاں اور مسلسل موجودگی، شدید فکر کہ اپنے اختیار سے باہر واقعات کے نتائج کا بھی وہی ذمہ دار ہے ۔بعیدا ز فہم اور تقریباًنا معقول حد تک خود کو موردِ الزام ٹھرانا۔

4 ۔انتہائی شدید ، وہم کی حد تک بڑھا ہوا احساسِ ذمہ داری۔(مثلاً اگر 3000میل دور زلزلہ آئے تو مریض

(خود کو الزام دے کہ اسکے جبری افعال کی عدم ادائیگی کی وجہ سے ایسا ہوا۔
15۔ مسلسل سست روی ،کاہلی کی پریشانی :
سوال : ''کیا آپ کوکام شروع کرنے یا ختم کرنے میں دشواری ہوتی ہے؟۔''کیا آپ اکثر روز مرہ کے کاموں میں جتنا وقت لگانا چا ہئے اس سے زیادہ وقت لگاتے/ لگاتی ہیں''؟۔[ڈپریشن کے باعث ہونے والی نفسی حر کی معذوری (Psychomotor Retardation) میں تمیزکیجئے۔ اگرچہ مخصوص وہم کی نشاند ہی نہ بھی ہوسکے، روز مرہ کی سرگرمیوں میں لگنے والے فالتو وقت کا تخمینہ لگائے ۔]
0۔ بالکل نہیں۔
1۔ معمولی، آغاز یا اختتام میں معمولی تا خیر۔
2۔ درمیانی ، روز مرہ کاموں میں اکثر تاخیر، مگر عام طور پر کاموں کا مکمل کر لیا جانا۔
3۔ شدید، روز مرہ کے کام شروع اور ختم کرنے میں مسلسل اور نمایاں دقت ، اکثر تاخیر۔
4۔ انتہائی حد تک ، بغیر کسی کی پوری طرح مدد کے کام شروع یا مکمل نہ کر سکنا۔
16۔مریضانہ شک و شبہ:
سوال:''کیا کام کو مکمل کر لینے کے بعد آپکو شک رہتا ہے کہ جیسے آپ نے اسے صحیح طرح نہیں کیا؟'' '' کیا آپ شک میں رہتے/رہتی ہیں کہ شاید آپ نے اسے بالکل کیا ہی نہیں؟'' ''معمول کا کام کرتے ہوئے کیا آپ کو لگتا ہے کہ آپ کو اپنے حواس پر اعتبار نہیں(جیسے کہ جو آپ دیکھتے سنتے یا چھوتے ہیں۔)''؟
0۔ بالکل نہیں
1۔ معمولی ، صرف پوچھنے پر پتہ چلے، معمولی مریضانہ شک، دی گئی مثالیں نار مل حدتک ہیں۔
2 درمیانی ، بیان کردہ خیالات کی برجستہ اور مریض کے بعض افعال میں نمایاں نظر آنے والی موجودگی، مریض کا ذرا سے مریضانہ شبہ سے بھی پریشان ہو جانا، کارکردگی قدرے متاثر مگر قابو میں ہے ۔
3۔ شدید، ادراک یاحافظہ کے لیے غیر یقینی پن نمایاں، مریضانہ شک اکثر کارکردگی کو متاثر کرتا ہے۔
4 انتہائی حد تک، ادراک کا غیر یقینی پن ہر وقت موجود ، مریضانہ شک نمایاں طورپر تقریباً ساری کارکردگی کو متاثر کرتا ہے۔لاچار کردینے والا۔(مثلاً مریض کہتا ہے ، میرا ذہن یقین نہیں کرتا جو میری آنکھیں دیکھتی ہیں)۔
[شق17 اور 18 بیماری کی مجموعی شدت کی طرف اشارہ کرتے ہیں، تخمینہ لگانے والے کو مجموعی کارکردگی کو مدنظر رکھنا چاہیے، تاکہ صرف خبط و جبری افعال کی علامات کی شدت کو]
17۔ مجموعی شدت:
[یہ مریض کی بیماری کی مجموعی شدت کے بارے میں انٹرویو کرنے والے کا تخمینہ ہے۔ اس میں'0' (کوئی بیماری نہیں) سے' 6'(شدید ترین مرض)تک کی درجہ بندی ہے ۔مریض کی بیان کردہ تکلیف کو ، نظر آنے والی علامات اور کارکردگی میں بیان کردہ خرابی کو مد نظر رکھئیے۔ آپکا فیصلہ نہ صرف ان حاصل کردہ معلومات کی اوسط بلکہ ان معلومات کی معتبری و صداقت کا جائزہ لینے کیلئے ضروری ہے ۔ ہر فیصلہ انٹرویو کے دوران حاصل کردہ معلومات پر مبنی ہے۔]
0۔کوئی مرض نہیں
1۔ذرا سا مرض، مرض مشکوک، کوئی فعلیت و کارکردگی کی خرابی نہیں۔
2۔معمولی علامات،فعلیت و کارکردگی میں معمولی خرابی۔

3-درمیانی علامات، کوشش کے ساتھ فعلیتو کارکردگی
4-درمیانی شدید علامات،فعلیت و کارکردگی محدود
5-شدید علامات،فعلیت و کارکردگی محض کسی کی معاونت میں
6-انتہائی شدید علامات،مکمل طور پر غیرفعال

18-مجموعی بہتری:

[بحیثیت مجموعی موجود ہ بہتری کا تخمینہ لگائیے۔ آپ کے خیال میں ابتدائی تخمینہ سے لے کر یہ بہتری خواہ علاج بالدوا کے باعث ہو یانہ ہو۔]

0-بہت زیادہ ابتر
1-زیادہ ابتر
2-تھوڑی زیادہ ابتر
3-کوئی تبدیلی نہیں
4-تھوڑی بہتری
5-زیادہ بہتری
6-بہت زیادہ بہتری

19-معتبری:

[حاصل کردہ درجہ بندی کے سکورز کی مجموعی معتبری کا تخمینہ لگائیےمعتبری پر اثر انداز ہونے والے عوامل میں مریض کا تعاون اور ابلاغ کی فطری صلاحیت شامل ہے ۔وہمی جبری بیماری کی علامتوں کی شدت مریض کے ارتکاز ، توجہ اور برجستہ بول سکنے کی آزادی میں مخل ہو سکتی ہے(مثلاً کسی وہم کے مواد کے باعث ہو سکتا ہے کہ مریض کو الفاظ کے انتخاب میں بہت احتیاط برتنی پڑے)

0-شاندار،معلومات پر غیر معتبر ہونے کا شک پڑنے کی کوئی وجہ نہیں
1-عمدہ،معتبری پر اثر انداز ہونے والے عوامل کی موجودگی
2-اچھی،معتبری کو لازماً کم کرنے والے عوامل کی موجودگی
3-خراب، بہت کم معتبری

چیچب

نام: تاریخ

ییل-براؤن وہمی جبری علامات کی فہرست

(9/89) Yale-Brown obsessive Complusive Symptom Checklist

کا ’P‘ ان تمام علامات پر ’228‘ کا نشان لگائیں جو مریض میں موجود ہیں، مگر نمایاں علامات کے ساتھ واضح طور پر نشان لگائیں۔ (درجہ بندی کرنے والے کے لئے یہ ضروری ہے کہ اس بات کو یقینی بنائے کہ مریض کے تمام بیان کردہ رویے وہمی جبری بیماری کی حقیقی علامات ہیں نہ کہ کسی اور مرض مثلاً بے (Obsessive Compulsive Disorder--- OCD)

جا خوف
کی علامات ۔ جن علامات کے ساتھ '*' کا نشان ہے (Hypochondriasis) (یا مراق (Simple Phobia)
کا حصہ ہو بھی سکتی ہیں (Obsessive Compulsive Disorder) (OCD --- وہ وہمی جبری بیماری
اور نہیں بھی ہو سکتی۔

موجودہ گزشتہ
1۔جارحانہ وہم:
i)) یہ خوف کہ خود کو نقصان سے نہ پہنچا لوں --------- ----------
(ii) یہ خوف کہ دوسروں کو نقصان نہ پہنچادوں
(iii) پرتشدد یا ڈراؤنے تصورات
(iv) یہ خوف کہ اچانک کوئی بے ہودہ (فحش ، گندی) بات یا گالیاں منہ سے نہ نکل جائیں
(v) *یہ خوف کہ کچھ اور ایسا نہ کر گزروں جو شرمندگی کا باعث ہو جائے
(vi) ان چاہی تحر یک (شدید خواہش پر فوری عمل کرنے کا اندرونی دباؤ)پر عمل کر بیٹھنے کا خوف
((مثلاً کسی قریبی عزیزیا دوست کو زخمی کر دینا
(vii) یہ خوف کہ کچھ چُرا لوں گا / گی
(viii) یہ خوف کہ محتاط نہ ہونے کی وجہ سے دوسروں کو نقصان پہنچا دونگا /گی (مثلاً گاڑی سے
(کسی کو ٹکر مار دینا وغیرہ
(ix) (کسی نقصان دہ واقعہ / حادثہ کے ذمہ دار بن جانے کا خوف (مثلاً آگ لگ جانا، ڈکیتی ، وغیرہ
دیگر _____

2۔گندگی آلودگی کے وہم:
(i) جسم سے نکلنے والے فاسد /فالتومادوں یا رطوبتوں (مثلاً پیشاب ، یا خانہ ، تھوک) وغیرہ کے لئے
فکر یا گھن
(ii) گندگی یا جراثیم سے متعلق فکر
(iii) ماحولیاتی آلودگی (گندگی) سے متعلق حد سے زیادہ فکر (مثلاًفیکٹریوں ، گاڑیوں سے نکلتا دھواں
(فیکٹریوں کا فالتو مادہ وغیرہ
(iv) گھریلو استعمال کی چیزوں کے متعلق حد سے زیادہ فکر (مثلاً صفائی میں استعمال ہونے والے
(کیمیائی محلول وغیرہ
(v) (جانوروں سے متعلق حد سے زیادہ فکر (مثلاًکیڑے مکوڑے ، حشرات
(vi) چپکنے والی چیزوں یا فالتو مادوں سے پریشان ہو جانا
(vii) گندگی کی وجہ سے بیمار ہو جانے کی فکر
(viii) (یہ فکر کہ گندگی پھیلانے کی وجہ سے دوسروں کو بیمار نہ کردوں (جارحانہ
(ix) گندگی کے نقصانات یا نتائج کی فکر کے بجائے صرف گندگی کی وجہ سے پیدا ہونے والے
احساسات (گھن ، پریشانی) کی فکر
دیگر ----------

