Cognitive Drill Therapy

Fast Phobia & OCD Relief

Dr. Rakesh Jain, Ph.D

Easy and Effective Techniques

Cognitive Drill Therapy (CDT) is developed by Dr. Rakesh Jain, Ph.D. Clinical Psychologist, specifically for the management of phobia and obsessive-compulsive disorder (OCD). It is a structured, directive and collaborative form of psychological treatment based on theories of conditioning, cognitive appraisal and linguistics.

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At the Lotus Feet of
GOVIND JI

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PREFACE

Phobia and OCD have very high prevalence to the extent that a large number of population is affected by these disorders. With the advent of newer forms of psychotherapies and medicines, the awareness of OCD and the persons seeking treatment have increased tremendously. Still phobia is the condition, which is relatively a less priority for both the affected persons and mental health professionals. We infrequently talk of phobia. The primary reason of this less attention is that the persons with phobia do not recognize that they have a phobic condition, or if they recognize; they do not consider it as treatable or not aware that effective forms of psychotherapeutic measures are available to address the phobic condition. Instead the persons with phobia and some patients of OCD get involved in self-help books, inspiration and motivational quotes and programs. Also they are likely to consider self-hypnosis and affirmations to overcome the phobic condition. The attempt to deal with phobia and OCD through self-help books and other similar programs yield partial success in some cases as seen in clinical set up. The patients come to us after reading lots of such books and fail to resolve the phobia.

While working with the patients of phobia and OCD, I realized that these patients suffer silently to the deeper levels of their being. They also have associated feelings of sadness, inadequacy, shame and humiliation. They do not open up easily and completely before their friends and well wishers. The topic itself becomes so overwhelming to them that they feel it as fearful and even disgusting to give a detailed narrative of their problems.

All emotional disorders be it phobia or OCD impose certain limitations on the functioning of the affected persons and their family members. A person affected by social anxiety disorder feels inadequate and worries about being judged by others cannot function optimally in his/her workplace. He would keep on shying away from fellow workers and avoid the assignments involving speaking or presentations before others. Such kind of scenario is a restriction on the expression of full potentials of the affected person which in turn causes National loss due to sub-optimal functioning.

I am grateful to my patients who provided me an opportunity to develop Cognitive Drill Therapy for efficient resolution of Phobia and OCD.

I wish that this therapy should reach to most if not all persons affected by phobia/OCD and the professionals world-wide dealing with such simple and pious souls terrified by creation of their own imagination.

Place: Agra (India) **Dr. Rakesh Jain**
Date: 15th October 2016

01
WOUNDED BY WORDS

I was comfortably pursuing my passion of hypnosis and conducted workshops in many centers of academic learning. I conducted one such workshop in RG College, Meerut (India) in December 2007 which was covered by the print media. Having read the content in a newspaper, a patient named Mr. Chand (disguised name), an adult, approached me for treatment of his problem through hypnotism. He was having thoughts of 'nash' (ruin) of his family members which kept on troubling him for 15 years. He comes from a rural background where the 'nash' and similar words are used frequently by the local people as an expression of anger and curse in particular. He was unable to face the persons who use this term and would change the route to avoid encounter with the people involved in a conversation that could involve the usage of word 'nash'. Due to avoidance of many known people in his village, his life became almost dysfunctional over the years. He was not able to talk to people and even stopped discharging his family and occupational responsibilities. He would keep on removing the 'nash' word from his mind. He was severely disturbed. Whenever, he bought new pair of clothes, and upon wearing the new pair of clothes, if he heard the 'nash' word from any person, he would associate 'nash' with the new clothes and then he will not wear those clothes and would go to the outer of the village and through the clothes in pond/river.

He unsuccessfully tried to suppress the 'nash' word from his mind for several years. He is a graduate and has an interest in spiritual and hypnosis related literature. He also read self-help books. He formed an opinion that 'nash' word could be wiped away from his conscious mind through the application of hypnosis. He was in search of a hypnotist who could help him out in removal of 'nash' word from his conscious mind. When he read my coverage of hypnosis in newspaper he got thrilled and highly optimistic and located me in Agra (India).

I listened to his full story which revealed that he was wounded by following words: (a) Nash (2) Guldiva (3) Punja Chhipna. He was scared that by having these thoughts in his mind, there can be an actual loss/devastation in the family. There can be a substantial loss of life and material in the family. He also felt that if any such loss occurs he will be held responsible for having such thoughts in his mind.

He had already seen some psychiatrists and clinical psychologists and also received some sessions of CBT. Since he was not getting the desired relief he was looking for a hypnotherapist for pushing his thoughts to deeper layers of subconscious mind. Being into the field of hypnosis, I knew very well that I would not be able to push away his thoughts through hypnosis. Neither, I was confident that I could achieve desired success by teaching him the technique of thought stopping. In this thought stopping technique, we teach the patients to sub-vocally shout stop as and when an unwanted thoughts intrudes the mind. In fact, I did not know how to handle his problem through

psychological means. Also I was not finding myself in a position to refuse hypnotherapy/psychotherapy to him for two reasons. (1) He would get demoralized. (2) I would also feel bad for not able to help him out.

I regained my composure and made a referral for psychiatric consultation. He was not much inclined to do so. Since I recommended him and impressed that it should be a combination treatment, he accepted the idea. On priority, I am inclined for a combination treatment for OCD instead of standalone psychotherapy. He had come specifically for me and stayed in Agra.

We commenced our psychotherapy session next day. While he was reporting his problems, I noticed that he was using future tense in most of his problems. His statements were as under:

1. My brother will be ruined
2. My mother will be ruined
3. I will be ruined
4. I will be held responsible for the ruin

I could not let him know that hypnosis would not serve his purpose. Instead, I impressed him that let us first try something else prior to resorting for hypnosis. Although I was not fully clear what alternative I would be doing. Since my attention was drawn to his usage of future tense, an idea of linguistic pattern crossed my mind. I thought let me try changing the sub-vocal linguistic pattern. I had pre-existing idea that the language patterns affect emotions and behaviors. Keeping this in mind, I decided to give the idea a try.

Specifically I considered changing the statements of future tense into past tense. After changing the tense to the past, the above statements would become as under:

1. My brother has been ruined
2. My mother has been ruined
3. I have been ruined
4. I have been held responsible for the ruin

For modifying linguistic pattern, I would require him to repeat these statements. The idea of 'ruin' was frightening to him. He thought the repeated idea would get converted into objective reality.

Before making him to rehearse above tense converted statements, I decided to correct his magical thinking. In magical thinking, a person thinks that mere mental repetition of some words can cause physical events in the external world. His repetition of 'nash' in his mind can actually cause 'nash' in his family. I had to correct his magical thinking by explaining that only by repeating thoughts in his mind, he cannot cause a physical event. I invited him to move his mobile only by his thoughts; or kill an ant by performing mental acts or repetition of any words mentally. He could understand the concept of magical thinking. He seemed to accept the idea that thoughts by themselves cannot cause physical events. Now the ground for repetition

of the scary words was set in.

I also explained him the idea of tense and its neural correlates. I told him that let us call three tenses – Past, Present and Future as ABC. A=Past Tense; B=Present Tense (c) C=Future Tense. The three tenses do not have identical neural correlates in the brain. We can speculate separate areas for each tense in the brain. If it is so, let us call the corresponding centers in the brain as ABC (A for past tense, B for present tense and C for future tense). Whenever, a person uses past tense (A) the information travel to the A centers in the brain; during usage of present tense, the information travels to B centre and during usage of future tense, the information travels to C center in the brain.

Anxiety looks into the future. Fear is future. As and when the mind is affected by fear, the sub-vocal language becomes future oriented and the centre C in the brain become more active. Over the years of fearful state, the C centre in the brain remains active and the person also continues to remain fearful. If we change the language pattern in above statements, the information will not travel to C centre in the brain and the fear associated with these words will cool down. This linguistic pattern was totally my speculation which I was trying for a few years with other patients too; albeit in other forms and problems.

Now the actual rehearsing of tense converted statements was in order. Having educated him in above concepts, I asked him to repeat above statements. The statements were to be taken up in sequence. The first chosen statement was "I have been ruined" (In Hindi: mera nash ho chukka he). When I asked him to repeat that, instantly there was a withdrawal response and visible signs of fear were present. He found it extremely scary to repeat this statement. I reminded him of the concepts of magical thinking but still he failed to accept the idea of repeating the words which have been wounding him for several years.

I wanted him to repeat the tense converted statement in a row. I could understand his fear and inability to speak the tense converted statement. I then resorted to approach the task by diluting it. I told him that let me repeat it for me and just listen to it. I started verbalizing "I have been ruined" (in Hindi: mera nash ho chukka he), "I have been ruined", "I have been ruined"… The signs of distress were visible in him even if I was repeating it for me. I kept him encouraging that whenever he feels comfortable, he can begin to repeat it. Then I shifted to enemies; "enemies are ruined" (In Hindi: Shatruaon ka nash ho chukka he). He quickly picked up it and commenced repeating. Gradually, I removed the enemy word from it and now he was required to repeat "ruined" (In Hindi: nash ho chukka he). I noticed that upon commencing the verbalizations in such manner he was having distressed reaction, which got raised to high level.

I explained him the concept of anxiety curve. I told him that while repeating, his distress will rise from low to medium and then to high level; and then it will show a declining pattern to medium and low and finally zero. If this pattern of rising and

declining pattern of anxiety is plotted on a graph, it will result in a curve similar to bell shape.

Also I reminded him of the magical thinking; that mere repetitions in this manner will not produce actual physical effects and urged to keep on repeating. He kept on repeating. The anxiety which rose to high level now began to resolve and cooling down. After a few minutes of repetitions, he reported minimal distress for repeating the statement.

When his fear reaction subsided to the spoken statements, I gave a pause of about 3-5 minutes and chatted with him on other topics. After a gap of this pause, I once again asked him to repeat "ruined" (In Hindi: nash ho chukka he). This time, withdrawal reaction was not present. He readily accepted the idea of repetition. When he repeated it this time, the fear reaction did not shoot up. Within a few minutes he reached the minimal level of distress. Again a pause of 3-5 minutes was given. Once again he was required to repeat the above statement, this time he found it comfortable to repeat. Even if there was no discomfort this time, I made him to repeat for over learning. When both of us agreed that there were no distress while speaking it, we decided to switch over to other statement. In the course of applications, I finalized a criterion of three or more consecutive repetitions without or with minimal distress as the pass criteria to move on to other statement.

The session continued for about one hour. Seeing the response of reducing fear to the verbal exposure of fear provoking words, I got thrilled and optimistic that this approach can be continued on him for other statements too. I thought if this pattern can be replicated to other statements, then he can be expected to make substantial healing of his psychic wounds.

I labeled the bulk repetition of fear related terms and statements as "Drill". We met daily for further sessions except on Sunday. He seemed to have regained his hope and optimism. We identified more objects and situations associated with fears. Following additional objects/situations were identified:

1. Ladies in his village speaking 'punja chhip jayega'
2. Ladies conversing amongst themselves, 'Guldiva ho jayega'
3. Vansh nash ho jayega
4. Group of people conversing themselves in the front portion of his house and using the word 'nash'
5. Hearing the word 'nash' while wearing new pair of clothes

I then encouraged him to take up other statements for drill. "Guldiva ho chukka he", "Guldiva ho chukka he", "Guldiva ho chukka he"… Upon commencement of this statement, again the fear reaction showed spike to medium and then high to very high levels. Since the fear reaction was shooting almost instantaneous to high or very high level; I gave him pauses for a couple of minutes. I reasoned that during the pause his mind will become prepared to handle the massive emotional processing rapidly. My this idea of giving pauses worked exceedingly well in expected direction. After pause,

when he resumed to verbalize "Guldiva ho chukka he"… the fear reaction did not shoot up to very high level. He continued to perform the drill which was essentially involving verbal exposure. His distress was perfectly following the pattern of anxiety curve. The remarkable feature was that the pattern of his fear reaction was returning to minimal level within a few minutes of repetitions; approximately 5-10 minutes.

