CHAPTER IV
METHOD

The Present research is an attempt to study obsessive compulsive patients’ insight and motivation for change

SAMPLE

108 cases of OCD diagnosed by a trained psychiatrist using DSM IV-TR (2000) criteria were drawn from different Psychiatric clinics of Bathinda, Barnala and Patiala. These subjects were requested to participate in the study. With their consents, when it was found that they fulfilled inclusion criteria, the subjects were taken for the study.

Out of the total sample of 108 subjects 10 Subjects were dropped because of ambiguities in information provided by them.

Inclusion criterion:

Patients primarily diagnosed as Obsessive-compulsive disorder according to DSM IV-TR (2000) by a trained psychiatrist from the OPD and by using Yale_ Brown Obsessive Compulsive Scale (Goodman, Price, Rasmussen, & Mazure, 1989).

Exclusion criterion:

❖ Patients suffering from organic disease or mental retardation.
❖ Patients less than 18years of age were also excluded.

Tools: Keeping in view the objectives of the present study the selected sample was assessed using the following tools:

(i) *Scale for the assessment of motivation for change* (Neeliyara &. Nagalakhshmi, 1996).
(iii) **Yale_Brown Obsessive Compulsive Scale** (Goodman, Price, Rasmussen, & Mazure, 1989).

(iv) **The Attributional Style Questionnaire** (Peterson et al, 1982).

(v) **The Coping Checklist** (Rao & Prabhu, 1989).

Description of tests

(i) **Scale for the assessment of motivation for change** (Neeliyara & Nagalakhshmi, 1996). This scale is 80 item five point measure of an individual’s motivation for change, developed for Indian population. In the current study, it was used to assess its total score as well as the sub scales which include self esteem, locus of control internal, growth motivation, religious attitude, and self criticality. According to Neeliyara and Nagalakshmi (1994) **Self esteem** refers to the perception the individual possesses of his worth. It refers to the individual’s sense of personal worth, his feeling of adequacy, worth and value as a family member and it reflects the person’s sense of adequacy and worth in social interaction with other people in general. **Locus of control internal** refers to the extent to which an individual is self motivated, directed or controlled. **Growth motivation** reflects positive mental health aspects, like trusting one’s ability to size up in any situation and being certain of one’s relationship with others. It also refers to being content with life and being assertive. **Religious attitude** reflects contents such as attributing success and failure to God and feeling deeply about religious fulfillment in one’s life. It also indicates that faith in God helps one obtain peace of mind. **Self criticality** means that the person is aware of one’s own assets and short comings. This self criticality is viewed as a positive aspect of self.
Drinking related locus of control is another subscale in this measure. It is particularly related with drinking disorders, and was thus dropped for assessing motivation for change in the current study. The scale has been reported to possess good validity for alcoholics as well as other psychiatric disorders (Neeliyara and Nagalakshmi, 1996). It is a reliable measure (reliability quotient=0.897) (Neeliyara and Nagalakshmi, 1994) with a strong theoretical grounding.

(ii) **Yale_Brown Obsessive Compulsive Scale**

(Y-BOCS)(Goodman, Price, Rasmussen, & Mazure, 1989). The Y-BOCS severity scale is an assessor rated measure of the intensity of OCD. The Y-BOCS, which assesses the overall severity of OCD symptoms, is considered the gold standard of tools in the assessment of OCD symptom severity. Psychometric studies indicate that the Y-BOCS exhibits high convergent validity with the *NIMH Obsessive-Compulsive Scale* ($r = 0.67$) and is sensitive to change and improvement in OCD, relative to the *Clinical Global Impressions-Obsessive Compulsive Scale* ($r = 0.89$) (Goodman et al., 1989a, b). The Y-BOCS measures five dimensions independently for obsessions and compulsions, namely (a) time spent on these behaviours, (b) interference that these behaviors cause, (c) distress that the individual experiences, (d) degree of resistance to the symptoms and (e) amount of control that the individual has over these behaviours. Each item is rated from 0 (*lowest severity*) to 4 (*highest severity*). The total Y-BOCS is typically utilized as one of the several assessment tools to aid in the diagnostic process and as a measure of symptom severity. The developers of the Y-BOCS scale provide the following recommended descriptors for
assessing symptom severity: score of 1-7 is considered *subclinical*; score of 8-15 is considered *mild*; score of 16-23 is considered *moderate*; score of 24-31 is considered *severe*; score of 32-40 is considered *extreme* (Goodman et al., 1989). The *Y-BOCS* also contains a symptom checklist which measures the current and past experience of 15 categories of obsessions and compulsions. This measure has been found to be appropriate for use with non-clinical samples too and was reported to be superior to other instruments for detecting the presence and severity of obsessive and compulsive symptoms (Frost, R.O., Gail Steketee, G., Krause, M., S., Trepanier, K. L., 1995).