3جنسی وہم-:
(i) ممنوعہ یا گمراہ کن (برُے) جنسی خیالات ، تصورات ، یا ان پر عمل کرنے کی شدید خواہش
(ii) بچوں یا محرمات(رشتے جنکے ساتھ جنسی تعلق منع یا حرام ہے) کے بارے میں جنسی خبط
(iii) ہم جنس پرستی پر مبنی (کے متعلق) خبط
(iv)جارحانہ (دوسروں کے خلاف جنسی رویہ)*
دیگر ----------

4ذخیرہ کرنے/ بچت کرنے کے وہم:
[انہیں مشاغل ،مالی یا جذباتی اہمیت کی چیزوں کو جمع کرنے کی عادت سے الگ رکھیے-]

5اخلاقیات (مذہبی وہم):
(i) مقدس ہستیوں کی بے حرمتی اور کفر آمیز باتوں ، خیالات و تصورات کے بارے میں حد سے بڑھی ہوئی فکر
(ii) صحیح / غلط ، اچھے /برے کاموں یا اخلاقیات کے بارے میں حد سے بڑھی ہوئی فکر
دیگر ----------

6توازن یا درستگی کی ضرورت کے وہم-:
i)) جادوئی (عجیب و غریب) سوچ سے جڑے توازن و درستگی کے وہم(مثلاً یہ پریشانی کہ اگر چیزیں (صحیح جگہ پر نہ پڑی ہوئی تو والدہ کو حادثہ پیش آ جائے گا
(ii) جادوئی (عجیب و غریب)سوچ کے بغیر توازن و درستگی کے وہم (مثلاًبار بار یہ خیال آنا کہ چیزیں درست جگہ پڑی ہیں یا نہیں)

7متفرق /ملے جُلے وہم-:
(i) کسی چیز کو جاننے یا یاد رکھنے کی ضرورت
(ii) مخصوص چیزوں سے متعلق کچھ کہہ دینے کا خوف
(iii) ہر لحاظ سے درست بات نہ کہہ پانے کا خوف
(iv) چیزوں کو کھو دینے کا خوف
(v) ذہن میں زبردستی گھس آنے والے (بلاتشدد)وہم
(vi) سوچ میں رکاوٹ ڈالنے والی بے معنی /فضول آوازیں، الفاظ یا دُھن/موسیقی
(vii) مخصوص آوازوں/شور سے پریشان ہو جانا*
(viii) مبارک ومنحوس اعداد کا وہم
(ix) خاص اہمیت والے رنگ
موجودہ گزشتہ
(x) توہماتی خوف/بدشگونی سے جڑے خوف
دیگر----------

9جسمانی وہم-:

*بیماری سے متعلق فکر و تشویش(i)
* جسم کے کسی حصے یا شکل و صورت ,خدو خال کے کسی پہلو کے لیے حد سے زیادہ تشویش(ii)
دیگر----------

10۔ صفائی دھلائی کے جبری افعال:
ضرورت سے زیادہ یا مخصوص طریقے سے ہاتھ دھونا(i)
ضرورت (یا معمول) سے زیادہ یا مخصوص طریقے سے نہانا دھونا، راتوں کو برش کرنا، (ii)
سنورنا(تیار ہونا) یا لیٹرین جانے / استعمال کرنے کا مخصوص معمول اور مخصوص طریقہ
گھریلو استعمال کی یا بے جان چیزوں کی صفائی سے متعلق جبری افعال(iii)
گندگی سے بچاؤ یا گندگی پھیلانے وا لی چیزوں کو چھونے سے بچنے کے دوسرے طریقے(iv)
دیگر----------

11۔معائنہ / جانچ کرنے کے جبری افعال:
تالوں،چولہے اور دوسرے استعمال کے آلات وغیرہ کا معائنہ(i)
یہ جانچنا /معائنہ کرنا کہ کہیں دوسروں کو نقصان نہ پہنچ گیا ہو/پہنچ نہ جائے(ii)
یہ جانچنا/معائنہ کرنا کہ کہیں خود کو نقصان نہ پہنچ گیا ہو/ یا پہنچ نہ جائے(iii)
یہ معائنہ کرنا کہ کہیں کچھ برُا نہ ہو گیا ہو/ہو نہ جائے(iv)
یہ معائنہ کرنا کہ کوئی غلطی نہ ہو گئی ہو(v)
جسمانی خبط کی وجہ سے یاجسمانی خبط سے متعلق معائنہ و جانچ پڑتال (vi)
دیگر ----------

12۔دہرائی کا باربار کیا جانے والا عمل/دہرائی کا لگا بندھا عمل:
دوبارہ پڑھنا یا دوبارہ لکھنا(i)
روز مرہ کے /معمول کے کاموں کو دہرانے کی ضرورت (مثلاً اندر/باہر آنا جانا، کرسی سے اوپر (ii)
نیچے اترنا چڑھنا)
دیگر----------

13۔گننے کے متعلق جبری افعال:

موجودہ گزشتہ
14۔ترتیب /تنظیم کے جبری افعال:

15۔ذخیرہ کرنے /جمع کرنے کیجبری افعال:
مشاغل اور مالی و جذباتی اہمیت کی چیزوں کے لیے فکر سے فرق واضح کررکھیے (مثلاً پرانے یا
فالتو خطوط کو غور سے پڑھنا، پرانے اخبارات کا ڈھیر جمع کرنا ، کوڑا کرکٹ کی تلاشی لینا/چیزیں
الگ کرنا، فالتو یا بے فائدہ چیزوں کو جمع کرنا)]

16۔متفرق جبری افعال:
(ذہن میں کئے جانے والے جبری افعال (معائنہ کرنے /گننے کے علاوہ(i)
بار بار چیزوں کی فہرست بنانا(ii)

کچھ بتانے ، پوچھنے یا (کسی جرم و گناہ کا) اعتراف کرنے کی ضرورت محسوس کرنا(iii)
*کسی چیز کو چھونے ،تھپکنے یا مسلنے کی ضرورت محسوس کرنا(iv)
آنکھیں جھپکنے یا گھورنے پر مبنی لگے بندھے افعال(v)
خودکو نقصان یا تکلیف سے بچانے کے لئے طریقے اپنانا(معائنہ و پڑتال کے جبری افعال کے (vi)
(علاوہ
،دوسروں کو نقصان یا تکلیف سے بچانے کے لئے طریقے اپنانا(معائنہ و پڑتال کے جبری افعال کے (vii)
(علاوہ
(خوفناک نتائج سے بچنے کے لئے طریقے اپنانا(معائنہ و پڑتال کے جبری افعال کے علاوہ(viii)
کھانا کھانے کے لگے بند ھے یامخصوص طریقے (ixi)
توہماتی(شگون بد شگون) رویہ یا طرز عمل(x)
*سر اور جسم کے مختلف حصوں کے بال نوچنے کی بیماری(xi)
دوسری طرح کے خود اذیتی یا خود کو زخم لگانے کے رویے (xii)
دیگر ----------

Appendix C2

Obsessive Belief Questionnaire (OBQ-44-PK)

ہدایات

اس فہرست میں مختلف رویے یا خیالات درج ہیں جو بعض اوقات لوگوں کے ہوتے ہیں ۔ ہر بیان کو احتیاط سے پڑھیں اور یہ فیصلہ کریں کہ آپ اس سے کس حد تک متفق ہینیا غیر متفق ہیں۔ ہربیان کے لیے اس نمبر کو منتخب کریں جو آپ کے اس جواب کے ساتھ مطابقت رکھتا ہو جو بہترین طور پر کہ آ پ کی سوچ کو واضح کرتا ہو ۔ کیونکہ لوگ ایک دوسرے سے مختلف ہوتے ہیں اور ان کی سوچ بھی مختلف ہو سکتی ہے اس لیے کوئی بھی جواب صحیح یا غلط نہیں ہے۔

نوٹ: یہ فیصلہ کرنے کے لیے کہ کیا دیا گیا بیان آپ کے چیزوں کو دیکھنے کے مخصوص انداز کے عین مطابق ہے ،صرف یہ ذہن میں رکھیے کہ آپ زیادہ تروقت کس انداز میں سوچتے ہیں۔

نیچے دیے گئے پیمانے کو استعمال کرتے ہوئے ہر بیان کو نمبر دیجئے۔

7
6
5
4
3
2
1

بہت زیادہ متفق
درمیانی حد تک متفق

بہت کم متفق
معلوم نہیں
بہت کم غیر متفق
درمیانی حد تک غیر متفق
بہت زیادہ غیر متفق
بیان کو نمبر دیتے وقت کوشش کیجئے کہ پیمانے کے درمیانی نمبر(4)کو استعمال کرنے سے گریز کریں۔ اس کے بجائے اس بات کی نشاندہی کریں کہ کیا آپ اپنے عقائد(خیالات) اور رویوں کے بارے میں بیانات کے ساتھ عام طور پر غیر متفق یا متفق ہوتے ہیں۔
سوالنامہ
1-مجھے اکثر خیال آتا ہے کہ میرے ارد گرد چیزیں محفوظ نہیں ہیں۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق
2-اگر مجھے کسی چیز کے بارے میں مکمل طور پر یقین نہ ہو تو مجھ سے ضرور غلطی ہوجاتی ہے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق
3-چیزوں کو میرے اپنے معیار کے مطابق ہر لحاظ سے بہترین ہونا چاہئے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق
4 -اگر مجھے ایک قابل قدر (فائدہ مند) انسان بننا ہے تو اس کے لیے ضروری ہے کہ میر اہر کام ہر لحاظ سے بہترین ہو۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق
5-جب بھی مجھے برے واقعات کو ہونے سے روکنے کا موقع ملے تو مجھے انہیں ضرور روکنا چاہئے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق
6 -نقصان ہونے کے کم سے کم امکان کے باوجود بھی مجھے اسے ہر قیمت پر روکنے کی کوشش کرنی چاہئے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق
7-میرے خیال میں بری خواہش کا میرے ذہن میں آنا اتنا ہی برا ہے جتنا کہ حقیقت میں اس پر عمل کرلینا۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق
8 -اگر خطرے کو پہلے سے جان کر بھی میں اسے روکنے کے لئے کچھ نہیں کرتا /کرتی تو ہر طرح کے نتائج کے لیے مجھ پر ہی الزام لگنا چاہئے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