The pattern of resolution of anxiety boosted the self-efficacy of both me and the patient. We were feeling happy that this method of healing the wounds was working perfectly well. After 2-3 days of application, he softly asked me "Sir, can I buy a register?". I got surprised and asked what he would do with the register. His response simply illuminated me. He told that he was not having any work to do after one hour session with me; he can write all these statements repeatedly on the register. Without any second thought I told him to go ahead. Most psychotherapy work happen between sessions. Homework is an essential and important aspect in psychotherapy. I was missing this component of homework with him. He himself came up with the idea of homework even without me suggesting for it. He bought a register and kept on writing the statements on the register. The writing drill accelerated his improvement to a great extent. Now I think, I could also have given him MP3 recordings of drill statements for him to listen as homework. The homework in any form is bound to reinforce the improvement.

As sessions progressed he was verbally exposed to following statements through drill:

1. My brother has been ruined
2. My mother has been ruined
3. I have been ruined
4. I have been held responsible for the ruin
5. Punja chhip chukka he
6. Guldiva ho chukka he
7. Vansh nash ho chukka he
8. People around in the village 'nash' bol chuke hn.
9. I have heard the word ruined while wearing new clothes

It was readily apparent that mere repetition of these words were producing visible psychophysiological reactions. As he continued to perform drill, the reactions were cooling down and he was feeling comfortable. Extinction was taking place. As and when he was found to express future oriented statements of fears, all such statements were taken for drill.

He continued to gain mastery over fear reaction for the drilled statements. The surprising feature of the application of the drill was that little if any generalization was taking place from statement to statement even if the key term in the statement was identical. For example, I have been ruined vis-à-vis my brother has been ruined. Each drilled statement contained some distinguishing mental image and features which was not amenable to spontaneous generalization. He had to perform drill for each identified statement for extinction to take place. However, the generalization

gains were visible in the quantum and duration of repetitions. With progressive applications of drill, he needed relatively less time and frequency of repetition for extinction to take place.

He was giving me surprise after surprise in most sessions. Upon commencement of one session, he reported that he heard two persons using the 'nash' word at his place of stay in Agra. He went near those persons and intently listened them using 'nash' word. His body and mind no longer reacted fearfully to the usage of 'nash' word by them. He designed his own behavioral experiments in real life situations. His confidence in improvement and the procedure got strengthened tremendously. Had he shown fear reaction to real life situations, I would have taken it as an evidence for doing more drill for the word for those situations.

The sessions were being conducted through verbal exposures and imagination of objects and situations which were linked with his irrational fears. I noticed that spontaneous generalization was taking place from verbal and imagination level work ups to the real objects/situations. I did not purposely exposed him to the real objects and situations. Neither, I had an opportunity to do so. But his own intellect was doing it for me.

In another session, he added one more pleasant surprise for me. He came wearing casuals to my session and revealed that he had heard 'nash' word for these pair of clothes. He had purposely brought that pair as a testing and confirmation of improvement. That is, if after the treatment he could wear that pair and felt comprtable then he would consider it as a positive and strong evidence of improvement. While wearing that pair he reported nil distress. He was as comfortable as with other pair of clothes.

He improved tremendously. I myself was not believing to the quantum of improvement which happened very fast. But it was there. I had nothing to prove it as otherwise. I tested him for all the statement repeatedly. I asked other neutral persons to speak all the statements before him. He felt comfortable and did not react in feared manner to any of the verbalizations of third party. I had no other way than to accept the improvement as authentic.

Only seven sessions were conducted on him and he declared himself completely out of the irrational fear of these words. His psychic wounds had healed substantially. He expressed his desires to take leave from me in Agra and return to his village. I could not identify any further statement for drill and no work left for further sessions, I agreed to his request for termination of therapy with follow up recommendations of psychiatric medications and applications of drill.

I continued to follow him up over phone and he maintained his improvement beyond six month follow up. I was quite happy and got involved deep into theorization and conceptual understanding of the work done with him. My own core striving and passion to heal the scary wounds of mind were healed. I too got a sense of relief that at least I could change the life of one person through applications of the

principles of psychology. This case was a turning point in my practice of clinical psychology. I was finding myself full of enthusiasm but at the same time felt that I need to refine my conceptual understanding as well as applications of this unread and untaught form of psychological treatment.

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02

DANGER IN IMAGINATION

Words are the medicines to heal the wound of words. It is the formulation and composition of words that can make a difference whether it would cause injury to the psyche or it would act as soothing balm on the existing wounds. The words become associated with the emotions. The words become objects of emotions, that is, a word or set of words can elicit emotional response in a person. 'Nash' word is symbolically associated with devastation and it elicited an abnormally elevated fear response in Mr. Chand. 'Nash' was the key word in his problems which he survived for over 15 years.

The word 'nash' stirred a network of mental images symbolizing the devastation and its consequences. It represented actual danger for him. Excessive fear is the appropriate emotion to be experienced at the face of danger. Had there been an actual danger then his response of excessive fear could have been appropriate. The expression of fear from mild to severe level can be appropriate when it occurs proportionately to real life situations. But his fear reaction was associated with creations of his own imaginations. There were no actual signs of danger in his milieu. This is the difference between fear and phobia. Fear is a response to the perception of an actual or objective danger. For example, if a snake appears in your bedroom, you will feel terrified because there is a possibility of actual threat to life. Such scary reactions are called fear. Phobia on the other hand is an irrational fear. In phobia the object of fear does not pause a real threat to life or there is minimal risk; but the person perceives it equivalent to real danger and responds with excessive fear. This equivalence or real like life threat is created in the imagination of the person which makes his being to respond excessively with fear. Since, imagination is in action in phobia/OCD; the imagination magnifies the perception of danger; it becomes imperative to correct the imagined magnification of the danger perception in the patient. Once, there is correction in threatening imagination of the patient, then the perception of objects of fear gets normalized and the hitherto abnormal emotional reactions also becomes normalized proportionate to the value of actual threat contained in the objects of fear.

In phobia/OCD, the patient remains aware of irrationality of his excessive emotional reaction to minor or neutral objects of fear. Even then, he feels compelled to avoid or involve in safety behaviors. Mr. Chand was seeking safety from distorted danger perception by avoiding the people, situations and objects that could remind him of 'nash'. He was aware of the irrationality of his reactions, still he was struggling to push away 'nash' word from the content of awareness.

A person with phobia/OCD engages in avoidance and safety behaviors because encounters with objects of fear alter the functioning of the body and mind which is painful and distressing to the individual. The body and mind of affected person react in following manner during the exposure or possibilities of exposure of the objects of phobia/OCD:

Body Reactions:

1. sweating
2. trembling
3. hot flushes or chills
4. shortness of breath or difficulty breathing

5. a choking sensation
6. pounding or racing heart
7. pain or tightness in the chest
8. rapid speech or inability to speak
9. a sensation of butterflies in the stomach
10. nausea
11. headaches and dizziness
12. feeling faint
13. dry mouth
14. a need to go to the toilet
15. ringing in ears
16. elevated blood pressure

Mind Reactions:

1. Perception of some danger or a threat to life
2. Feelings of uneasiness
3. Feelings of confusion
4. Disgust
5. Fearfulness
6. Difficulty in decision making
7. Mind going blank
8. Restlessness
9. Feeling entrapped
10. Thoughts of avoiding/escaping the objects of phobia

When a person is successful in avoiding the objects of phobia/OCD then he/she feels relieved from these emotional reactions. The aborting of stirred emotional reactions on actual or anticipated exposure by avoidance or engaging in safety behavior creates a myth in the mind of the affected person. He comes to believe that avoidance or engaging in safety behaviors are the only solutions to his/her problems of phobia/OCD. This myth gets reinforced upon each repeated instance of avoidance/safety behaviors because in reality the stirred body and mind reactions subside. This is what happened with Mr. Chand. At times, he was successful in pushing away 'nash' word from his awareness; also he was successful in keeping himself aloof from the potential exposure to 'nash' word. But unfortunately, pushing away and avoidance are temporary mechanism because the sooner or later, the affected person is likely to have encounters with his/her objects of phobia/OCD. This struggle of removal of the content from mind and avoidance become so pervasive that the affected persons at times become housebound and dysfunctional due to the fear of possible exposure to the objects. Mr. Chand struggled more and more to remove 'nash' word and keep himself away from situations and objects that could remind him of 'nash'. The end result of this trap was a dysfunctional person who lost his occupation, his social relations, freedom and joy in life. He remained preoccupied with 'nash' and his life was revolving around the 'nash' and safety mechanisms.

My task was to correct his distorted perception of life threat and devastation; to correct creations of his imaginations. He was scared of his own imaginations. He imagined real life threat. A simple act of impressing him with arguments and reasoning that the word 'nash' itself does not represent real danger was not going to help him. I disputed his magical thinking and impressed him that the thoughts of 'nash' in his mind are meaningless and they are unlikely to

cause real 'nash'. This disputation was not healing his wounds.

He was carrying products of his own imaginations in his mind. There was an obvious mismatch between his imagined threat of 'nash' and the actual threat of 'nash'. Exposure is one of the best methods to correct this mismatch between imagination and reality. I am taught exposure to fear provoking objects/situations either in imagination or with real objects. I am not aware of any practice or teaching of exposure at verbal level. The verbal exposure is almost an ignored area in the practice of psychology. Long back I had read that words represent higher order conditioned stimuli. In exposure, we expose the persons with phobia/OCD to corresponding real objects or their mental representations. For example, a person scared of dogs; will either be exposed to real dogs or mental images of the dogs. Both the actual dogs and their mental representations are neutral objects which have become associated with phobic reactions.

It is seen that actual objects activate phobic reaction in affected individual; also the mental representations of the actual objects also activate the phobic reaction. A person phobic to dogs will also display body and mind reaction to the mental images of the dogs. In exposure in imagination, it is believed that when phobic reaction subsides to the mental images of the feared objects, then there is corresponding decline in the phobic reaction to actual objects also.

While working with Mr. Chand, I prominently realized that it is not only the actual objects or their imagination but also speaking of the words related to the objects of phobia/OCD also elicit the phobic reactions in affected individuals. Precisely, this was the reason that he was not able to verbalize 'nash' word because verbalizations did elicit severe phobic reactions in him. It was quite obvious that 'words' belong to the class of conditioned stimuli.

According to the principles of psychology, when a person is exposed for sufficient frequency and duration to the conditioned stimuli (feared object) then the body and mind will cease to respond fearfully to such objects. It is technically termed as Extinction. Since, the exposure to real objects or objects in imagination produce extinction, I reasoned that exposure to feared words should also result in extinction in similar manner. That is what exactly happened with Mr. Chand. I repeatedly exposed him to the feared words and asked him to keep on verbalizing the same; and the magic happened. This verbal exposure in a manner of drill, lead to faster extinction with minimal arousal of body and mind reactions. The real exposure takes longer time for reactions to subside; but in this case the resolutions of activated reactions were taking place very fast. It was a pleasant surprise to note that smooth and spontaneous generalization was taking place only with verbal exposure. He tested the generalization to natural settings by moving nearer to the persons who were using 'nash' word.

I could see many advantages of verbal exposure in this person. This kept on stirring my own imagination to formalize more and more this form of verbal exposure in the service of persons affected with phobia and OCD. I continued my quest and applications of this form of treatment to other patients as well.

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03
THE SAFETY TRAP

In order to escape and avoid the unpleasant body-mind reactions the patients affected by phobia and OCD in particular get involved into a safety trap to the extent that many affected persons almost lock themselves into their house and become practically non-functional and abandon their occupation and even tend to deny promotions. The condition becomes painful for the patients as well as their family.

Mrs. HR came to see me with more than o8 year history of intense suffering. She was terrified of the possibility of having a heart attack. In order to prevent the possibility of heart attack she had thoroughly changed her life style and made extensive safety arrangements. While taking bath she would not close the bathroom doors for the fear that if heart attack occurred inside the closed bathroom she might not be rescued. She would not leave her house alone. She needed a person with whom she could go outside the home; in the presence of such a person called as phobic companion she felt safe to some extent. Even with the phobic companion she would not go outside the city, on expressways or long distance. She thought that in case there was heart attack the medical facilities would not be available immediately. When away from home within city, she would keep reading the boards and mentally recalling nearby hospital facilities. She worked as a teacher in a well reputed school. She had to travel to attend the school. She resigned from the job due to this terror of heart attack. She would avoid malls, crowded places and far off places in the city even with the phobic companion. She even got admitted in Intensive Care Units and got her cardiac examination done on a few occasions. She was thoroughly reassured by cardiologists about not having any abnormality in the functioning of the heart. Despite reassurance from qualified and experienced heart specialists, she kept on fearing the possibility of heart attack. This demonstrates how the mind can rule over the body and distort the reality within mind.