(iii) **Brown assessment of belief scale** (Eisen et al 1998). The BABS is a 7-item, clinician-administered semi-structured interview designed to quantify delusional thinking related to a dominant belief along a spectrum from good insight to delusional thinking in a wide range of psychiatric illnesses. Psychometric properties of this scale have previously been established: inter-rater reliability and internal consistency are excellent; validity has been established via convergence with other measures of insight and symptom severity; intraclass correlation coefficient was 0.96 for the total score; Cronbach’s alpha coefficient was 0.87; mean test retest reliability was 0.95 (range 0.79–0.98). (Eisen et al 1998) In administering the BABS assessment, a dominant belief is first determined in a semi-structured, open interview. In this study, the dominant belief was elicited by explaining to the patient that the interview aimed to assess beliefs that interfere with eating, even if these
beliefs seem irrational. The seven items on the BABS assess conviction, perception of others’ views, explanation of differing views, fixity of beliefs, attempts to disprove beliefs, insight, and ideas of reference. The questions have five anchors, with descriptions corresponding to each anchor. The score for each item ranges from 0 (non delusional or least pathological) to 4 (delusional or most pathological). The total score ranges from 0–24 (ideas of reference are not included in the total score). Ratings reflect an average score for the past week. Items are summed to reach a total score (dimensional). As in previous studies of OCD and BDD, 20 participants in this study were given the categorical score “delusional” if they received a 4 on item 1 and a total score ≥ 18 (categorical); this cutoff point was previously empirically derived.16 Participants were categorized as having “poor insight” if they received a 3 on item 1 and a total score ≥ 13.

(iv) **The Coping Checklist by Rao and Prabhu. (1989)** – The Coping Checklist developed by Rao is an open ended questionnaire consisting of 70 items relating to things that people do in times of stress in general, and is scored on a yes/no format. The scale was self administered. The subject is required to check those coping mechanisms that he uses when faced with a problem or stressful situation. The total number of items reported by an individual is indicative of the size of his coping repertoire.

Subbakrishna and Prabhu (1989) coping checklist is used in this study to find out the coping strategies used by OCD patients to cope with their mental illness. Test-retest reliability is 0.74 (p 0.01). This checklist has 70 items. There are 9 coping strategies – (1) cognitive positive, (2) cognitive
negative, (3) problem solving, (4) distraction, (5) magical thinking, (6) avoidance, (7) religious, (8) help seeking, and (9) external attribution. Individual has to answer YES (score = 1) if he is using a given method often or frequently and answer NO (score= 0) if he is using the method infrequently or not at all.

(v) **The Attributional Style Questionnaire** (ASQ; Peterson et al, 1982) The ASQ (ASQ; Peterson, et al., 1982) was used to measure Explanatory Style. The ASQ is a self-report instrument that consists of twelve hypothetical situations; six of the situations are positive, and six are negative. Respondents are asked to vividly imagine each situation happening to them and to write down one major cause of the event. On a 7-point rating scale, respondents are asked to indicate the degree to which the cause is perceived to be internal (factors related to the individual) or external (factors related to other people or circumstances), stable (will always be present) or unstable (is fleeting), global (affects all areas of life) or specific (is only specific to the current situation). As mentioned earlier, the ASQ yields a composite score for positive events (CoPos) one for negative events (CoNeg) and an overall composite score, which consists of the difference between CoPos and CoNeg (CPCN). Additionally, individual dimension scores can be computed by summing all of the scores for each dimension (i.e., InternalNeg, StableNeg and GlobalNeg). The three composite scores (CoPos, CoNeg and CPCN) in addition to the individual dimension scores for negative events were used for the analyses. Reported reliability of the ASQ for each dimension evaluated for the negative situations is .46 for internality, .59 for stability and
.69 for globality (Golin, Seweeney, and Schaeffer, 1981; Peterson et al., 1982; Sanjuán and Palomares, 1998).

**Administration and scoring**

All the scales and questionnaires were administered in an individual setting. The administration of all the five scales and questionnaires required approximately one and a half hour per subject. The scales and questionnaires were administered in a uniform sequence. A time gap of 10-15 minutes was allowed in between the administration of different scales so that the effect of fatigue etc. may be dissipated.

The consent and cooperation of the patients was difficult to secured and maintained throughout the lengthy process of data collection, due to hectic schedule of the patients. However sincere efforts were made to secure their cooperation and to establish a rapport with the patients in order to elicit authentic and reliable information from them. The patients were apprised of the purpose of the investigation as being purely scientific and academic. The patients were assured of the confidentiality of the information collected from them.

All the scales and questionnaires were administered and scored strictly according to the instructions provided in their respective manuals.

**STATISTICAL ANALYSIS**

Statistical analysis of the data would involve:

1. The computations of means, SDs and t-values of the scores on the variables under study.
2. Computation of the correlation and regression analysis as per need.