9. اگر میں کسی کام کو ہر لحاظ سے بہترین نہ کر سکتا / سکتی ہوں تو مجھے اسے کرنے کی کوشش ہی نہیں کرنی چاہئے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

10. مجھے ہر موقع پر اپنی مکمل اور تمام تر صلاحیتوں کے مطابق کام کرنا چاہئے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

11. میرے لیے یہ بے حد ضروری ہے کہ کوئی بھی فیصلہ کرنے سے پہلے کسی بھی صورتحال کے تمام تر ممکنہ نتائج کو دھیان میں رکھوں۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

12. کسی کام میں معمولی غلطیاں ہوجانے کا بھی یہی مطلب ہے کہ کام مکمل نہیں ہوا۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

13. اگر میرے ذہن میں اپنے قریبی عزیزوں کے بارے میں غصے والی سوچیں یا تحریک (ان سوچوں پر عمل کرنے کی شدید خواہش) ابھرتی ہے تو اس کا مطلب ہے کہ شا ید میں انہیں خفیہ طور پر تکلیف پہنچانا چاہتا / چاہتی ہوں۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

14. مجھے اپنے کئے گئے فیصلوں کے بارے میں مکمل طور پر پرُ یقین (پرُ اعتماد) ہونا چاہئے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

15. روز مرہ کی صورتحال میں نقصان کو روکنے میں ناکام ہوجانا اتنا ہی برا عمل ہے جتنا کہ جان بوجھ کر نقصان کی وجہ بننا۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

16. شدید نوعیت کے مسائل (مثلاً بیماری، یا حادثات) سے بچنے کے لیے مجھے اپنی طرف سے مسلسل کوشش کرنے کی ضرورت رہتی ہے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

17. میرے خیال میں نقصان کو نہ روکنا بھی اتنا ہی برا ہے جتنا کہ نقصان کی وجہ بننا۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

18. مجھے اپنی غلطی پر ضرور پریشان ہونا چاہئے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

19. مجھے اس بات کو یقینی بنانا چاہئے کہ دوسرے لوگ میرے فیصلوں اور کاموں کے کسی بھی طرح کے منفی اثرات سے مکمل طور پر محفوظ رہیں۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

20. میر ے خیال میں اگر چیزیں ہر لحاظ سے بہترین نہ ہوں تو وہ درست نہیں ہوتیں۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

21. گندے خیالات آنے کا مطلب یہ ہے کہ میں ایک حد سے زیادہ برا انسان ہوں۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

22. اگر میں زیادہ محتاط نہ رہوں تو مجھ میں شدید حادثات کا نشانہ بننے یا ان کی وجہ بننے کے امکانات دوسروں کی نسبت زیادہ ہوتے ہیں۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

23. خود کو محفوظ محسوس کرنے کے لیے جہاں تک ممکن ہو مجھے ہر اس واقعہ کے لیے تیار رہنا چاہئے جو نقصان یا خرابی کی و جہ بن سکتا ہو۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

24. مجھے عجیب و غریب یاگندے خیالات نہیں آنے چاہئیں۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق1

25. میرے نزدیک غلطی کرنے کا مطلب مکمل طور پر ناکام ہوجانا ہے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

26. معمولی سے معمولی معاملات میں بھی مجھے ہر کام کرنے سے پہلے ذہنی طور پر بالکل واضح ہونا ضروری ہوتا ہے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

27. کسی پاک انسان کے بارے میں گستاخانہ (بری) سو چ آنے کا اتنا ہی گناہ ہوتا ہے جتنا کہ اس ہستی کی اصل میں بے عزتی کرنا۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

28. مجھے اپنے ذہن کو فضول خیالات سے چھٹکارا دلانے کے قابل ہونا چاہئے۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

29. دوسرے لوگوں کی نسبت میرے لیے یہ امکان زیادہ ہوتا ہے کہ میں اپنے لیے یا دوسروں کے لیے

حادثاتی تکلیف کی وجہ بن جاؤں۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق
بہت زیادہ غیر متفق
برے خیالات آنے کا مطلب ہے کہ میں ایک عجیب و غریب یا پاگل انسان ہوں۔30.
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق
بہت زیادہ غیر متفق
مجھے اپنے اہم کاموں میں ہر لحاظ سے بہترین کارکردگی دکھانی چاہئے۔31.
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق
بہت زیادہ غیر متفق
جنسی خیالات یا تصورات آنے کا مطلب یہی ہے کہ میں حقیقت میں ان پر عمل کرنا چاہتا / چاہتی 32.
ہوں۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر 7
متفق بہت زیادہ غیر متفق
اگر میرے کا موں کا کسی بھی ممکنہ (آنے والی) تباہی پر ذرا سا بھی اثرپڑ سکتا ہو تو میں ہی نتائج 33.
کا مکمل طور پر ذمہ دارہوں گا / گی۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق
بہت زیادہ غیر متفق
بہت زیادہ محتاط ہونے کے باوجود مجھے اکثر یہ خیا ل آتا ہے کہ کبھی بھی کوئی برا واقعہ ہو جائے 34.
گا۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق
بہت زیادہ غیر متفق
ذہن میں زبردستی گھس آنے والے خیالات کا مطلب یہ ہے کہ مجھے خود پر بالکل قابو نہیں۔35.
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق
بہت زیادہ غیر متفق
نقصان دہ واقعات ہوتے رہیں گے جب تک کہ میں بے حد محتاط نہ رہوں۔36.
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق
بہت زیادہ غیر متفق

مجھے کوئی بھی کام اس وقت تک کرتے رہنا چاہئے جب تک وہ بالکل ٹھیک نہ ہوجائے۔37.
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق
بہت زیادہ غیر متفق
غصے سے بھرپور خیا لات آنے کا مطلب یہی ہے کہ میں خود پر قابو کھو کر ان سوچوں پر عمل کر 38.
بیٹھوں گا/ گی۔
بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق
بہت زیادہ غیر متفق
میرے خیال میں کسی تباہی کو روکنے میں ناکامی اتنی ہی بری بات ہے جتنا کہ اس تباہی کی وجہ 39.

بننا۔

بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

اگر میں ایک کام کو ہر لحاظ سے بہترین نہیں کرتا / کرتی تو لوگ میری عز ت نہیں کریں گے۔40.

بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

مجھے اپنی زندگی کے عام سے تجربات میں بھی بہت زیادہ خطرہ محسوس ہوتا ہے۔41.

بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

اخلاقی طور پر برے خیالا ت کے آ نے اور برے کام کرنے میں کوئی فرق نہیں ہوتا۔42.

بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

کسی کام کے لئے میں جتنی بھی محنت کر لوں وہ نا کافی ہے۔ 43.

بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

اگر میں اپنے خیالات کو قابو میں نہ رکھوں تو مجھے اس کی سزا ملے گی۔44.

بہت زیادہ متفق درمیانی حد تک متفق بہت کم متفق معلوم نہیں بہت کم غیر متفق درمیانی حد تک غیر متفق بہت زیادہ غیر متفق

Appendix D2

معاہدہ برائے تحقیق

(Title: Development of therapeutic protocol of CBT for OCD patients in Pakistan)

---------- میں

اپنے معالج ماہر نفسیات کرن اشفاق سے یہ معاہدہ کرتا/کرتی ہوں کہ میں اپنی مکمل رضامندی سے اس تحقیق میں حصہ لے رہا/رہی ہوں اور میں تحقیق کے دوران اپنے معالج کی تمام ہدایات پر مکمل عمل کروں گا

گی اور میں جب چاہوں اپنی مرضی سے اس علاج اور تحقیق کو چھوڑ سکتا / سکتی ہوں اور میرے / ایسا کرنے سے میرے دوائیوں والے علاج کو ختم نہیں کیا جائے گا۔ ۔ مجھے اس تحقیق کے اغراض و مقاصد سے آگاہ کر دیا گیا ہے ۔مجھے یقین دلایا گیاہے کہ میری شناخت اور فراہم کردہ معلومات کو صیغہء راز میں رکھا جائے گااور تمام معلومات کو صرف تحقیق کے مقاصد کے لئے استعمال کیا جائے گا۔

دستخط شرکت کار: دستخط محقق:

Translation Appendix D2

Contract for Research

Title: Development of therapeutic protocol of CBT for OCD patients in Pakistan)

I am signing this contract with my therapist Ms. Kiran Ishfaq that I am participating in this research with my complete willingness and I will follow all instructions of my therapist during this research/ treatment. And I may quit this treatment and research whenever I want. And my medication treatment will not be stopped if I do so. I have been informed about aims and objectives of this reseasrch. And I am ensured that my identity and given information will be confidential and will only be used for research purposes.