It was not just a private mental experience for her. She actually felt severely disturbing symptoms in her body which consisted of accelerated heart beats, increased respiration, sweating and heaviness and pain in heart area. For her, she was having episodes that mimicked heart attacks. Periodically, she got terrified to the extent that she literally felt that she is just about to die. This phase of acute distress used to last for a few minutes. She would compel her family members to take her to hospital for medical examination and treatment. When the cardiologist and the family member reassured her for no signs of heart attack; she temporarily got solace from it. But her own acute symptoms were so intense and real that she thought that may be the doctors are missing something in her examination and understanding her condition. She was fully convinced of her symptoms and supported the possibility of having heart attack with the periodic and highly distressing symptoms she was experiencing.

Now she was almost house bound and dysfunctional. She stopped riding her scooter for three years. Now she was not feeling safe going outside home, hence she restricted herself to home. Even at home she did not feel reasonably safe and grounded. Even at home, she felt unsafe. She felt helpless, used to weep and lost all the motivations. She also started feeling sad because of these experiences.

She was also referred for psychiatric consultation, but she did not adhere to the treatment

as she was not convinced why she should be taking psychiatric medicines as she thought that her condition was physical in particular a case of heart attack. The possibility of heart attack was perfectly real for her.

A common acquaintance of ours, recommended her to see me. She complied and came to me. Having listened to her story, I considered her to be a case of Panic Disorder and Agoraphobia with secondary depression. I communicated my understanding of her problems and advised her to see a psychiatrist. I told her to take medicines for 2-4 weeks and then report back to me for psychotherapy.

She did not come within the timeframe. But her not coming was haunting my mind, because I knew she also needed psychological treatment for her problems. She appeared to me after three months and reported that she has been taking medicines regularly during this period but there were little gains in her condition. I instantly recommended her to commence psychotherapy with me. She agreed to do it. Without taking any other chance, I started my psychotherapy in the same session.

I sorted out the mess of her problems by partitioning its components. I told her that depression is secondary to the fear of heart attack and it will be healed upon removal of the fear of heart disease. The identified components of her problems were as under:

Objects of Phobia: Any object/situation/place/internal body or mind experience that activates phobic reaction is classified under Objects of Phobia. By listening to her story I identified following objects in her phobia:

1. Taking bath in closed bathroom
2. Shopping malls
3. Travelling on expressway
4. Air travel
5. Riding scooter
6. Living alone in house
7. Being in crowded place
8. Going alone outside house
9. Sensations and heaviness in heart area
10. Coming to my sessions alone
11. Visiting other cities
12. Travelling on highway
13. Using metro in Delhi
14. Places where medical facilities are not available immediately

Body & Mind Reactions:

1. Pounding heart
2. Sweating
3. Weeping
4. Irritability
5. Intense fear
6. Pain in the cardiac region
7. Trembling
8. Difficulty in breathing

Feared Cognition: Also called underlying fear structure and imagined feared consequences.

1. Fear of heart attack
2. Fear of death
3. Fear of non-availability of emergency medical help

Safety Mechanisms: The phobic person perceives a danger to his/her life in one or the other forms. All fears get zeroed down to a threat to life for the objects which are either 100% safe to non-phobic or cause minimal risk. There is an exaggeration of this danger perception. The affected person makes elaborate safety arrangements to prevent the occurrence of the dangerous consequences. Mrs. HR was no exception. She also took so many safety measures which consisted of:

1. Not leaving home alone
2. Rushing to ICU as soon as there were indications of potential heart attacks
3. Restricting herself to home
4. Avoided being in crowded, shopping malls, closed places.
5. Avoided travelling far away, expressway, other cities, even distant places in her city of residence

Despite extensive safety measures to prevent the danger of heart attack, she did not feel safe even inside her own house. This is because her phobia was inside her own mind. The danger of heart attack was not present anywhere in the outside world. Hence, wherever she would be, her phobia in her own mind accompanied her. Precisely, this is the reason that safety mechanisms do not eradicate the phobia instead they create an illusion in the mind by giving temporary relief. The avoidance of objects of phobia and imposing restrictions in life provide temporary and fleeting relief and expand the scope of phobia.

A Million Dollar Question: The phobic condition is so painful and problematic to the affected person, even then why it persists specifically after taking so many counter measures? The answer to this question is simple and straightforward. The phobic person does not attempt to eradicate the underlying fear structure. Avoidance-Avoidance-Avoidance are the solutions executed by such person. He/she does not acknowledge and deal directly with the feared consequences. All thinking and behaviors are centered on the avoidance of those consequences. The safety measures offer no solution to heal the phobia. Instead, the affected person should comprehensively identify all aspects of underlying fear structure and deal with them head on. It may appear as if things 'said easier but difficult to do'. Cognitive Drill Therapy has made it possible to do the seemingly difficult task very easily. Now it is "easier to do".

Drill & Daring: Based upon my conceptualization of conversion of feared cognition into past tense and their verbal repetition in bulk for each object of phobia one by one in sequence, I commenced drill therapy with her. This is a very powerful procedure which acts directly on the underlying fear structure and removes the fears associated with the feared cognition. During the course of Cognitive Drill Therapy, I prescribe home work of drill & daring. I ask the affected person to expose himself/herself to the objects of phobia in real life situations as far as possible and sub-vocally keep doing the drill. First perform the drill in imagination and then expose to the real objects while mentally doing the drill; and the magic happens. I did following drill on her in my sessions and prescribed the daring as home work.

While performing the drill, I ask the person to mentally imagine the objects of phobia and

verbally repeat the feared cognition by changing its tense to past or present. She did the following drills:

1. Imagine yourself in a closed bathroom and keep verbalizing 'heart attack ho chukka he' (I have had a heart attack).
2. Imagine yourself in a closed bathroom and keep verbalizing "main heart attack se mar chuki hun" (I have died of a heart attack)
3. Imagine yourself in closed bathroom and keep verbalizing "heart attack ho chukka he, koi hospital bi pas me nahi he" (I have had a heart attack and there is no hospital nearby)
4. Imagine yourself in closed bathroom and keep verbalizing "heart attack ho chukka he, pas me hospital bi nahi he, main mar chuki hun" (I have had a heart attack, there is no hospital in a nearby place, and I have died of heart attack)

At the commencement of drill, merely by repetition of above statements, she showed extreme emotional reactions, she cried, cried and cried. Literally wept, tears in her eyes. It was very painful. It was managed by giving pauses and drill dilution. In drill dilution, sometimes, I speak for the patient. I repeated verbally for her "mera heart attack ho chukka he" (I have had a heart attack). She had lots of vibrations and sensations in her body. She subjectively felt as if lots of negative energy was flowing out of her body. As usual, within 5-10 minutes her reactions to drill were getting subsided. But for each change in object of phobia or feared cognition, she had emotional bursts of equal intensity. As and when she had overwhelming anxiety experience during drill, I managed it by giving pauses of a couple of minutes and drill dilution.

Within 10 sessions, she processed all objects of phobia and the feared cognition. Each session lasted for about 60 minutes. She also started going for daring in real life situations. She was now comfortable in repeating all identified objects of phobia and feared cognition. She started going outside home alone. She started riding her scooter. She visited shopping malls. She started visiting to distant places in the city. She began to forget to scan the boards/hospitals in nearby places which she was doing earlier. She was no longer avoiding crowded places. She became at ease in most places in the city. I also enquired her to mentally scan all the places in the city and consider if there could be any place associated with phobic reaction. She was not able to mentally access any such place now. Her affect improved. Her sadness got lifted away. She was now cheerful. She was happy and contented. She did not take a job instead she set up her own coaching. She is being liked and appreciated by her students and their parents. She got fully occupied. She helped a few other patients known to her to get into the psychological treatment. Her husband used to keep worrying about her even at his workplace as distress calls were coming to him unexpectedly. Her husband also got relieved and now devoting full time to his occupation without the fear of distress calls.

She began to experience bliss and joy in her life and along with her me too felt joyous for seeing her so much improved with 10 sessions of Cognitive Drill Therapy. This extra-ordinary improvement in her boosted my self-esteem and self-efficacy. I looked forward to formalize this procedure more and more in order to heal the persons affected by phobia and OCD; also to train professionals on this novel form of psychological treatment.

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04

FEARED CURSE BY ANTS

A married adult came into my contact and shared his extreme distress caused by three major problems in his life (1) terrified by dirty things (2) feared loss of business documents (3) fear of curse by ants if required to sit on the floor. He was troubled by these problems for many years. He described each of his problems in great detail.

He is a science postgraduate. He was severely troubled by his problems with dirty things. He had an established business of manufacturing metal objects. His had a supply network in neighboring states. He had good turnover in his enterprise. He was required to travel and stay in hotels for his business. He would carry his linens. In hotel, he would remove and replace the bedcovers which he carries to ensure cleanliness. He will wash the bathroom, taps, mugs, buckets in the hotel bathroom prior to using that. At home and outside, he had developed elaborate rituals and patterns for cleaning hands and taking bath. He would wash his hand many times in defined patterns and associated washing with counts. The patients with OCD develops counting system to deal with their repetitive tasks. He thought of himself as extremely dirty and would not allow any other person including family members to touch him. He thought that if anybody could touch him, that person will become dirty. He even did not allow his children or wife to touch him. He has a single room at the upper floor of his own house. He locked himself in that room. He was being served food by moving the plate inside his room. The chapatti will have to be dropped to his plate from above to ensure that no physical connection is established with the person through his plates. His plate is dirty, while serving chapatti, the chapatti will touch the plate and the contamination of his plate would pass on to the person through the chapatti. He will not allow any family member to walk over his footsteps, because his footsteps were contaminated, if any person would walk over those footsteps the contamination would spread over to that person. Thus, living inside and outside the home had become extremely troublesome for him.

He also feared that his business documents can get lost. He would check the pocket of his clothes several times to ensure that no document was left in his pocket. The documents of concerns were his bills and payments receipts which were of small size in thin papers. While riding the bike, he would turn backwards to make sure that his documents did not fall on the road. He escaped accidents because of this checking behavior while riding the bike. The feared loss of documents and consequent loss of money were also major issues he was facing.

For three years his business had declined and he had already incurred a loss of millions. He was not attending to his business. Whatever the business dealings were remaining that were being looked after by his brother. He had almost become dependent on his brother for financial help. The situation had become too much problematic for him.

He maintained a diary of his problems and treatment. He told me that he has already taken several group of medicines like serotonin reuptake inhibitors and he had a long list of medicines by brand names and their grouping according to the mechanisms of action. He also used John Wort by importing from United States. He was using web for gaining knowledge on his problems and treatment. He has a friend who is equally intelligent and helped him in his problems and search on the webs. He was having secondary depression. He did not get relief so far.

Through internet he came to know about Gamma Knife which uses laser brain surgery and employed in some case of OCD. He considered himself as a case of Gamma Knife. He located and visited a reputed hospital in Delhi having this facility and impressed them to subject him for this surgery even if the specialists were not fully convinced by its indications in him. He shared that he also become aware that this surgery is partially successful and may even lead to more problematic side effects. He got afraid of side effects and also reasoned that what would be the use if only partial success is to be achieved.

He was a person with severe OCD with associated depression and prominent impairment in interpersonal and occupational functioning. He has good communication skills. He could describe his problems and issues in detail. He was on intensive and regular psychiatric treatment. I advised him to add Cognitive Drill Therapy to his treatment regime. He agreed to it and we began to work.

The underlying issues were semen linked with contamination, loss in business for document loss and curse by ants for losses. The drill therapy as usual was applied on him. He was exposed to real objects of fear such as toilet mug, wash basin, dirty clothes, clothes having patches and mental representations of objects such as actual loss of documents. He converted all future tense statements into past tense and repeated them.