Participant's Signature
Researcher's Signature

Appendix D 3

وہم کی بیماری کے بارے میں عام فہم معلومات

وہم کی ایک بیماری ہے ۔ جس میں انسان کو بار بار ایسی (OCD) Obsesive compulsive disorder سوچ یا وہم آتے ہیں جو اس کے لئے پریشانی / بے چینی کا باعث بن جاتے ہیں مگر وہ چاہتے ہوئے بھی انہیں روک نہیں پاتا۔ ان وہم کی سوچوں یا ذہنی تصویروں کو روکنے کے لئے کچھ لوگ بار بار ایسے عمل کرنے پر مجبور ہو جاتے ہیں ۔ جو ان کے لئے باعث تکلیف اور ان کے وقت اور صحت کے لئے نقصان دہ ہوتے ہیں مگر ان پر عمل کئے بغیر انہیں سکون نہیں ملتا ۔

یاد رکھیے کہ یہ ایک نفسیاتی بیماری ہے جس کی مختلف و جوہات ہیں بعض اوقات دماغ میں کچھ کیمیائی مادوں کی کمی یا زیادتی ہو جاتی ہے ۔ جس کی وجہ سے ہمارا دماغ اہم اور فضول سوچوں میں فرق نہیں کر پاتا اور بار بار فضول سوچیں ہمارے ذہن میں آتی رہی ہیں۔ جب ہم کسی سوچ کو بہت برا سمجھتے ہوئے سختی سے روکنے کی کوشش کرتے ہیں ۔ تو ایسی سوچ زیادہ شدت سے دماغ میں آتی ہے اور بار بار روکنے میں نا کام ہونے سے بے چینی اور ناکامی کا احساس بڑھتا جاتا ہے۔ اگر یہ سوچیں مذہب سے متعلق ہوں تو گناہ کا احساس اس تکلیف کو اور بڑھا دیتا ہے۔ اب جبکہ آپ یہ جان چکے ہیں کہ یہ ایک بیماری ہے بالکل ایسے جیسے شوگر یا بخار کا ہو جاتا تو اس بیماری کی وجہ سے خود کو کمتر ، گناہ گار یا برا سمجھنا سر اسر غلط ہو گا۔ کیا کبھی آپ نے کسی سے اس لئے نفرت کی ہے کہ وہ شوگر کا مریض ہونے کی وجہ سے روزے نہیں رکھتا ہے کھڑے ہو کر اس لئے نماز نہیں پڑھ سکتا کہ وہ فالج کا مریض ہے ؟

یقیناًنہیں کیونکہ آپ یہ جانتے ہیں کہ اپنی اس کیفیت پر اس انسان کا کوئی اختیار نہیں۔ جبکہ آپ یہ جانتے ہوئے بھی کہ یہ سوچیں یا وہم آپ کے اختیار میں نہیں خود کو انکا ذمہ دار سمجھتے ہوئے سزا دینا چاہتے ہیں۔ اس بیماری سے لڑنے کے لئے آپ کو سب سے پہلے خود کو یہ یقین دلانا ہے کہ یہ ایک ذہنی بیماری ہے جس پر آپ کا اختیار نہیں ہے ۔ اس لئے اس کے لئے گناہ گار یا قصور وار نہیں سمجھے جا سکتے ۔ مگر آپ دوائیوں اور ماہر نفسیات کے سکھائے ہوئے طریقوں پر عمل کرکے ان سوچوں سے چھٹکارہ حاصل کر سکتے ہیں ۔

! یاد رکھئے

انسان کے دو طرح کے اعمال ہوتے ہیں۔ خود اختیاری اعمال وہ روئیے / سوچیں جن پر ہمارا اختیار ہوتا ہے ۔ اور بے اختیاری اعمال وہ رویے یا سوچیں ہیں جن پر ہمیں اختیار نہیں اللہ تعالی صرف ان اعمال پر (سزایا جزا کا حکم لگاتا ہے ۔ جو انسان کے اختیار میں ہیں ۔ (مولانا اشرف علی تھانوی

جب آپ خود کو اس احساس سے نکال لیں گے کہ ان سوچوں پر آپ سے کوئی باز پرس نہیں ہوگی تو آپ بہتر طور پر ان سے لڑپائیں گے ۔ ورنہ گناہ کا یہ غلط اور بے بنیاد احساس آپ کو صحت مندانہ زندگی گزارنے نہ دے گا۔ اپنی زندگی میں ہر اس انسان کو جو سوچنے کی صلاحیت رکھتا ہے ۔ اللہ اور مذہب کے لئے شک کی سوچیں آتی ہیں ۔ مگر جو لوگ ان سوچوں کو سخت گناہ تصور کرتے ہوئے خود کو گناہ گار مان لیتے ہیں ۔ وہ ان سوچوں سے چھٹکارہ نہیں پا سکتے ۔ پھر یہی سوچیں بیماری کی روپ دھار لیتی ہیں جو انتہائی تکلیف دہ ہوتی ہے ۔

جب بھی آپ ان فضول اور تکلیف دہ سوچوں کو روکنے کے لئے کچھ عمل کرتے ہیں ۔ جیسے بار بار ہاتھ دھونا یا دل میں کلمہ پڑھنا ، وغیرہ وغیرہ تو وقتی طور پر آپ کی بے چینی یا گناہ کا احساس کم ہو جاتا ہے مگر اس طرح آپ خود کو ایک غیر صحت مندانہ اور زیادہ تکلیف دہ طریقے کا عادی بنا دیتے ہیں ۔ اس کا ایک نقصان یہ ہے کہ آپ ایک کے بعد دوسرے وقت کو ضائع کرنے والے اور تکلیف دہ مسئلے کا شکار ہو جاتے ہیں ۔ اور دوسرا نقصان یہ ہے کہ اس کے بعد یہ عادت بھی بڑھتی جاتی ہے ۔ لیکن اگر آپ بجائے اپنی بے چینی کو فوری طور پر کم کرنے کے اس کو کچھ دیر کے لئے برداشت کر لیں تو آہستہ آہستہ ان سوچوں کی بے چینی پیدا کرنے کی صلاحیت ختم ہوتی جائے گی ۔

یاد رکھئے کہ یہ بار بار کئے جانے والے اعمال بذات خود ایک بیماری ہیں جو بعض اوقات وہم کی سوچ سے بھی زیادہ تکلیف دہ ہو جاتے ہیں ۔ اس بیماری کے علاج کے لئے آپ کو دوا کے ساتھ نفسیاتی طریقوں کو بھی ضرورت ہے ۔ یہ نفسیاتی طریقے نہ صرف آپ کی بہتری کی رفتار کو بڑھا دینگے بلکہ بیماری کے دوبارہ آنے کے امکانات کو بھی کم کر دینگے ۔

General Information about OCD

OCD is a general ailment of obsession which makes a person think again and again about such matters which are painful for them, but they cannot overcome such thoughts. To counter such obsessive ideas and images in their mind, some people feel compelled to do certain acts which are actually quite disturbing, but which help them get calm.

It is to remember that this is a psychological ailment, which happens due to certain physiological reasons. Sometimes due to chemical imbalance, our mind totally fails to differ between important and useless thoughts. That is the reason why such useless thoughts bother us again and again. When we consider a certain thought pattern as evil and when we try to forcefully counter such a thought, as a reaction such a thought fights back and a failure to stop it creates a feeling of vulnerability and unrest. If such disturbing thoughts are about the religion, then the thought of sin associated with such ideas, only adds to the pain and agony of a patient. Now, that you have realized that it is just an ailment like diabetes or fever, considering yourself inferior, a sinner or evil is totally wrong. Did you ever hate a person only because they were unable to fast or offer a prayer standing on their feet for them being a patient of diabetes or paralysis?

Obviously no! Because you know that a human being does not have any control over such a medical condition. Whereas you want to punish yourself, even while you know such obsessive thoughts are not in your control. To counter this ailment, you would first have to believe that it is a mental ailment, which you do not have any control at. So, you cannot be considered responsible for having such an ailment. However, medicine and proper treatment from a psychologist may help you get rid of such obsessive thoughts.

Don't forget. Maulana Ashraf Ali Thanvi opined that human beings have two types of actions. Those which we have totally under control and those which are out of our control. Allah may only reward or punish for those actions which are originated from our free will. (5)

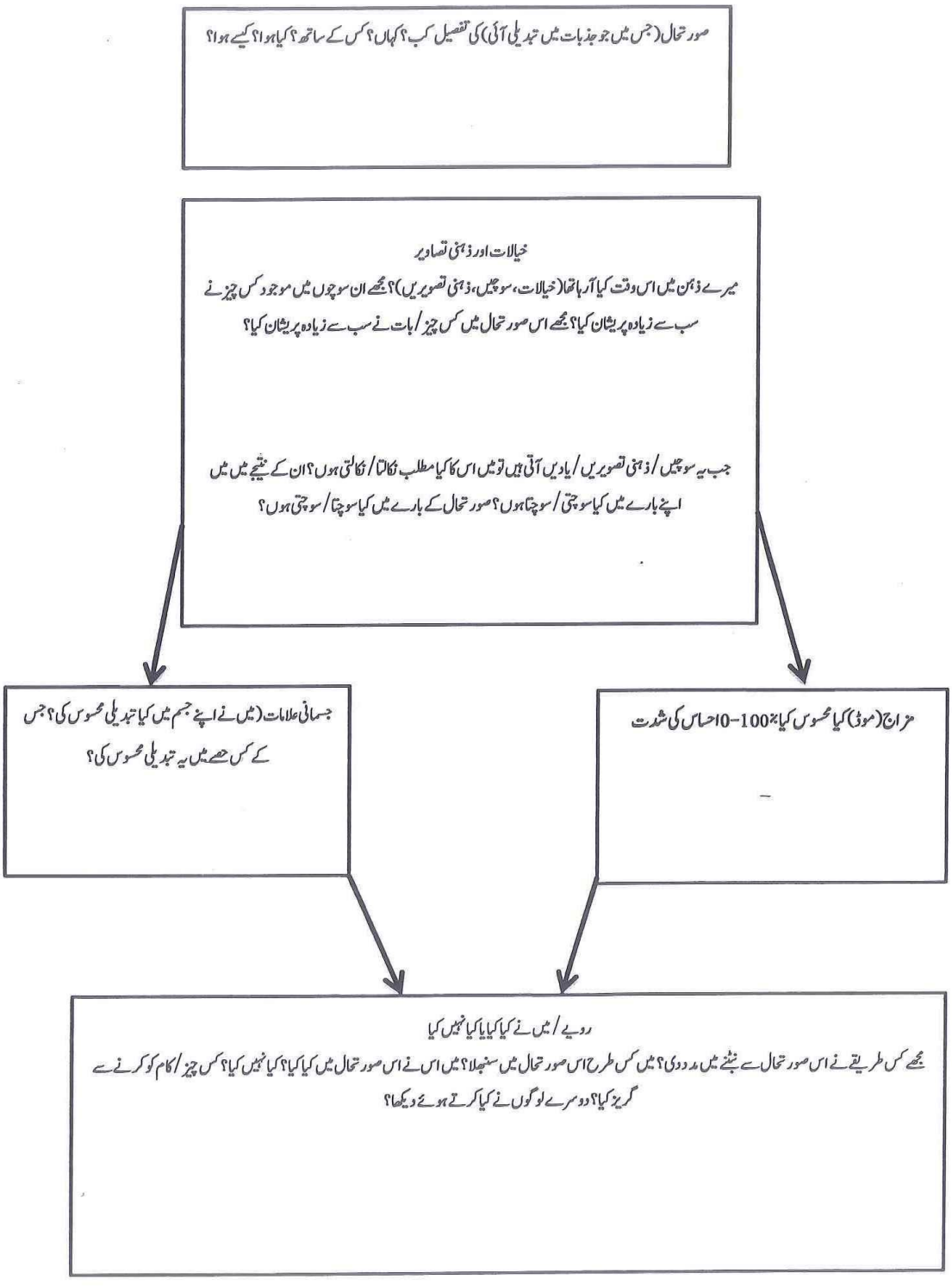
When you are able to set yourself free from thinking that you can be punished over your unintentional thoughts, you are able to counter them in a much better way. Otherwise, this sinful feeling and baseless guilt will not let you live a happy and healthy life. Every such human being who has the ability to think, has to face the disturbing thoughts about God and religion, at least once in their life. However, those who consider such disturbing thoughts as unforgivable sins, cannot get rid of such thoughts. Then the same thoughts turn into a very painful psychological ailment.

Whenever you commit certain acts in order to counter such disturbing thoughts, like washing your hands again and again or reciting Kalima, etc. you have a temporary feeling of relief from such thoughts, but by doing so, you force yourself into an unhealthy and painful habit. One disadvantage of such an approach is getting into a painful activity, in order to get rid of another painful issue. Another disadvantage is being forced of habit, because you become a subject to your own habit. Instead of being forced of habit, if you learn to tolerate this unrest in your mind, these thoughts will amazingly stop bothering you.

Please remember! That repetition of certain acts to counter your disturbing thoughts, in itself is a psychological ailment. Sometimes such actions become even more painful than the disturbing thoughts. You need to try the psychological treatment was well as medicine. Such methods of psychological treatment will not only expedite your recovery, but they will decrease the chances of this ailment fighting back.

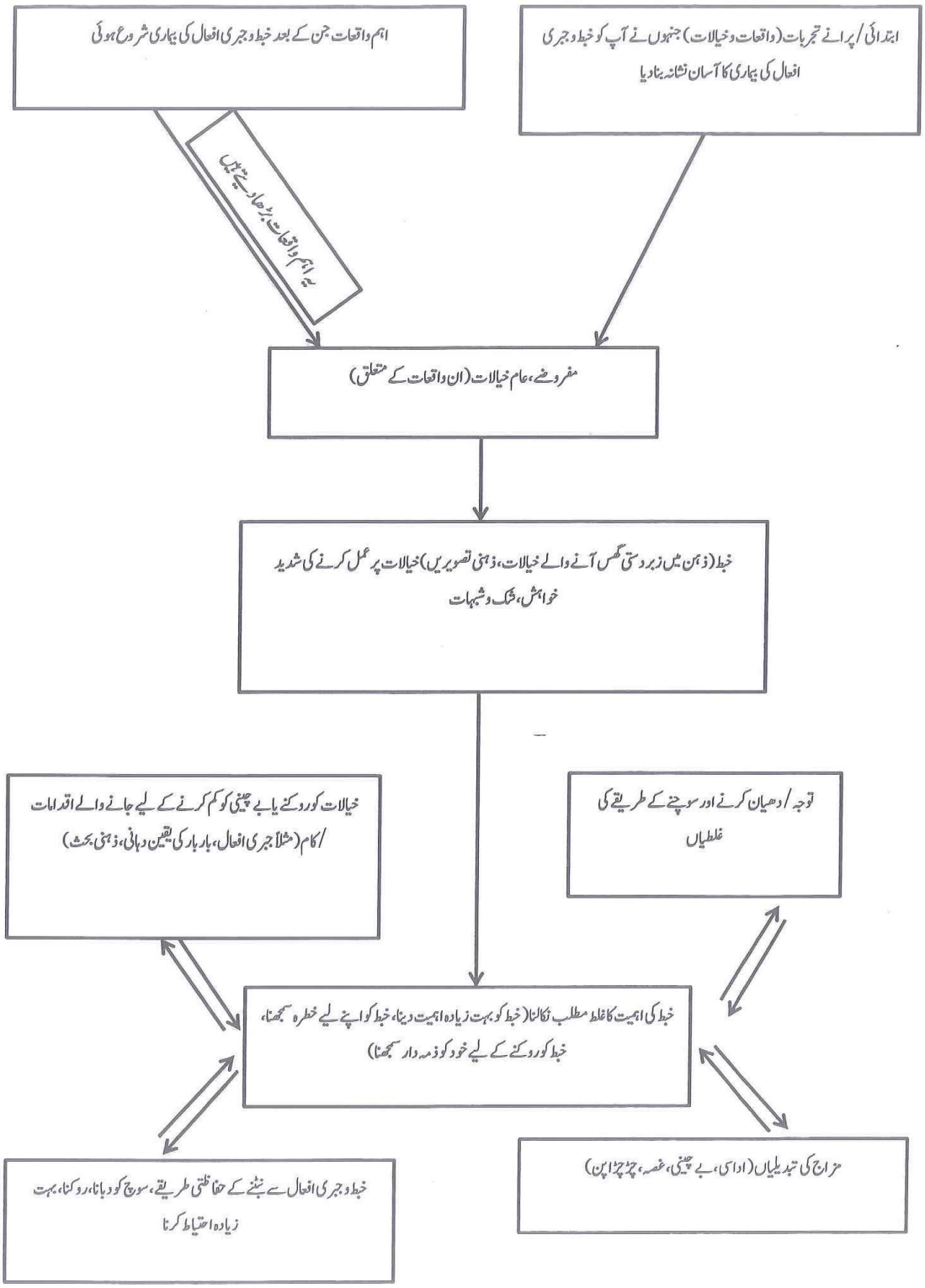
Appendix D4

خبط و جبری افعال کی بیماری کا عقلی نمونہ



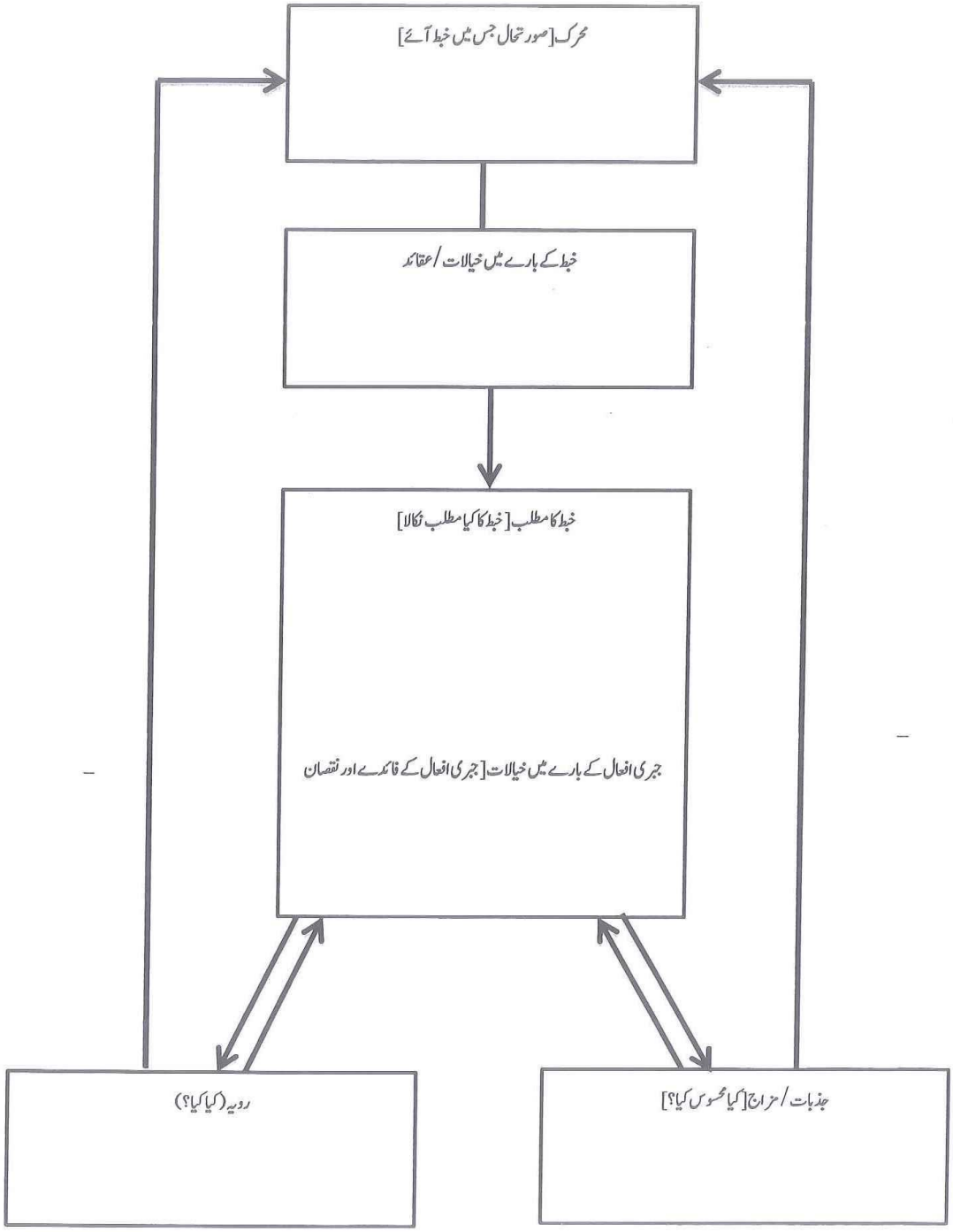
Appendix D4

خبط و جبری افعال کی بیماری کا عقلی نمونہ



Cognitive Model of OCD
Salkovskis, Forrester, Richards (1998)