He showed tremendous improvement in his condition within a few months. He locked the room on upper storey. Started living with family members, touching and allowing them to touch. He re-established his business and reclaimed his occupation over and above his previous level. He started visiting to other cities for his business purposes. He is a totally new person now. He is a live example of the miraculous approach of combination treatment.

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05
FEARED COGNITIONS

Feared cognition is the primary basis of phobia and OCD according to the theories of psychology. We also call it as underlying fear structure and imagined feared consequences which constitute the bottom layer of the problem in a Two Layer Conceptualization. While dealing with phobia/OCD, we must identify and enlist the feared cognition. To illustrate the range of feared cognition in various disorders, I am presenting the list of feared cognitions seen in various phobia and OCD. One of the distinguishing features of feared cognition is the use of future tense/future orientation in the internal dialogue of the affected person. It can be easily identified and enlisted.

Fear structure in examination anxiety:

A student during upcoming examination may experience severe anxiety reactions with following underlying fear structure:

1. fear of going blank
2. fear of forgetting
3. fear of failure
4. fear of embarrassment
5. fear of humiliation
6. fear of loss of self-esteem
7. fear of humiliation of parents
8. fear of career loss
9. fear of not able to manage things after failure
10. fear of ridicule by the rival etc.

Specific Phobia of Dogs:

The objects of fear in dog phobia could be exposure to a dog in various circumstances like on street, many dogs together, crossing roads while dog is there, diseased dog, barking dog, sound of barking dog etc. Such an exposure would activate body-mind reactions leading to the avoidance of streets and places in which an encounter with a dog is anticipated. The underlying fear structure could consist of following:

1. fear of dog bite
2. fear of helplessness if dog bites
3. fear of loneliness
4. fear of not able to defend oneself
5. fear of not able to hit the dog if it bites etc.
6. fear of the pain from dog bite
7. fear of catching rabies
8. fear of injections treatment if dog bites

Structure of Health Anxiety:

An adult person had come to me last week for two sessions of drill therapy for sexual OCD. While writing this chapter he just came to me for third session. He reported significant reduction in the fears elicited by sexual images and thoughts for religious idols and family

members. I tested by asking him to imagine all those thoughts of sex with family members and religious idols. He remained comfortable and did not report any distress.

Now his mind now got focused on excessive thoughts and health concern that run into his mind triggered by somatic sensations of heaviness in chest. A brief enquiry yielded following underlying fear structure. I recommended drill for these statements.

1. Fear of elevated levels of blood pressure
2. Fear of fainting spells
3. Fear of uncontrolled speech which might contain abusive language
4. Fear of seizures
5. Fear of vomiting
6. Fear of trembling
7. Fear of stiffness in limbs
8. Fear of mental illness
9. Fear of heart attack
10. Fear of unspecified disease

Lizard Phobia:

Lizard phobia is one of the most common phobias particularly in females. More than fear it involves feelings of disgust. In an affected person it can escalate to a very high level and can potentially affect most spheres of life. It is reported by affected persons that they have modified their place of living in a manner to shield the entry of lizard in the house by installing thick nets, installing glasses on the walls so that it cannot creep. Interestingly, one lady reported that she asked only two things from her prospective husband – (a) whether he is afraid of lizards (b) whether he smokes. She was concerned to the extent that if her husband would also have the fear of lizard, then there might be no one to help her out in case any lizard creeps in. Lizard phobia contains following structure:

Objects of fear: lizard, anything that resembles lizard, pictures of lizard, videos of lizard, places that reminds of lizard, lizard skin, the pattern on lizard skin, inside mouth of lizard

Body-Mind Reactions: trembling, shakiness, accelerated heartbeat, breathing difficulty, wringing hands, sweating, Goosebumps, restlessness, irritability, disgust, fear, helplessness, nausea feeling

Safety Behaviors: Running away from places having lizard, removing lizard, asking someone to remove lizard, sealing windows and rooms by installing nets or glasses.

Danger Perception:

1. Fear of getting jumped on body
2. Fear of getting unconscious
3. Fear of dying
4. Fear of unknown harm

It is very easy to identify underlying fear structure by asking simple questions like what scares the affected person when exposed to the objects of fear. The imagined feared consequences need be listed in detail which would form the basis of cognitive drill therapy.

Drill Statements for Social Anxiety:

1. People have considered me idiot
2. People have come to know that I am a psychiatric patient

3. People have lost faith in me
4. People have come to know that I do not even know very simple things
5. People have begin to show disrespect to me
6. I have become a strange person
7. All my respect is gone
8. I am feeling ashamed in front of others
9. People are doubting my skill and knowledge
10. People are thinking about me
11. I have been insulted
12. People are ignoring me
13. I have failed to perform to the level of people's expectations
14. I have become a laughing stock
15. I have become worthless in the eyes of others
16. People are rejecting me
17. I have failed in social life
18. People are finding fault in me
19. People are taking me casually
20. People have become dissatisfied of me
21. People have become irritated of me
22. People are getting surprised how bad I am
23. Others are repenting for inviting me to speak
24. Others are getting bored of me
25. Others are having disgusting feelings towards me
26. I have become blank before others
27. Others are considering me as a coward
28. Other drill statements can be drafted in similar manner.

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06

LAYERS OF IRRATIONAL FEARS

When affected persons come to me for seeking my help in the resolution of their irrational fears they describe their problems according to their own conceptualizations. If they are aware of diagnostic labels, they would mention that. But most of the time an affected person is not aware of the diagnostic labels, to the extent that he/she thinks that no other person in the world has the same problem. It is only he/she who is affected by it.

I would simply ask tell me your problems. In response to this question, they will narrate their problems. I conceptualize the problems narrated by the affected person into Two Layers (1) Top Layer (2) Bottom Layer. While the patient narrates, I keep on sorting the narrated problem according to this conceptualization. It is a simple method of making sense of the problems of the patients. A patient may have more than one phobia like claustrophobia, social anxiety, phobia of pointed objects and so on. The layers of each problem are identified separately.

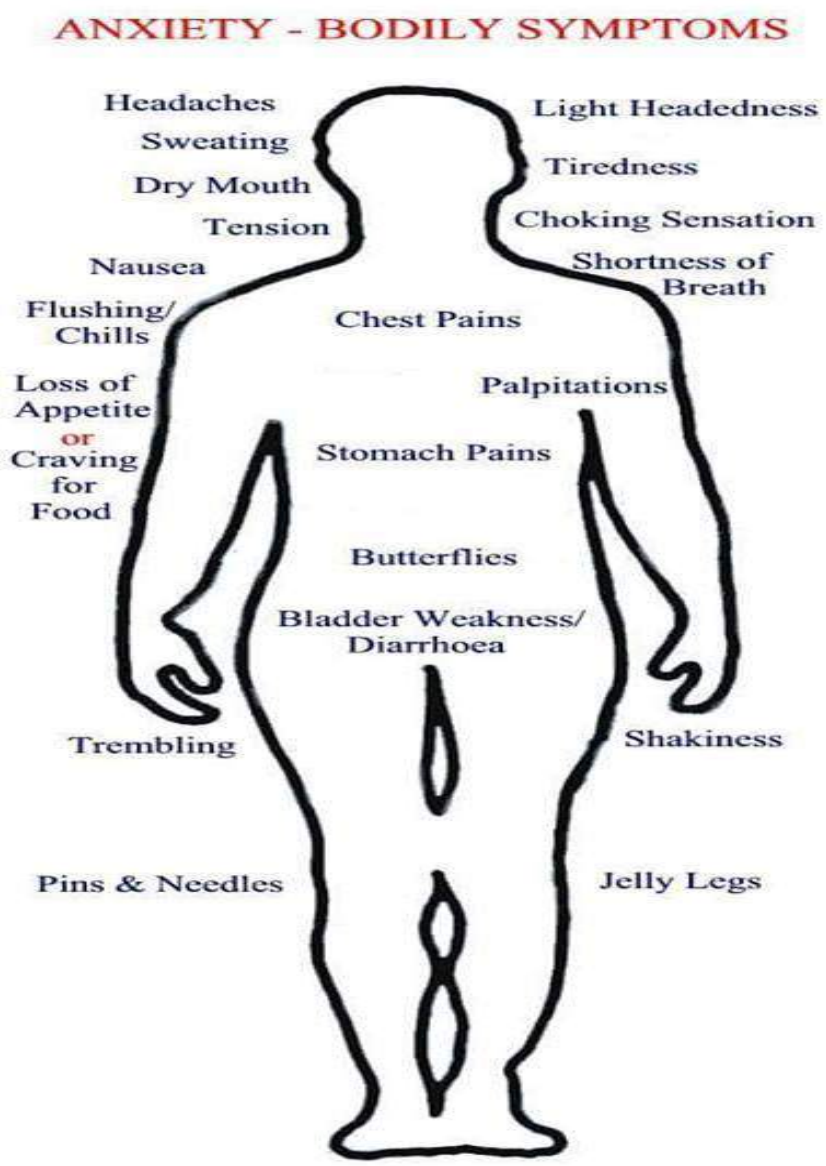
Top Layer: This is also called as surface structure or conscious structure. It consists of comprehensive bulleted lists of (a) Objects of Fear (b) Body Mind Reaction (c) Safety Measures

Bottom Layer: Also known as underlying fear structure, feared cognitions, imagined feared consequences or sub-conscious structure.

A person came to me with following problems (a) Trait anxiety (b) Claustrophobia (c) Social anxiety (d) Interpersonal problems in the family. Originally, he had requested me treatment of claustrophobia. In claustrophobia, a person has irrational fear of closed places like lift, car, metro, caves etc. I specifically told him that I shall deal with each of his problems in a sequence, one by one. We agreed to initiate the treatment of claustrophobia. He had this phobia since childhood. While he was describing his problems, I classified it into two layers and recorded on a piece of paper. The final output of one hour discussion of his problem is reproduced below:

Top Layer: consisting of objects of phobia, body-mind reactions and safety methods.

Objects of Fear: The objects of fear can be any object, situation, person, place, event, body sensations, thoughts, images and urges. Exposure to or an anticipation of exposure to these objects of fear trigger fear reaction in the affected person. Some objects activate severe fear, others moderate or low. If any object/situation does not trigger fear reaction in the affected person, that will not be listed under objects of fear. From his description of claustrophobia, following objects were identified: (i) closed type lift (ii) alone in the car with closed glass (iii) closing eyes while taking bath (iv) basements (v) sleeping in a dark room (vi) swimming pool (vii) imagery of getting sealed in a jute bag (viii) imagery of electricity failure in metro (ix) imagery of getting trapped in a trunk (x) sitting on the backseat of car (xi) airplane (xii) crowded lift (xiii) news items displaying people getting trapped in closed places.


ANXIETY - BODILY SYMPTOMS
Headaches
Sweating
Dry Mouth
Tension
Nausea
Flushing/ Chills
Loss of Appetite or Craving for Food
Trembling
Pins & Needles
Light Headedness
Tiredness
Choking Sensation
Shortness of Breath
Chest Pains
Palpitations
Stomach Pains
Butterflies
Bladder Weakness/ Diarrhoea
Shakiness
Jelly Legs

Body-Mind Reactions: Exposure to or an anticipation of an exposure or just images of objects of fear trigger body mind reactions in an affected person. Essentially, the objects of fear signify some kind of danger or threat to life. The systems of body react to this perceived danger and prepare the affected person to deal with the situation. This person reported following body-mind reactions (i) accelerated heart beats (ii) sweating (iii) blank mind (iv) thoughts of escaping (vi) Difficulty in breathing (vii) irritability (viii) fearfulness.

Safety Measures: Since the affected person perceives a danger or threat to life when exposed to the objects of fear, he/she either avoids the exposure or tries to escape from the situation as early as possible. This person makes himself safe by adopting following measures: (i) avoids lift if alone and uses staircase in multistory buildings (ii) keeps lights switched on in the night (iii) takes someone with him when he is about to get exposed to the objects of fear.