خبط و جبری افعال کی بیماری کا عقلی نمونہ



Appendix D5

سوچ کی تبدیلی کے علاج کے لیے تیاری

تبدیلی سے روکنے والے خیالات	متبادل متوازن خیالات۔ تبدیلی میں مدد دینے والے خیالات

Appendix D5

تبدیلی کیلئے حوصلہ افزائی

نام:_____ تاریخ:_____

بیمار رہنے کے فائدے	بیمار رہنے کے نقصان

خود کو بدلنے /تندرست ہونے کے فائدے	خود کو بدلنے /تندرست ہونے کے نقصانات

او-سی-ڈی کی سوچوں پر عمل کرنے کے فائدے اور نقصانات

سوچوں پر عمل کرنے کے فائدے	سوچوں پر عمل کرنے کے نقصانات

Appendix D6

سوچ میں موجود منطقی غلطیاں

ہم اکثر اپنی سوچ کے انداز میں منفی ہو جاتے ہیں اور کچھ ایسی غلطیاں کر جاتے ہیں جن کی وجہ سے وہ سوچ ہم پر منفی اثر کرتی ہے اور ہمیں بیمار کر دیتی ہے۔ سوچ میں پائی جانے والی کچھ خاص وہم کی بیماری کے مریض کرتے ہیں وہ یہ ہیں ۔ OCD غلطیاں جو

: سوچ کی غلطیاں

۱۔ خطرے / نقصان کا تخمینہ اصل سے زیادہ لگانا ۔

مجھے اپنے آپ اور میرے قریبی لوگوں کو ہر صورت میں اور مکمل طور پر حفاظت کرنی ہے ۔ ''
چاہے خطرے یا نقصان کا امکان بہت کم ہو مگر بالکل کم نقصان / خطرہ بھی اتنا ہی بڑا ہے جتنا کہ
بڑے خطرے یا نقصان کا ہو جانا '' ۔

مجھے مذہب کی ہر چھوٹی سے چھوٹی بات پر عمل کرنا ہے ۔ اور میرے لئے مکروہ اور حرام ایک ''
'' برابر ہیں اور جو عمل بھی میں نے چھوڑا وہ مجھے گناہ گاہ بنا دے گا ۔

: ۲۔ سیاہ / سفید میں سوچنا

اگر میں نے ایک گناہ کیا ، تو میں جہنمی ہوں '' ۔ ''
اگر میں نے اپنے ہاتھ خاص طریقے سے نہ دھوئے تو میں مکمل طور پر نا پاک ہوں ، خواہ میں نے ''
'' باقی جسم کی صفائی کر رکھی ہو ۔
لوگ یا تو نیک ہوتے ہیں یا مکمل طور پر برے '' ۔ ''

: ۳۔ اکملیت کا جنون

مجھے اپنی ہر سوچ اور عمل پر مکمل طور پر کنٹرول ہونا چاہیے ۔ ''
'' مجھے ہر کام کو مکمل اور ہر لحاظ سے بہترین کرنا چاہیے ۔ ورنہ میں ایک ناکام انسان ہونگا ۔''
کام یا تو مکمل اور بہترین ہو یا کیا ہی نہ جائے '' ۔ ''
مجھے ایک مکمل اور ہر لحاظ سے پاک ، پرہیز گار مسلمان ہونا چاہیے ورنہ میں گناہ گار / جہنمی ''
'' ہونگا ۔
'' میرے ہاتھ اور پورا جسم مکمل طور پر پاک ہونے چاہیے ورنہ یہ میرے لئے نا قابل برداشت ہو گا ۔''

۴۔ عمل اور سوچ کو برابر سمجھنا اور سوچ کو ضرورت سے زیادہ اہمیت دینا ۔
'' جو بھی بری سوچ میرے ذہن میں آتی ہے وہ اصل میں ویسا ہی کر دینے کی صلاحیت رکھتی ہے ۔ ''
اگر مجھے یہ سوچ آتی ہے کہ میں اپنے بچے کو مار دوں تو یہ ایسا ہی ہے جیسے میں نہ یہ کر دیا ہو ۔
'' میری سوچ میں اتنی طاقت ہے کہ جو سوچوں وہ ہو جاتا ہے یا ہو سکتا ہے ۔''
جب یہ سوچ آئے کہ میرے ہاتھ نا پاک ہیں تو یہ نا پاک ہو جاتے ہیں '' ۔ ''
میری سوچ اگر مذہب کے خلاف سے یا مجھے اللہ کے خلاف میری سوچ آتی ہے تو اس کا مطلب ہے ''
'' کہ میں گناہ گار ہوں۔

'' جو میں سوچتا ہوں میں ویسا ہی ہوں''

۵۔ غیر یقینی صورت حال کو برداشت نہ کر پانا ۔

'' مجھے ہر شے کے متعلق مکمل طور پر معلوم ہونا چاہیے اور اگر مجھے کسی بھی چیز پر شک ہے '' تو یہ میرے لئے قابل برداشت ہے

'' اگر مجھے یہ شک ہے کہ میرا وضو مکمل نہیں ہوا تو یہ میرے لئے نا قابل برداشت ہے ۔''

'' مجھے اپنے مستقبل اور دنیا کی ہر شے کے متعلق مکمل طور پر معلوم ہونا چاہیے اور اگر میں کسی لمبی چیز کے لئے غیر یقینی کا شکار ہو تو یہ میرے لئے بہت تکلیف دہ اور نا قابل برداشت بات ہو گی ۔ ''

۶۔ حد سے زیادہ ذمہ داری لینا ۔

'' مجھے ہر صورت میں مکمل طور پر ہر ایک کو ہر طرح کے نقصان سے بچانا ہے ورنہ میں ایک نا کام انسان ہونگا ''

'' اگر میرے گھر کے باہر کسی کی سائیکل چوری ہو گئی تو بھی یہ میری ذمہ داری ہو گی۔ اور لوگ مجھے اس کا ذمہ دار سمجھیں گے ۔ '' '

۷ - وہمی سوچ :

'' کلمہ پڑھنے سے سوچ کی وجہ سے جو میری زبان گندی ہو گئی ہے وہ پاک ہو جائے گی '' ۔ ''

''13 نمبر ایک منحوس ہندسہ ہے اور اگر میں نے کوئی کام اس دن شروع کیا تو مجھے نقصان ہو جائے گا '' ۔

'' مجھے ہر کاغذ کو سنبھالنا ہے کیونکہ اگر کوئی کاغذ کوڑے میں چلا گیا تو مجھے کوئی نقصان ہو جائے گا '' ۔

'' گناہ ، غلطی ، گناہ گار ، جہنمی ، مکروہ ، حرام میں فرق کا نہ معلوم ہونا '' ۔ ''

'' اگر مجھ سے کوئی معمولی غلطی بھی ہو گئی تو میں گناہ گار بن جاؤں گا '' ۔ ''

'' ایک گناہ پر بھی میں جہنمی بن جاؤں گا '' ۔ ''

''ہر چیز جسے اللہ نے پسند نہیں کیا اسے کرنا حرام ہے '' ۔''

Appendix D6a

Cognitive Distortions

Usually we become negative in our thinking pattern and commit some errors in our thinking. Because of these errors, our thinking effects on us negatively and makes us mentally ill/disturb. Some specific type of errors committed by OCD patients are mentioned below:

1. Over Estimation of threat

I have to make sure safety of myself and my closed ones, even if there is least probability of danger. But probability of least harm/danger is as much horrible as occurrence of any horrible danger.

2. Black-and-White thinking

If I committed one sin, it makes me sinful.
If I left one part of body unclean, it makes me totally unclean even if I cleaned other parts completely.
People are either good or completely bad.

3. Perfectionism

I have to control my each and every thinking perfectly.
Either do each task perfectly or just leave.
I should be a complete and perfect muslim otherwise I will be non muslim/sinful/ non believer.

4. Thought Action Fusion & Over Importance of thoughts

If I have blasphemous thoughts, it makes me non believer/sinful.
Thoughts are as bad as bad acts.
Any bad thought of my mind can create bad results.
Thinking bad is as worse as actually doing it.
Thoughts against God makes me non believer.

5. Intolerance of Uncertainty

I should be certain for each and every thing otherwise it will be intolerable for me.

6. Inflated Responsibility

I have to save everyone from harm otherwise I will be a failure.
If anything go wrong at my home I will be responsible for it.

7. Superstitious thinking

After reciting Quraanic verses, my tongue will be clean which got polluted after having blasphemous thoughts.