Bottom Layer: The bottom layer is the foundation on which the Top Layer rests. The affected person remains dimly aware of the bottom layer; hence it is called as subconscious structure. Most of the content of the bottom layer is usually accessible to the conscious mind when directed to do so. Since, the conscious mind can extract the content that lies buried into deeper layers of the mind, it is termed as subconscious. At times, it becomes a little difficult to dig deeper into the psyche and extract the bottom layer. With persistent query it can be brought to the conscious awareness. I usually ask the patients to tell me what scares you in that object of fear? What can happen to you? What kind of danger or threat to life is involved? What can be the outcome by being in the proximity of the object of fear?

The bottom layer should be identified accurately. I use following criteria to determine and list the bottom layers. (a) Bottom layer consists of feared cognition/thinking (b) It represents consequences of being exposed to the object of fear (c) It involves future orientation or use of future tense (d) objects of fear are antecedents and the underlying fear structure is triggered by the objects.

I insist on comprehensive listing of underlying feared cognition. An elaborate list is the key and should be aimed at mandatorily. I enlist underlying fear structure in either of the two ways or a combination of both. (a) recording of future tense statement verbatim e.g. I will become unconscious (b) in terms of fears such as fear of becoming unconscious. It does not make much difference how do you record the underlying feared cognition. Following underlying fear structure was identified in above person:

1. Fear of oxygen deficiency
2. Fear of death
3. Fear of suffocation
4. Fear of breathing difficulty
5. Fear of becoming unconscious
6. Fear of losing eyesight
7. Unknown fear.

The partition of the problems of the patient in this manner provides a wealth of data in an organized manner. It makes the entire gamut of the problem comprehensible and communicable. This framework can easily be communicated to the affected persons. This two layer partition sets in the systematic application of drill therapy. I am presenting partition of some more problems.

I am quoting an interaction with a person on facebook on 17th November 2015

C: I am a claustrophobic

Me: are you able to identify the underlying fear structure, i.e. of what you are scared of in closed places?

C: I need fresh air all the time, so I feel when I am at closed places like a lift for instance I get cut off from oxygen, so I refrain from using lifts. I feel I get suffocated and that makes me restless

Me: Exactly these were the issues in other person who was having claustrophobia and used to avoid lifts

C: I feel very uneasy. I start to sweat at times; at times I feel my heart starts to sink. I rush out for fresh air. I can't be at any place which does not have proper ventilation

Me: Since when you are having this problem?

C: It's been quite long now. I think 10 years or so, but never had too much problem, so never consulted anyone.

Me: do you have any past traumatic experience related to this problem?

C: I don't think so. I think I developed this only after once my BP was quite low, so I had to take medication for that. I don't remember any traumatic incident related to it as such

Me: What closed places you are avoiding?

C: Lifts for sure, or any room which has no doors or windows or if doors and windows are closed. Or any place which I think I will not be able to rush out for air easily. Even at movie theatre I take corner seat, because no one will be on one of my sides.

Me: Do you get anxious simply by imagining yourself in a lift?

C: Depends on what floor I have to go. One or two floors don’t matter much, but if more than that, then probably I get anxious at the very idea of getting into a lift. I then use stairs, no matter how much I will have to climb. I simply can't be surrounded by people I get suffocated in a crowd as well.

Me: Have you tried any method to overcome it?

C: Not as such. I just avoid all this.

Me: Do you want to overcome it now?

C: Yes of course sir!

Me: alright, we have two layers conceptualization for claustrophobia. Fear of closed places like lifts, crowd etc is the surface structure. The fear of suffocation and decreased oxygen level constitute the underlying fear structure. We need to correct this underlying fear structure through Cognitive Drill Therapy. When this underlying structure will get resolved the surface structure will also disappear.

C: OK sir. What will I have to do for this?

Me: So you need to work directly on fear of suffocation

Structure of Social Anxiety: In social anxiety the person is distressed and wants to avoid exposure to social situations such as speaking in public, interview, group discussion, debate, giving lectures and presentations, performing before an audience, interacting with superiors and authorities. This is a surface structure which consists of social situations as stimuli and fear as reaction. The underlying fear structure consists of following fears:

a. Fear of humiliation
b. Fear of embarrassment
c. Fear of devaluation
d. Fear of negative evaluation
e. Fear of non-specific outcomes
f. Fear of negative impression on others
g. Fear of ridicule
h. Fear of losing trust of others
i. Fear of letting others down
j. Fear of rejection
k. Fear of loss of self-esteem
l. Fear of being ashamed
m. Fear of going blank
n. Fear of somatic symptoms such as trembling, stammering

Illustration of Two Layers Conceptualization in Social Anxiety:

An adult male came to me with significant distress in social situations involving boss, persons in authority, group of people or girls. The distress is somatically represented primarily on face and feelings of discomfort. He tries to deal with the distress by avoiding the situations both at Cognitive level or if possible at behavioral level. When he is not able to avoid, he becomes absorbed in anxiety reaction and mentally get focused over the sensations and feelings on face. This entire pattern exemplifies the top layer (also called as surface structure or conscious structure).

A brief interview quickly led to the identification of following underlying fear structure (also called as bottom layer, sub-conscious structure).

i. fear of humiliation,
ii. fear of ridicule,
iii. fear of devaluation,
iv. fear of negative view by others,
v. fear of nonspecific outcomes,
vi. fear of negative impression on others,
vii. fear of embarrassment,
viii. fear of increased distress with passage of time

He is engaged in behavioral and cognitive avoidance of social situations. His strategies of cognitive or behavioral avoidance would not change the underlying fear structure. Cognitive Drill Therapy acts directly on the underlying fear structure to modify the top layer structure.

Two Layers Structure in Contamination OCD:

Layer-1: **Surface Structure**:

Acquired associations between Exogenous/Covert Conditioned Stimuli and anxiety response, for examples, seeing dirty objects, touching dirty objects, thoughts of getting dirty leads to severe anxiety response.

The patients are struck in this surface structure in the form of avoidance of dirty objects and repeated cleaning of self or objects. This focus on avoidance and cleaning is negatively reinforced by temporary reliefs obtained through cleaning and avoidance. The patient remains struck in this elusive state for years.

Layer-2: **The underlying fear structure**:

This is the foundation of the surface structure. We can dig deeper into the psyche of the patients and can discern the underlying fear structure. This underlying imagined fear structure gets reflected in following future orientations such as

i. Fear of spreading contamination to other household objects,

ii. Fear of inhaling germs,
iii. Fear of contamination of religious objects,
iv. Fear of being blamed in case something happens due to contamination,
v. Fear of punishment by god if religious objects get contaminated,
vi. Fear of jeopardizing safety and security of family members due to contamination.

This underlying fear structure can be destroyed through Cognitive Drill Therapy or any other methods. The patients' surface structure will get collapsed proportionate to the destruction of underlying fear structure and there will be rapid significant improvement in the contamination OCD.

Specific Phobia of Snakes:

A senior faculty member met me in a conference in November 2015. He reported that he was having a fear of snake for a long time. He had participated in one of my lectures on Cognitive Drill Therapy about two years back. He applied the concepts to this problem. His fear disappeared within a few days which is still maintained.

Two Layers Conceptualization of such phobias (1) the surface structure consists of exposure to snake or thoughts, images of snake leading to anxiety reaction (stimulus-response association). (2) Underlying fear structure such as fear of snake bite, fear of death due to snake bite etc. This underlying fear structure can conveniently be destroyed through Cognitive Drill therapy leading to fast or even instant relief in such irrational fears.

Fear structure in examination phobia:

The underlying fears in examination phobia include - fear of going blank, fear of forgetting, fear of failure, fear of embarrassment, fear of humiliation, fear of loss of self-esteem, fear of humiliation of parents, fear of career loss, fear of not able to manage things after failure, fear of ridicule by the rival etc. This fear structure can be processed through Cognitive Drill Therapy.

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07

WORDS CAN HEAL!

Words have enormous power. Merely listening to some words or speaking of particular words can make us sad, angry, happy and jealous. The feelings are expressed through words and gestures; similarly usage of specific words and gestures can activate specific feelings. Words become tied with feelings and emotions. Words can create mental pictures of objects and situations. Words can also trigger body-mind reactions. To exemplify this power of words, I give following example:

I am having a ripe lemon of yellow color in my hands… I am cutting it into two halves by a knife… I am holding one piece of lemon between my thumb and index finger… I am opening my mouth… now I am squeezing the lemon on my tongue… the lemon juice is spread all over my tongue… I am squeezing it … squeezing… squeezing…

My above words create mental picture of lemon in the listener's mind, also make many of them can feel the sour taste and increased salivation. In reality there is no lemon, no cutting or no squeezing on the tongue; still it creates body-mind reaction. This further demonstrates that words have power to create mental image and body & mind reaction. Words become attached to emotional experiences.

Since words have such a power, the power of words can be put to use to heal psychological conditions, phobia and OCD in this context. This method of manipulation of words to heal can be extremely powerful and easy for the affected persons.

The anxiety and fear looks into the future. There is a future orientation and use of future tense in the language of the fearful persons. His/her language and tenses contain will/shall in underlying feared cognition. The use of will/shall under conditions of anxiety activate brain areas that are related with future tense.

One of the important task is to convert the tense of underlying feared cognition into present or past. This tense modification will result in linguistic level changes in the structure of covert/sub-vocal language used by the affected person in fearful situations. I am giving an example of tense conversion from the script of a real case worked out by me.

Underlying Feared Cognition in Claustrophobia:

1. There will be reduction in oxygen
2. I will become unconscious
3. I will experience suffocation
4. I will die of suffocation

Tense Converted Drill Statements in Claustrophobia: The future tense is converted into past or present.

1. There is reduction in oxygen level
2. I have become unconscious
3. I am experiencing suffocation
4. I am dying because of suffocation

Verbal Exposure: The best treatment of fears is the exposure. One need to expose oneself to the fears repeatedly. The repetition is the key to exposure. Expose-Expose-Expose.

According to the theories of psychology, when a person is repeatedly exposed to the fears, the fear initial increases then keeps on declining. The end result of exposure is reduction in fears. Previously, this exposure was being done either in imagination or with real objects/situations. The person who is fearful of closed places, would be asked to imagine the closed places. This may be coupled with relaxation. For real exposure, the affected person will be taken to the lift or closed places, and would be encouraged to be there.

The idea of verbal exposure largely has gone unattended. It is very easy to implement the repeated exposure at verbal level. In a claustrophobic, the usage of words associated with closed places, itself trigger fear reaction. The repetitions of simple statements such as 'I am in the lift"; 'I am in the lift"; 'I am in the lift"; will activate fear reaction. If the repetition is continued for sufficient duration and frequency, the fear will get detached from these words.

The verbal repetitions are termed as 'Drill'. This form of exposure provides unique opportunity to practice exposure therapy. The person with claustrophobia performed following drill before me.

1. There is reduction in oxygen level
2. I have become unconscious
3. I am experiencing suffocation
4. I am dying because of suffocation

The repetitions of these converted feared cognition, elicited anxiety reaction in the person. He kept on repeating the statements and then within few minutes noticeable changes were observed. He felt relaxed and free. I noticed that the repetitions of the emotional words used by the patients are more powerful for both triggering fear reaction and achieving extinction of the fear reaction. So I use the words being used by the patients. If I replace the key words used by the patient with my words, it may or may not impact the psyche of the patients. The rule is Go by the words of the patient.

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08
DEALING WITH BODY-MIND REACTIONS

The repetitions of tense converted statements, also called as drill statements, can activate severe body mind reactions to the extent that the affected person may experience increased heart rate, sweating, heaviness, discomfort in any part of the body. These reactions can rise to very high levels. Also, some affected persons, refuse to repeat the drill statements because of the fears of escalation of body-mind reactions and danger perception. I adopt many methods to successfully deal when body-mind reactions shoot up to the high level. These methods essentially involve moment to moment monitoring of body-mind reactions, pauses and drill dilution. There are multiple approaches to implement reaction monitoring and dilution of drills.

Reactions Monitoring: To keep a vigil on the magnitude of reactions, I keep on asking the person to report the level of discomfort every 30-60 seconds. I will be asking the questions such as, how much distress you are feeling now. The affected person is required to report on any scale which includes (a) Zero-low-medium-high-very high. (b) Assign a number on a scale of 0-10. Zero means no distress and 10 means maximum distress. (c) In terms of percentage. Out of 100, how much distress you are feeling.