Number 13 is bad, and if I will start any task at that date, it will be harmful

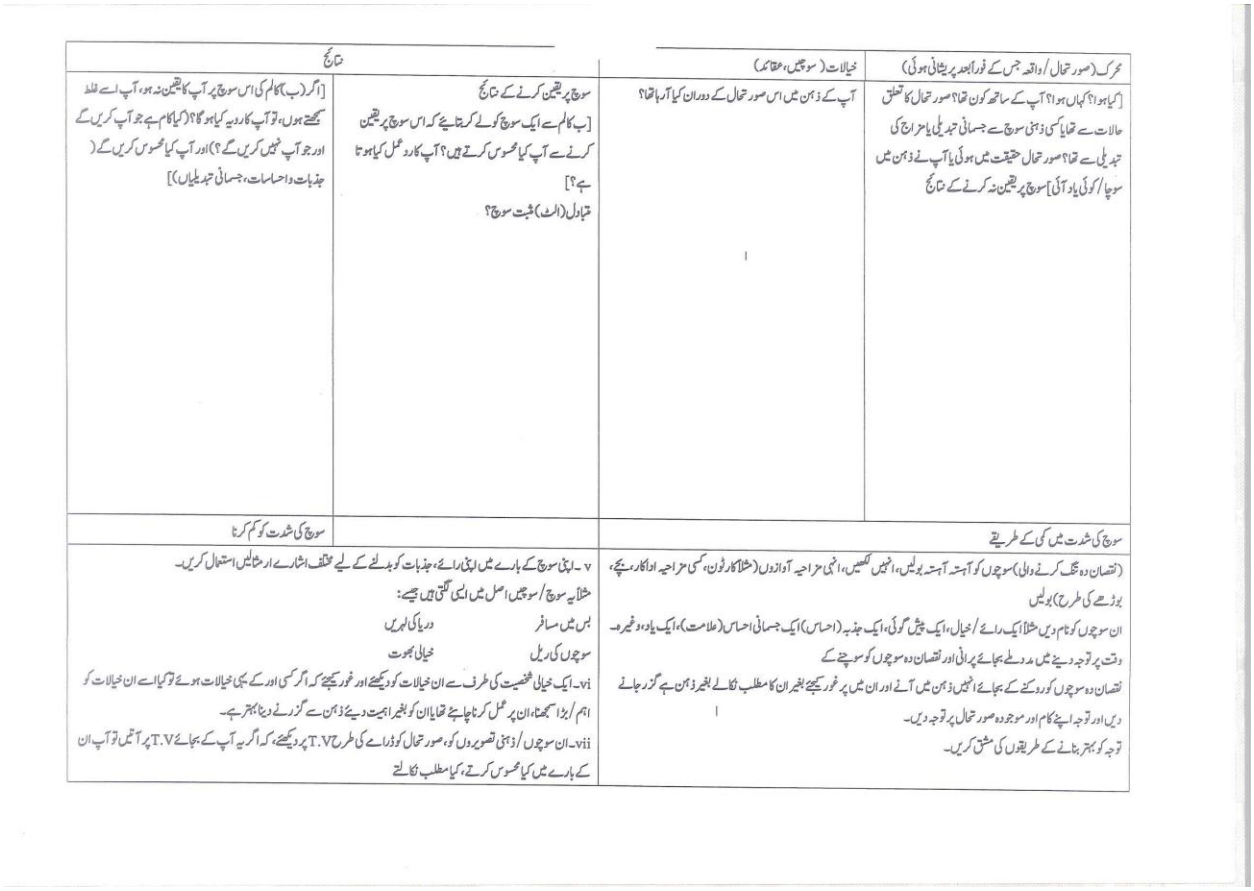
Appendix D7

سوچ کا چارٹ

محرک (صورتحال / واقعہ جس کے فوراً بعد پریشانی ہوئی	خیالات	نتیجہ
	سوچیں، ذہنی تصویریں	جذبات و احساسات اور ان کی شدت (100–0) (کیا محسوس کیا؟) جسمانی علامات (100%–0)
	ان سوچوں کا کیا مطلب نکلتا ہے؟	
	ان میں ایسی کیا بات ہے جو مجھے سب سے زیادہ پریشان کرتی ہے؟	رویے (کیا کیا / کیا کرنے کی شدید خواہش ہوئی)
	ان میں کیا عقلی غلطیاں ہیں؟	
	ان کے ذہن میں آنے سے میں خود کو کیا سمجھتا / سمجھتی ہوں؟	
	ان کے ذہن میں آنے سے میں کیسا انسان بن گیا ہوں؟	

Translation Appendix D7

A **Activating / Triggering Event Situation** (Trigger may also be a feeling) • **What was happening just before I started to feel this way?** • What was I doing? Who was I with? Where was I? When was it?	B **Beliefs** □ Thoughts and/or Images *What was going through my mind at that time?* □ Meanings & interpretations What did this say or mean about me? What was the worst thing that could happen?	C **Consequences** □ Emotions Describe as in one word/s & rate intensity 0-100% □ Physical sensations *What did I feel in my body?* □ Behaviours: actions & urges *What did I do?* *What did I feel like doing?*



محرک (صورتحال / واقعہ جس کے فوراً بعد پریشانی ہوئی)	خیالات (سوچیں، عقائد)	نتائج	
[کیا ہوا؟ کہاں ہوا؟ آپ کے ساتھ کون تھا؟ صورتحال کا تعلق حالات سے تھا یا کسی ذہنی سوچ سے جسمانی تبدیلی یا مزاج کی تبدیلی سے تھا؟ صورتحال حقیقت میں ہوئی یا آپ نے ذہن میں سوچا / کوئی یاد آئی] سوچ پر یقین نہ کرنے کے نتائج	آپ کے ذہن میں اس صورتحال کے دوران کیا آرہا تھا؟	سوچ پر یقین کرنے کے نتائج [ب کالم سے ایک سوچ کو لے کر بتایئے کہ اس سوچ پر یقین کرنے سے آپ کیا محسوس کرتے ہیں؟ آپ کا ردِ عمل کیا ہوتا ہے؟] متبادل (الٹ) مثبت سوچ؟	[اگر (ب) کالم کی اس سوچ پر آپ کا یقین نہ ہو، آپ اسے غلط سمجھتے ہوں، تو آپ کا ردِ عمل کیا ہوگا؟ (کیا کام ہے جو آپ کریں گے اور جو آپ نہیں کریں گے؟) اور آپ کیا محسوس کریں گے (جذبات و احساسات، جسمانی تبدیلیاں)]
سوچ کی شدت میں کمی کے طریقے			سوچ کی شدت کو کم کرنا
(نقصان دہ تنگ کرنے والی) سوچوں کو آہستہ آہستہ بولیں، انہیں گھسیں، انہی مزاحیہ آوازوں (مثلاً کارٹون، کسی مزاحیہ اداکار، بچے، بوڑھے کی طرح) بولیں ان سوچوں کو نام دیں مثلاً ایک رائے / خیال، ایک پیش گوئی، ایک جذبہ (احساس) ایک جسمانی احساس (علامت)، ایک یاد، وغیرہ۔ وقت پر توجہ دینے میں مدد ملے بجائے پرانی اور نقصان دہ سوچوں کو سوچنے کے نقصان دہ سوچوں کو روکنے کے بجائے انہیں ذہن میں آنے اور ان میں پر غور کیجئے بغیر ان کا مطلب نکالے بغیر ذہن سے گزر جانے دیں اور توجہ اپنے کام اور موجودہ صورتحال پر توجہ دیں۔ توجہ کو بہتر بنانے کے طریقوں کی مشق کریں۔			v۔ اپنی سوچ کے بارے میں اپنی رائے، جذبات کو بدلنے کے لیے مختلف اشارے / مثالیں استعمال کریں۔ مثلاً یہ سوچ / سوچیں اصل میں ایسی لگتی ہیں جیسے: بس میں مسافر — دریا کی لہریں سوچوں کی ریل — خیالی بھوت vi۔ ایک خیالی شخصیت کی طرف سے ان خیالات کو دیکھئے اور غور کیجئے کہ اگر کسی اور کے بھی خیالات ہوئے تو کیا اسے ان خیالات کو اہم / بڑا سمجھنا، ان پر عمل کرنا چاہیے تھا یا ان کو بغیر اہمیت دیئے ذہن سے گزرنے دینا بہتر ہے۔ vii۔ ان سوچوں / ذہنی تصویروں کو، صورتحال کو ڈرامے کی طرح T.V پر دیکھئے، کہ اگر یہ آپ کے بجائے T.V پر آتیں تو آپ ان کے بارے میں کیا محسوس کرتے، کیا مطلب نکالتے

Translation Appendix D7

A Activating Event

What, where, when, who with. Outside event or internal trigger, real or imagined.

B Believable Thoughts

What went through your mind at that time.

C Consequences

Consequences of Believing the Thought
Pick a thought from column B. How do you react when you believe this thought?
Balanced alternative thought- optional

D De-fuse
Defusion involves seeing thoughts and feelings for what they are (streams of words, passing sensations), not what they say they are (dangers or facts).
What defusion technique could you use?

Examples of Defusion Exercises

Notice unhelpful thoughts. Say them slowly. Write them down.
Say them in funny voices.
- Label unhelpful thoughts and emotions, e.g. an judgement, a prediction, a feeling, a sensation, a memory etc
- Practice mindfulness so that you can better notice when you are in the present moment versus when you are stuck in your head in the past or future.
- Use metaphors to help get a different view of your thoughts, feelings, and self evaluations
  - E.g. Passengers on the Bus, The Beach Ball, The River, The Thought Train, Radio Doom & Gloom, Mind Monsters, Quicksand, Storyteller
- STOP, STEP BACK. OBSERVE (what you are feeling and thinking; how the other person is acting).