The monitoring of discomfort in this manner is also known as Subjective Report of Discomfort (SRD) or Subjective Unit of Discomfort (SUD). The reaction monitoring is extremely important and one of the core techniques of Cognitive Drill Therapy. During the personal sessions of drill, the patient is not left unattended at least during initial stages. Continuous monitoring is done and the drill application is modified in accordance with the feedback on reaction monitoring.

Pauses in Drill: When distress shoots to very high level, I give a pause of 1-2 minutes. In this pause, I suggest the affected person to stop doing the drill and allow the mind to wonder. I can also engage him in general talks. During the pauses, sometimes, I maintain silence and do not initiate any discussion. However, I keep on monitoring the magnitude of the reactions during pauses. When the affected person reports, zero or low distress; I once again initiate the same drill.

Giving pauses during drill is extremely important. It is mandatory to give pauses as and when the distress shoots up to very high level. I have not yet continued drill with any person when he/she reports very high distress. I invariably give pauses. Pauses allow the brain and mind to handle the massive distress activated by the drill.

Handling Hanged Distress: Sometimes, the magnitude of distress gets hanged at medium or high level for more than 3-5 minutes. When I observe such plateau of hanged distress, I adopt two methods (1) I allow a pause of 1-2 minutes. The pause itself clears the plateau and the distress slips down. (2) Sometimes, it happens that during drill, other object of fear or feared cognition becomes dominant which is not being drilled at the moment. This cognition, does not allow the fear to subside. To detect the simultaneously activated cognition, I ask the subject to share with me if anything else is running in the mind. If it is the case, most person

would tend to report it. Once it is shared, I formulate the drill of this feared cognition and switch over to the drill execution of this feared cognition. The drill of simultaneously activated feared cognition, cools down the hanged distress within a couple of minutes.

Drill Dilution: The idea of drill dilution is to present the drill in lighter form to mitigate body-mind reactions. The drills in divided dosages and bit by bit enable the affected person to experience lesser amount of distress and accelerate the rate of improvement. The drill dilution is done when the original drill statement is too heavy for the body and mind to process and shoots up the reactions. Usually, drill dilution s required in the initial stages of commencement of Cognitive Drill Therapy. The drill can be diluted in a number of ways.

I am illustrating the methods of drill dilution which I applied on one or the other affected persons with phobia/OCD:

Repetitions of drill statements by the therapist: Mr. Chand was scared of the 'nash' word. His feared cognition was 'mera nash ho jayega' (I will be ruined). The original drill statement was 'mera nash ho chukka he' (I am ruined). When I asked him to repeat this drill statement, he showed body-mind reactions of turning away face, eye closure, stiffness in body and expressed denial to verbalize it. For drill dilution, I told him that I will be speaking the same drill statement for me, he should just listen to it. I kept repeating for him 'mera nash ho chukka he' (I am ruined), 'mera nash ho chukka he' (I am ruined), 'mera nash ho chukka he' (I am ruined)… After my repetitions for a few minutes, he gathered the courage to repeat the drill statement for himself.

Invoking Imaginations: Ms. HR was scared of heart attack. The formulated drill statement was 'mera heart attack ho chukka he' (I have suffered a heart attack). This drill statement resulted in shoot up of extreme distress. For drill dilution, she was asked to repeat and say that it is only in imagination. The diluted statement was 'kalpanaon me heart attack ho chukka he' (I have suffered heart attack in imagination). This drill dilution enabled her to take up original drill statement; and she began to repeat 'mera heart attack ho chukka he' (I have suffered a heart attack).

Keyword Drill: At times, I identify key words in the drill statement. The key word is the word that represents feelings and emotions. For example, Mr. RP, was terrified of getting cursed by ants. The formulated drill statement was 'cheentiyan shrap de chuki hn' (I am cursed by ants). The key word in this drill statement is 'curse'. I recommended him to repeat only this key word for some time. He repeated 'curse', 'curse', 'curse'… This enabled him to verbalize and repeat 'cheentiyan shrap de chuki hn' (I am cursed by ants).

Breaking Drill Statements into Parts: A person with agoraphobia, was terribly scared of suffocation. He was not able to speak full drill statement 'akele lift hu, suffocation ho chukka he' (I am alone in the lift, experiencing suffocation). This drill was implemented by breaking it into parts (a) lift me akela hu (I am alone in lift); (b) suffocation (c) ho chukka he (experienced). These three parts were implemented one by one. He was required to drill each part separately. When distress got reduced to parts, then the parts were combined and full drill was presented.

Adding Imagination Component: At times I would dilute the drill in following manner: 'I am scared of the dog in my imagination'. This is more or less a factual statement. Since it is true it appeals to the reason of affected person and he/she finds it acceptable to repeat.

Action Drill: Also called as non-verbal drill. The patterns of rituals get conditioned with ritualistic patterns performed by the affected persons of OCD such as hand washing. I prescribe the affected person to perform dummy ritualistic actions. The action drill itself activates anxiety reactions. The continued drill in this manner reduces the body-mind reactions associated with the ritualistic actions.

There can be many more ways of drill dilution. The affected persons and the therapists can come up with versatile and creative options to dilute the drill.

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09
REACTIONS TO DRILL

Cognitive Drill Therapy acts very fast on underlying feared cognitions. The affected persons show a variety of reactions before, during and after using drills. At the onset of drill, affected persons need reassurance that drill will be working. Initially, there can be total disbelief that such an easy and straightforward technique will work and melt the fear reactions. I simply say to the persons who initiate drill therapy that let us practice it and see if it works. Let the mind be open to the effects of drill.

Some of the affected persons will show marked fear reactions just by listening to their objects of phobia and the underlying feared cognition. The auditory input of underlying feared cognition can activate body-mind reactions. This reactivity to auditory input and verbalizations, is cited as an evidence to convince the affected person that see merely by listening and verbalizing the feared cognition is eliciting body-mind reactions. With continued verbalizations, the fear will begin to melt down. The problem lies within head. It is not in the outside world. It was created in your imagination. Once your imagination clears up, the fear reaction will subside. The person is urged to continue to verbalize and pauses are given on high/very high distress. When the fear reaction subsides, it is again cited as evidence that see merely by repeating the feared cognition in past tense is causing the reduction in fears.

Each unprocessed trigger or feared cognition will activate body-mind reaction. The affected person may expect spontaneous reduction in unprocessed objects/cognition via generalization effect. But spontaneous generalization to unprocessed objects/cognition does not occur in drill therapy. When drill for an unprocessed object/feared cognition is applied and there is an activation of body-mind reaction, it is used to educate the affected person that upon commencement of drill for all new triggers/cognition, there will be body-mind reactions of more or less equal intensity. Hence, he/she need to apply drill to each and every identified objects/feared cognition.

When this is told to the affected person that he would be required to drill for each object/cognition, it can trigger a fear reaction that the task is overwhelming and it would take too much time to drill all the objects/cognition. He/she is reassured that the list is finite. Initially, one or two objects/cognition would be processed for 2-3 days, then it will get multiplied and in a day 5-6 objects/cognition would get processed. Initially, it appears to be an overwhelming list but it will come under control within a few days. Just keep on drilling.

Cognitive Drill is performed preferably at imagination and verbal level. Upon dissolution of fears during drill, the affected person becomes apprehensive and may say that at verbal and imagination level it is fine now, but what about the real situations. It will appear in real situations again. The affected person is to be told that usually there is spontaneous generalization to the external real world. However, if he/she would feel body-mind reactions in real life situations, then drill can conveniently be performed on the spot in those situations. The problem lies in the mind and it is to be cleared at mental plane. To dilute this fear of lack of generalization to the real life situations, on the spot drill is prescribed in following manner: 'real life situation me problem ho chuki he' (the problem got surfaced in real life situation). Within a couple of minutes this apprehension will subside.

Drill therapy can act very fast and dissolve fears. When the affected person develops confidence and realizes substantial fear reduction due to drill, then he/she may become apprehensive of relapse. He/she may say that now it is fine. I am feeling in-charge of my fears, but these fears may re-surface after some time. This fear emerges in large number of affected persons after dissolution of fears. He/she needs be told that if there is any relapse, then he/she could perform the drill at that point of time. For managing fear of relapse on the spot, I ask the affected person to perform following drill: 'relapse ho chukka he' (relapse has happened); 'dubara problem ho chuki he' (problem has appeared again). This drill dissolves the fear of relapse within a few minutes.

Most affected person will comply with the homework of drill applications and 'drill and daring'. There will be only a few persons who would not comply with the homework assignments. These persons will get sub-optimal benefits of drill therapy. Efforts are made to encourage them to apply drill and daring as homework. Their family members are encouraged to act as co-therapist and ensure that the affected person really does homework.

At times, I recommend the patients to give me feedback and reports on whatsapp. But invariably I have noticed that the patients usually do not submit their reports despite reminders and encouragements. Also they fail to record entries in drill diary prescribed to them for recording their experiences on day to day basis. We are required to operate within this constraint and heal them.

In view of the recording behaviors and poor compliance of homework in some patients, I conduct extended and intensive sessions of the patients which may extend up to 90 minutes to two hours. Rarely, the session extends beyond two hours.

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10
KEY CONCEPTS

There are more than 100 concepts and techniques which are involved in cognitive drill therapy. I am summarizing many of them. With continued applications and practice, I keep on adding more concepts which I shall update in next revisions. The concepts elaborated here may be repetitive but for the sake of emphasis and clarity I am opting for the repetitions.

1. **Triggers**: Any object, mental image, stimulus, situation, sensation, thought, feeling, cue and person that elicit body-mind reactions and emotional state are called triggers. For example, a sensation in heart region which activates fear of heart attack, a closed bathroom that activates fear of suffocation.
2. **Body-Mind Reactions:** The physiological and psychological reactions elicited by an exposure to Triggers or mental representations of triggers. For example, body responds to triggers by increasing heart beat, difficult breathing, sweating, dizziness, nausea, butterflies in stomach, dilated pupil, dry mouth. The mind responds to triggers by going blank, fearfulness, disgust, danger perception, irritability, becoming impatient.
3. **Safety Behaviors**: Mental or behavioral avoidance of the triggers manifested in repetitive mental acts, keeping oneself away from triggers, exiting triggers as early as possible, changing routes, abstaining from activities which may involve exposure to triggers, seeking reassurance from oneself, practicing positive affirmations to ensure safety.
4. **Anticipatory Fea**r: When a person is exposed to triggers in real life, he/she displays fear reaction. But when an exposure to the triggers is scheduled, the person becomes fearful even before actual exposure just by contemplating and imagining the prospective encounter with triggers. A person with social anxiety becomes anxious upon scheduling of an interview which he would be facing after a few days even months. He/she becomes uncomfortable in advance.
5. **Secondary Fear**: An exposure to trigger activates fear reaction; and then the fear reaction itself becomes a trigger which further intensifies the fear. A person with social anxiety becomes fearful in the presence of his boss at working place; the awareness of fearfulness and body-mind reactions, scares him/her further that this reaction could escalate and become uncontrollable.
6. **Secondary Depression**: With persistent phobia/OCD, a person struggles a lot to overcome his painful emotional conditions. His most attempts fail and he/she feels hopeless and helpless. He/she feels ashamed of the phobic and OCD conditions. These reactions to the phobic/OCD conditions can cause low self-esteem, worthlessness and sad mood. The affected person may become pessimistic to the extent of developing ideas of self-harm and destruction.
7. **Feelings of Shame**: A person affected by phobia/OCD may believe that only he/she is affected by this condition in this world. He/she fails to consider that others too might be having the same situation. They would ask the therapist whether he/she has seen such cases earlier. Because of feeling of shame, these persons may refrain from sharing their anguish with other persons.

8. **Resorting to Faith Healing**: Many affected person pray to the God to heal them or they can visit faith healers, tantric, shamans for seeking healing. In most cases, these practices are unlikely to provide durable relief.
9. **Basis of Substance Abuse**: Because of social anxiety and other conditions of fear, a person tends to lose their self-confidence and their self-image becomes distorted. To divert themselves or appear as confident and smart, some person may opt for using substances such as alcohol, cannabis and smoking. But these substances, complicates the fear condition and the person may get entrapped into substances.
10. **The Idea of Negative Thinking**: Most affected persons are not aware of their psychological conditions and label their suffering as an instance of negative thinking or lack of self-confidence. They think that if they replace their negative thinking by positive thinking they can overcome their problems. They may resort to meditation and self-hypnosis or auto suggestions. These may be partly helpful in some patients.
11. **Adoption of Happy Go-Lucky Attitude:** Some persons may advise the affected person that he/she should become careless and enjoy one's life. For some moments, it appears to be working but it does not last longer.
12. **Motivational Books**: These books are available in thousands. Many affected persons read these books and try to regulate their cognitions and life according to the advices given in these books. Such books do have their role in shaping the optimism and rationale coping. But in many cases, these books are not sufficient enough to eradicate the conditions of phobia and OCD.
13. **Non-acceptance of Professional Support:** Many affected persons feel it as a disgrace to themselves to consult a professional psychologist for seeking help in remediation of their phobia and OCD. They consider these problems linked to their will power and a prestige issue. This attitude often delays the treatment. They should consider it as a disorder of emotion which can be healed by application of scientific theories by professionally trained psychologists.
14. **Stigma**: Stigma is widely prevalent in the society. Because of stigma of psychiatric disorders, these persons may refrain from consulting professionals for their problems. They think that they do not have a disorder. The comments like "I am not insane why I should go to a psychologist/psychiatrist" is a barrier in their choice of early treatment.
15. **Disguised Identity**: Some affected persons approach the professionals by hiding their identity and assuming a fake name or creating a fake ID on social media. They are scared that if someone known to them comes to know about their problem or consultation with a psychologist, it will be a humiliating experience. They want to protect themselves from such happening. Also they remain hyper-vigilant at the consultant's place and keep on scanning if there is any person known to them.
16. **Dependence**: Some affected persons tend to become overly dependent upon their psychologist and seek advice even on their mundane routine matters of life. They may seek frequent appointment just to be with their therapist. The therapist's aim is to enable such persons and make them self-reliant. Whenever, a therapist notices this pattern he/she reduces the frequency of contact to ensure that the affected person learns to face his real

life situations independently.

17. **Missed Appointments**: Some affected persons schedule their appointment with the therapist but do not turn up at the scheduled time, either they come late or do not appear for the scheduled session. This causes loss to the therapist because the time might have been allocated to other patients.
18. **Search for Magic Formula**: The persons affected by OCD keep on searching for a magical solution to their problems. They think that by extensive and in-depth thinking they could come out with a magical solution which will eradicate their problems instantly. The illusion of magical formula keeps them engaged in thinking and thinking for several years. No such magical formula exists. They should consider this search of magical formula as part of the problem instead of solution.
19. **Impact on Life**: The problems of OCD/phobia can disrupt life severely. A student may not be able to continue his/her studies; the person in service may find it difficult to perform on duty or can even resign from the job; a business person may see downfall in his/her business. The affected persons think that once they get out of their OCD/phobia they could restore their functioning. They keep on waiting for cure to restore their work. They are advised to restore their work as early as possible at the onset of the treatment. Do not wait for the recovery to happen for restoration of the work. They should consider work as therapy and get into it as early as possible.
20. **Medicine Treatment**: As an standard practice, I recommend that persons with OCD should continue their psychiatric treatment along with drill therapy. However, for phobia the requirement of medicine treatment depends upon the severity of the condition and its influence on the life of the affected person. Medicines provide good support in OCD for drill therapy as well as maintenance of treatment effects and for prevention of relapse.
21. **Over-enthusiasm**: When drill is prescribed as homework, some affected persons become enthusiastic about its applications and try to perform drills simultaneously on many objects/feared cognitions. My recommendation is that the drill should be applied in sequence one by one. When the fear reaction subsides to one object/feared cognition, the second should be taken up and so on. However, there may be some circumstances when drill can be performed on more than one item simultaneously but not as a routine matter.
22. **Drop Outs:** Exposure and response prevention is reported to have high dropout rates. But in drill therapy I am seeing low dropout rates. Sometimes, an improving person can also leave the drill therapy which causes pain to the therapist. The dropouts in Exposure and Response Prevention result from the pain and suffering experienced by the affected person during exposure to the real objects. But in drill therapy this pain and suffering is relatively less.
23. **Fear of Aggravation**: An affected person when comes to know about the protocol of drill therapy may feel that this therapy is quite scary. It can aggravate the phobia/OCD. Actually, it does not aggravate the condition. I reassure the affected persons that drill is being performed in imagination and at verbal level. There is no point to become scary due to the nature of exposure. Having reassured about aggravation I require the affected person to drill for aggravation. ‘meri problem aggravate ho chuki he’ (My problems have aggravated).

24. **Disbelief in Drill Therapy**: Some affected persons show their disbelief and skepticism for drill therapy. They may say that how verbalizations could heal their problems of phobia/OCD. I explain to them that the problem lies within their mind. Also verbalization itself activates fear reaction. Since verbalizations activate the fears, the continued verbalizations will remove the fear from feared object/cognition. Also I require them to drill 'drill therapy is not helpful'.
25. **Persistent Reactions**: Upon doing the drill, usually the body-mind reactions subside within a few minutes due to drill or intermittent pauses and distractions. However, in some cases the activated reaction may continue longer to the extent of a day or two. The persistent reactions can be converted into therapeutics by adopting an attitude that the reactions are temporary and would subside; and the affected person need to continue more drill to master the persistent reactions.
26. **Influence of Suggestions of Friends/Family Members**: It may happen that a family member, relation or friend may advise the affected person to discontinue the drill therapy. They may minimize the role of therapy and the problems being faced by the affected person. I recommend the patients to go by their own understanding and the rate of improvement; and not to discontinue the therapy because the person who advised to leave the therapy is not familiar with the nature of the disorder and its treatment.
27. **Leaving Drill Therapy after Partial Relief**: Some affected persons would leave the therapy in between even if a trend of improvement was visible. After exiting the therapy, they may continue to use the drill by their own.
28. **Abreactions**: When an affected person commences the drill, he/she may show severe body-mind reactions characterized by crying, breathing difficulties, accelerated heart beat and the like. I allow the person to do so. This I consider as ventilation of pent up feelings and weeping is the natural mechanism to dilute and release the heavy feelings stored in the body and mind.
29. **Gradual Reductions in Applications**: In the process of learning an affected person will be required to spend about 1-2 hours per day for nullifying the anxiety potentials and this application will effectively switch off anxiety from several triggers. With passage of time, approximately after 10-15 days he/she will feel lesser and lesser need to apply the cognitive drill. The application time will get reduced to a few minutes per day and ultimately forgetting of both the drill and the problems of anxiety.
30. **Law of Anxiety:** When an affected person is exposed to a Trigger and prevented from getting engaged in safety behaviours, then anxiety follows a defined pattern which is as follows: Activation of anxiety □ rising anxiety to the peak, its maximum heights □ staying of anxiety at peak level for some time □ a declining course of anxiety from high to medium □ reduction of anxiety to low level □ Zero anxiety. If we plot this pattern of anxiety on a graph it will yield an inverted U shape curve. With continued practice of drill, the peak of anxiety activated by triggers will begin to get lower and lower and finally the triggers would lose the power to activate anxiety.
31. **Law of Habituation:** If a person is continuously exposed to anxiety provoking triggers without involvement in safety behaviors, the anxiety will tend to decline and the triggers will gradually lose their anxiety potentials. The Triggers will no longer trouble the person.

The mind will become comfortable, at ease and habitual to the Triggers. Think of a situation, when you visit your relations who stay near a railway line. Your sleep gets disturbed because of the noise of passing by trains. But your relations are quite comfortable and they may even not notice the noise of a passing by train. How it happened with them? Initially they were also troubled by the noise, but because of repeated exposure to train noise, their mind got adapted with the situation and lost its power to trouble them. If you stay in such house for a few days, then similar thing will happen to you also because of the Law of Habituation.

32. **Inter-relatedness of Sense Modalities**: When a trigger troubles an affected person and activates anxiety, it means that he/she is likely to experience anxiety in following manner of exposure to that Trigger – (a) by looking at the Trigger (b) by speaking about the Trigger (c) by thinking about the Trigger (d) by touching the Trigger (e) by writing about the trigger (f) in anticipation of the exposure to Trigger. If there is an involvement of multiple-modalities in anxiety response, then reduction of anxiety in one modality will tend to reduced anxiety in all other modalities too. For example, if an affected person is merely looking at a Trigger for extended period of time and it reduces anxiety, then the reduction in anxiety through visual inspection will have similar positive effects on anxiety reduction in other modalities of touching, thinking, speaking, writing and so on.
33. **External Trigger vs. Imagination:** There is a difference between having a Trigger in the external environment and mental representation of the Trigger. The presence of Trigger in external environment means, that the Trigger is outside of one's body and mind e.g. door knob, dirty piece of paper, gas cylinder, a car, a person with dirty clothes. These are the instances of actual physical objects which can be touch and photographed. A person also has mental representation of these actual objects. A mental representation means, the object is not physically present before the person; but can be seen in mind's eyes. A person cannot touch or take a photograph of this mental representation. It is inside mind. Both the actual physical objects and mental representations of the objects can activate body-mind reactions of distress.
34. **Power of Mental Representations:** The mental representation of a Trigger can have potentials for activating anxiety response. The Trigger lies in the mind as its mental representation and a person can respond anxiously to his/her own mental representation. The cognitive drill utilizes this potential of the mind to disconnect trigger and anxiety. While performing cognitive drill, a person need to remind oneself repeatedly that he/she is dealing with own mental representations; it is in own thinking and own imagination. The Trigger is being processed in one's imagination. This awareness of imagination puts the person at ease and which helps in continued attacks on the Trigger-Response connection. For example; only in my imagination, I am touching the dirty door knob; only in my imagination, I have touched a diseased person, I am now infected, truly I am infected.
35. **Fear is Future:** An affected person can quickly review his/her diary and memory bank, how long has he/she been using a future reference, future tense. It may extend back to a few months to several years. Suppose, a person has been using an anxious future reference program for last ten years. Now if he/she is asked to just pause and recall how many times, the actual events happened exactly the way he/she anticipated. He/she is likely to have a zero or very low level of matching with future reference and actual events. It means, he/she

is living in two parallel realities. One is of a future reference and the other one is of the present as it happens in real life. If there were an opportunity to enlist all future thoughts on day to day basis since the beginning of the phobia/OCD vis-à-vis the actual happening of apprehensive events, then one could be surprised to realize that there is little correspondence. Despite, this realization that feared consequences do not occur, the mind remain engaged in apprehension almost in autonomous mode.

36. **Concept of Spontaneous Recovery:** After successful processing of a Trigger through cognitive drill, the anxiety may re-surface after some time gap of a few days. This re-activation of anxiety is usually of low intensity. The repeat application of cognitive drill would quickly detach anxiety associated with spontaneous recovery phenomenon.
37. **Difference between spontaneous recovery and exposure to new triggers:** After working through several Triggers through cognitive drill, an affected person may become anxious during exposure to a new Trigger which has not yet been drilled and mistakenly conclude that the condition got relapsed. An affected person should make a difference between getting anxious in response to the processed Triggers vis-à-vis getting anxious in response to non-processed Triggers. This distinction will provide confidence and a framework that there may have been some left out Triggers which need be processed through cognitive drill. Once additional Triggers are also processed in this manner; they too would lose their anxiety provoking potentials..
38. **Easy to Difficult:** Initially, an affected person should grade your Triggers in terms of their anxiety provoking potentials. He/she should apply cognitive drill to low anxiety provoking Triggers and with practice and continued applications he/she can proceed to the Triggers of more and more severe anxiety potentials. Once several Triggers of low anxiety potentials are drilled then the severity of anxiety evoked by more powerful Triggers will also get reduced and the affected person would be able to deal with them with ease.
39. **Cognitive Exposure vs. Exposure to Real Object**: When a person is asked to imagine the object of fear and perform the drill in the absence of real objects; it is called cognitive exposure. When a person is exposed to real objects and asked to perform drill, then it would constitute exposure to real objects. For example, asking a person to imagine holding a dirty mug and drill that I have become dirty is cognitive exposure. Asking a person to hold a real dirty mug in his/her hands and drill that I have become dirty would be an instance of exposure to real object.
40. **Using Own Language for Cognitive Drill**: Remember that an affected person's own specific language and words are associated with activation of brain centers and neurotransmitters. When formulating converted statements or Keywords for cognitive drill, one should choose own words. A change in words or phrases that are not used by the affected person may not activate anxiety reaction and would not lead to reduction in anxiety and discomfort. For example, if typical future statement is "If I touch door knob, I shall get allergy"; then the affected person should use words from this statement only e.g. "I have touched the door knob, I have developed allergy". The incorrect statement is – "I have touched the door knob and I have developed some disease".