Appendix D8

سوچ کی جانچ کا تجربہ

پہلا قدم: خیال یا اصول جس کو پرکھنا ہے؟

خیال / اصول پر یقین کی حد (0-100٪)

خیال / اصول کی مضبوطی / شدت (0-100٪)

اس خیال / اصول کا کوئی متبادل خیال / اصول

دوسرا قدم: منصوبہ بندی

متفقہ تجربہ

تجربے کے ممکنہ نتیجہ کے بارے میں آپ کی پیش گوئی

آپ کو کس حد تک پیش گوئی پر یقین ہے؟ (0-100٪)

حفاظتی طریقے جو اس تجربے میں چھوڑنے ضروری ہیں

اپنے خیال / اصول کو درست ثابت کرنے کیلئے میں کیا ثبوت کرونگا / گی

تیسرا قدم: تجربہ

چوتھا قدم: جانچ پرکھ

جس خیال / اصول کو پہلے قدم پر لکھا تھا اس کی شدت کو دوبارہ ناپیں (0-100٪)

اس پر اپنے یقین کی حد کو دوبارہ ناپیں (0-100٪)

تجربے کا کیا نتیجہ نکلا؟

کیا یہ نتیجہ آپ کی پیش گوئی کو درست ثابت کرتا ہے؟

اس پیش گوئی پر اپنے یقین کی حد کو دوبارہ ناپیں (0-100٪)

اس تجربے سے کیا نتیجہ نکل سکتا ہے؟ اس تجربے سے آپ کیا مطلب نکال سکتے ہیں؟

کیا کوئی اور تجربہ اس خیال / اصول کو پرکھنے کے لئے کرنے کی ضرورت ہے؟

Translation Appendix D8

Behavioural Experiment Worksheet

Step 1 - Belief or Rule to be tested

Right now, the strength of this belief is %

An alternative might be

Step 2 – Planning

The experiment we've agreed:

What do you predict will happen?

How sure are you that this will happen? %

Safety Behaviours I need to drop during this experiment

The evidence I will use to judge which belief is more likely to be true

Step 3 – Experiment

Now carry out the experiment and note what happened / what didn't happen

Step 4 – Debrief

Re-rate beliefs in Step 1. Right now the strength of my belief is %

What happened? Did it fit with your prediction?

Re-rate your belief in the original prediction %

What can I conclude from this experiment?

Do I need to do any further experiment in the light of this one?

Appendix D9

مثبت خیالات

* میرے ہاتھ پاک ہیں ۔

My hands are clean.

* جس شے پر سے 3 بار پانی گزر جائے وہ پاک ہے (حدیث پاک) ۔

After washing something 3 times, it is clean (Haith)

* میں اس وہم پر قابو پا سکتا ہوں اور میں اس وہم پر قابو پارہا ہوں ۔

I can over come this obsession and I am overcoming it.

* یہ وہم ایک بیماری ہے اور میں اسے ہرا دونگا ۔

This Obsession is an illness and I will defeat it.

* جس سوچ یا عمل پر انسان کا اختیار نہ ہوں اس پر کوئی گناہ نہیں ۔

The unintentional thoughts and involuntary actions are not consider as sins.

* میرا اللہ مہربان اور رحم کرنے والا ہے وہ مجھے بیماری پر کوئی سزا نہیں دے گا ۔

My Allah is kind and he will not punish me for illness i am suffering.

‘‘ میں اپنی بیماری کا ذمہ دار نہیں ۔ لیکن میں اپنی صحت یابی کی ذمہ دار ہوں ۔’’

I am not responsible of this illness but i am responsible for my

treatment/therapy/prognosis.

‘‘ میں بار بار آنے والے خیالات کیوجہ سے ہونے والی بے چینی برداشت کر سکتا ہوں ۔’’

I can tolerate anxiety caused by obsessions.

زندگی بذات خود ایک وہم ہے یعنی بے چینی پر مبنی ہے ۔ میں بے یقینی کے ساتھ زندہ رہ سکتا ہوں ۔’’

‘‘

Life itself is uncertain, so i can live with uncertainity.

Appendix E

Bonferroni Post hoc for YBOCS

Group		*MD (I-J)*	*SE*	*p*
(I)Time	(J) Time			
Pre-CBT	Mid-CBT	1.96	.78	.17
	Post-CBT	15.67	.63	.001
	Follow-up	12.54	.84	.001
Mid-CBT	Pre-CBT	-1.96	.78	.17
	Post-CBT	13.71	.62	.001
	Follow-up	10.58	.9	.001
Post-CBT	Pre-CBT	-15.67	.63	.001
	Mid-CBT	-13.71	.62	.001
	Follow-up	-3.12	.83	.006
Follow-up	Pre-CBT	-12.54	.8	.001
	Mid-CBT	-10.58	.94	.001
	Post-CBT	3.12	.83	.006

Appendix F

سوچ کی غلطیاں

۱۔ میرے لئے ضروری ہے کہ ہر کام کومکمل کروں۔

۲۔ سوچ پر مکمل قابو ضروری ہے۔

۳۔ وہ انسان ہی نہیں جو اپنی سوچ کو قابو نہ کرسکے۔

۴۔ یہ میری ذمہ داری ہے کہ میرے اردگرد کے لوگوں کو میرے کسی عمل یا سوچ سے نقصان نہ پہنچے۔

۵۔ محتاط نہ رہنے کا مطلب ہے کہ میں نقصان پہنچانے والا ہوں۔

۶۔ ایک اچھا انسان کہلانے کے لئے یہ ضروری ہے کہ میں اپنی ہر سوچ میں پاکیزہ رہوں۔

۷۔ برا سوچنا اور براکرنا ایک جیسا ہے۔

۸۔ بری سوچ اسی کو آتی ہے جو برا ہوتا ہے۔

۹۔ اللہ کے خلاف سوچ آنے کا مطلب یہ ہے کہ میں کافر ہوں۔

۱۰۔ برے انسان کو ہی بری سوچیں آتی ہیں۔

۱۱۔ مجھے اپنی سوچوں پر پورا قابو ہونا چاہئے۔

۱۲۔ مجھے چاہئے کہ میں ہر صورت میں نقصان ہونے سے روکوں۔

۱۳۔ مذہب کے خلاف سوچیں انہی کو آتی ہیں جو برے لوگ ہوتے ہیں۔

۱۴۔ یہ سوچیں صرف مجھے آتی ہیں کیونکہ میں گناہگار ہوں۔

۱۵۔ میری نماز مکمل طور پر درست ہونی چاہئے۔

۱۶۔ ذرا سی غلطی کسی بڑے نقصان کی وجہ بن سکتی ہے۔

۱۷۔ ایک اچھا انسان وہ ہے جو ہر نقصان سے محتاط رہے۔

۱۸۔ میری ذرا سی کوتاہی -----

۱۹۔ ایسی سوچیں آنے سے میں گناہگار ہو جاؤں گا۔

۲۰۔ ایسی سوچیں آنے سے میں جہنمی ہو جاؤں گا۔

۲۱۔ اللہ مجھے سزا دے گا اگر مجھے ایسی سوچیں آتی رہیں۔

۲۲۔ میں اسلام سے خارج ہو جاؤں گا۔

۲۳۔ میری بخشش نہیں ہوگی۔

۲۴۔ وضو میں تسلی نہ ہوئی تو نماز نہیں ہوگی۔

۲۵۔ ایسے لگتا ہے جیسے میں پاگل ہو جاؤں گا۔

۲۶۔ میں گناہگار ہوں؛ یہ سوچیں اس کی سزا ہیں۔

۲۷۔ ان خیالات کے آنے کا مطلب ہے کہ میں اچھا مسلمان نہیں ہوں۔

۲۸۔ نماز بہترین طریقے سے پڑھنی چاہئے۔

۲۹۔ کسی کام میں ذرا سی غلطی کرنے سے بہتر ہے کہ کام کیا ہی نہ جائے۔

۳۰۔ کوئی کام کرتے ہوئے اگر شک گذرے تو اسے ازسرِنو کرنا ضروری ہے ورنہ غلطی رہ جائے گی۔

۳۱۔ تسلی ہونا ضروری ہے۔

۳۲۔ میں بے چینی برداشت نہیں کر سکتا۔

۳۳۔ اگر میں نے پوری طرح احتیاط نہ کی تو میرے گھر والوں کے ساتھ کچھ برا ہو جائے گا، جسکا ذمہ دار میں ہوں گا۔

۳۴۔ میری وجہ سے عذاب آ جائے گا۔

۳۵۔ میری وجہ سے سب ناپاک ہو جائیں گے۔

۳۶۔ میں قصور وار ہوں گا۔

۳۷۔ جہاں گندے ہاتھ لگیں گے وہ سب ناپاک ہو جائے گا۔

۳۸ً۔ اگر دوسروں سے بار بار یقین دہانی نہیں کرواؤں گی تو میں غیرمحفوظ ہو جاؤں گی۔

۳۹۔ یہ وہم کی بیماری میری سزا ہے۔

۴۰۔ ان گندی سوچوں کے آنے کا مطلب ہے کہ میں نے زنا کیا ہے۔

۴۱۔ جو سوچیں ذہن میں آتی ہیں وہ سچ بھی ہو سکتی ہیں۔

۴۲۔ اللہ کے بارے میں برا نہیں سوچنا چاہئے۔

۴۳۔ میں اللہ کے بارے میں برا سوچ رہا ہوں، وہ مجھے کبھی معاف نہیں کرے گا۔

۴۴۔ میں ایک گندا انسان ہوں کیونکہ مجھے گندی سوچیں آتی ہیں۔

انسان ہوں۔ abnormal ۴۵۔ ان سوچوں کے آنے کا مطلب ہے کہ میں ایک

۴۶۔ میرا کردار صحیح نہیں ہے۔

۴۷۔ کپڑے ناپاک ہوں گے تو نماز نہیں ہوگی۔

۴۸۔ اگر بار بار کپڑوں کو نہ دھوئیں تو یہ پاک نہیں رہیں گے۔

۴۹۔ چیزوں کو ویسا صاف ہونا چاہئے جیسا میں چاہتا ہوں۔

۵۰۔ اگر صحیح طرح سے وضو نہ کیا یا اگر وضو کی تسلی نہ ہوئی تو مجھے گناہ ہوگا۔

۵۱۔ اگر گندی سوچیں آئیں تو میرے ساتھ کچھ برا ہو سکتا ہے۔

۵۲۔ نقصان دہ سوچیں نقصان کی وجہ بن سکتی ہیں۔