Similar other reactions may be noticed in the persons affected by phobia/OCD. A therapist as well as the affected person is required to consider those reactions and solve them through

proper cognitive perspective and performing the drill. I am able to manage most such reactions using this approach.

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11

ASSESSMENTS

In this chapter, I would elaborate most of the assessment procedures for Cognitive Drill Therapy. The repetitions are inevitable but for good. Repetitions should be considered as emphasis and be learnt clearly for enhancing applications and deriving maximum benefits from Cognitive Drill Therapy.

Gather Relevant Case History: It is essential to acquire relevant case history about the problems. An affected person may bring a long list of phobia/OCD and other problems. The problem desired to be healed on priority should be singled out. For example a person came with following problems:

1) Irritability
2) Social anxiety
3) Academic difficulties
4) Obsession for symmetry
5) Obesity

CDT is not applicable in all of the above problems. Other forms of psychological treatment such as Cognitive Behavior Therapy (CBT) may be required. Through mutual discussion, we identified obsession for symmetry as the most prominent problem at the moment. Hence, this problem was taken up for further exploration and application of CDT.

Having selected a specific problem, a relevant history was gathered. In history, I focus on following questions which elicit relevant history in most cases.

i. Tell me in detail about your problem
ii. Tell me when and how this problem started
iii. Tell me how this problem is affecting your life
iv. Tell me some life experiences related to the problem
v. Tell me what body-mind reactions get activated during the problem
vi. Tell me how you have been dealing with this problem
vii. Tell me what scares you in this problem
viii. Tell me the objects/situations/events that trigger this problem
ix. Tell me how your family members react or help you during this problem
x. Any other thing you would like to share with me regarding this problem.
xi. Would you be able to share dark sides of your life?

I recommend maintaining a written record of the replies given by the affected person to these questions. Interview is also conducted with family members and they are also asked similar questions and their replies are also to be recorded. I may also submit the above questions to the affected person through whatsapp or email and ask him/her to record his replies in Drill Diary. As far as possible the dark aspects of life which the affected person keeps on hiding should be gently understood. No force or digging should be done to elicit them. One should be alert and open to take the dark aspects as

and when they emerge.

Drill Diary: I recommend the affected person to procure a diary or notebook to record the assessment and on-going activities of CDT. The affected person is required to record as many details of the problems as possible. I also record the drill statements and other homework to be carried out by him/her. Diary is very important as most of the affected persons tend to forget the session details. Also it helps them in revising the work done so far which act as a reminder for applications of drill therapy. We need to appreciate the diary records even if they are sketchy and abridged. The affected persons do not have the clarity of the concepts, theories and procedures as the therapists have.

Formal Assessments: Psychologists and psychiatrists have developed various tools for assessment of anxiety, phobia, depression, OCD and other aspects of human functioning. Some of the relevant tools are listed below and can be downloaded from Internet.

I. Yale-Brown Obsessive Compulsive Scale (Y-BOCS): This is the most frequently used scale to assess the nature and severity of OCD. It assesses both obsessions and compulsions.

II. Beck Depression Inventory (BDI): This is standard and widely acceptable tool to assess severity of depression.

III. Beck Anxiety Inventory (BAI): This is a good tool to assess severity of anxiety.

IV. Generalized Anxiety Disorder Scale (GAD-7): This is a brief scale to quantify Generalized Anxiety.

V. Fear Questionnaire (FQ): This can be used to assess agoraphobia and social phobia.

VI. Sheehan Patient-Rated. Anxiety Scale: This is a good scale to assess anxiety and it can provide rich information on body-mind reactions of the patients.

VII. Depression, Anxiety and Stress Scale (DAS): As the name implies, this single scale can assess three emotional aspects – depression, anxiety and stress.

VIII. Agoraphobic Cognitions Scale: This scale can point out to the underlying fear structure.

IX. Severity Measure for Panic Disorder

X. The Panic Attack Questionnaire

XI. Liebowitz Social Anxiety Scale

XII. Subjective Units of Distress Scale (SUDS)

There are other scales too for which relevant books and internet can be browsed. Some of these tests are available for online administration. An affected person can fill up and get an analysis report online.

It is recommended that a few scales 2-3 should be chosen to assess the current status of the affected person on the selected problem for drill therapy and the same assessment should be repeated periodically in the middle phase of the therapy, at the termination of therapy and on follow ups of one month, three months and six months. This will yield a convincing data to the affected person as well as the therapist.

Moreover, this assessment would form the basis of writing case reports for scientific journals and book writing which many therapists and even the affected persons would be writing in coming years about their personal experiences with Cognitive Drill Therapy.

Global Subjective Rating (GSR): It is useful to ask the affected person to rate the severity of his selected problem out of 100. For this, a simple question, tell me out of 100, how much problem do you have? The affected person would say any number 80% and the like. Keep a record of this global severity. During the course of therapy intermittently this global rating can be obtained, may be after every 3-4 sessions. This single subjective rating would provide extremely useful information to both the affected person as well as the therapist. Even a line diagram of this global rating can be constructed in the records of the therapist as well as the drill diary of the affected person.

Subjective Reports of Distress (SRD): This is a system of moment to moment, on the spot quantification of fear and distress. Any of the following questions can be asked to the affected persons to quantify the anxiety level on a given moment during the application of Cognitive Drill Therapy.

i. Tell me how much fear/distress/anxiety you are experiencing right now: zero-low-medium-high-very high
ii. Out of 100 how much fear/distress/anxiety you are experiencing right now
iii. Out of 10 fear/distress/anxiety you are experiencing right now. 10 is maximum.
iv. Tell me whether it is a mild, moderate, severe or profound reaction

This moment to moment monitoring of distress level is extremely important in CDT. This quantification forms the basis of continuation, modification and pauses during the application of drill therapy. During application of drill, this quantification is done every 30-60 seconds.

Psychophysiological Monitoring: Cognitive Drill Therapy provides a unique opportunity in monitoring of psychophysiological parameters during the actual application. Devices for following psychophysiological responses can be attached to the affected person while he/she is performing the drill. It is not necessary to monitor all the function. Even a single parameter could be useful and serve the purpose. Apart from the listed parameters, any other suitable parameter of monitoring may also be considered.

i. Galvanic Skin Response
ii. Heart Rate Variability
iii. Blood Pressure
iv. Brain Wave Activities
v. Oxygen Saturation

Monitoring through psychophysiological measurement devices provide an objective

evidence of what is happening to the body-mind reactions of the affected person in the real time when he/she is performing the drill. The feedback of such a monitoring system can boost the confidence of the person in drill therapy as well as his/her potentials of getting improved through psychological methods.

Reports of Family Members: Some affected persons minimize their problems and even the role of treatment. At times, they can also exaggerate the rate of improvement and the modifications they did in their living style after commencement of the treatment. Family members, can give the accurate picture of the patients functioning in between the sessions of cognitive drill therapy. But even the family members can minimize or exaggerate the reports. A therapist need be vigilant about the progression of drill therapy and the impact on the life of the affected person. There are some tools on Phobia and OCD which can be used on family members to chart the progress of the affected person during therapy. If convenient these tools should also be considered. The tools can be obtained from the internet.

Monitoring Somatic Representations: Emotional reactions such as anxiety, fear and disgust are usually accompanied by body reactions. Each affected person has his/her own patterns of representations of distress in the body. Some will experience it in eyes, others in throat, heart or stomach regions. During drill therapy, I recommend that a note be taken where the distress is located in the body. To capture the body site for the distress, I ask following question, where in your body you are experiencing this distress? Initially, the distress will spread over several body parts, but there will be prominence of one part of the body where it is felt most and which dissolves towards the end during the application of drill therapy. The dissolution of distress from all body parts is accompanied by resolution of anxiety and distress.

Audio Recording: With permission of the affected person a therapist can record the entire session through mobile or Dictaphone. This record will be useful to the person undergoing drill therapy as well as to the therapist for session review which can be used in teaching drill therapy to the students and preparing reports and presentations.

Behavioral Tests: Cognitive Drill Therapy is usually executed at verbal and imagination level. With drill, the distress gets substantially reduced at verbal and imagination level. Often there is spontaneous generalization of the reduction of distress from imagination and verbal level to actual real objects. To ensure, if this generalization has taken place, the affected person is encouraged to expose himself/herself to real objects in order to assess whether, the exposure to real objects still elicit distress reaction. If there is resolution of distress and actual objects fail to elicit the distress, then authentic improvement has taken place and the affected person can be considered to have overcome the reactions to those objects which have passed the behavioral tests. If there is a failure and the actual object still elicit the distress reaction, in that case additional drill can be performed at verbal/imagination level or drill can be performed by exposing to the real objects. This assessment through behavioral test is the ultimate assessment of the efficacy of drill therapy in ameliorating fear/disgust in the affected persons. It must be performed in all cases. The behavioral tests can be conducted in

therapist's clinic and as homework in real life situations.

Recording of Two Layer Structure: Two layer partition of the problem of the affected person is the core foundation of drill therapy. I recommend that comprehensive listing should be done for the following. It should be as comprehensive as possible.

i. List of objects of fear
ii. List of body-mind reactions
iii. List of safety measures and avoidance patterns
iv. List of feared cognition (imagined feared consequences)

It may appear that this assessment would take lots of time. But it is not so. Assessment is an integral part of Cognitive Drill Therapy and should be performed on each affected person. The data generated from formal assessment would go a long way and serve multiple purpose for monitoring the progress and the current status of the problem in the affected person.

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TECHNIQUES OF DRILL THERAPY

In Cognitive Drill Therapy I utilize a number of techniques to make the task simplified and straightforward. With time and experience more and more techniques could be added to the list presented in this chapter. The practitioners and the affected persons may also come up with creative solutions to master distressing emotions.

Psychoeducation: After taking relevant case history and conducting formal assessment of the problems of the affected person and prior to commencement of drill therapy, psychoeducation of the affected person and family members if available should be done. It is an essential component in drill therapy and mandatorily be done with every affected person. No drill therapy be commenced without proper psychoeducation. In general terms, psychoeducation involves educating the affected person on the nature of his problem, its causes, psychological theories, two layer conceptualization, cognitive drill, anxiety curve, homework and the like. I usually cover psychoeducation in following format which is open to adaptation by the therapists:

I. At the outset, I convey the label of the problem to the affected person. A person came to me with 08 years history of extreme fearfulness. After listening the story I communicated that it is a case of Agoraphobia and Panic Disorder. You should actually read about it on the internet and match the symptoms. This was the first time when she came to know about the diagnosis of her problems. She checked it and confirmed. Conveying the label of the disorder itself is a part of healing process; it implicitly implies to the affected person that his/her problems have been understood. For several years, the affected persons keep on worrying what the problem is and what are the solutions? A definite labeling of the problem straighten the task and consolidates the mind of the affected persons to adopt remedial measures accordingly.

II. Then I would explain the causal hypothesis to the affected person. I would say that such problems are caused by a combination of biological, psychological and social factors in more or less quantity. At biological level there may be a sort of chemical disturbances in the brain that may originate from biological or psychological reasons.

III. If I consider the role of biological factors in the continuation of the problem, I would invariably recommend the affected person to go for a psychiatric consultation along with drill therapy I will encourage by saying that for correction of chemical disturbances it is recommended that you see a psychiatrist and if he/she prescribes a medicine based upon his/her evaluation; then continue with the medicines and join me for drill therapy sessions as per my schedule.

    The affected person or the family members may express their stigma or concern for side effects. I would try to deal with both. For stigma, physical diseases also range from minor fever to the most fatal categories. Your problems require medicines for effective management. For the concern over side effects and potentials for dependence on medications; discuss this issue with your psychiatrist. He/she would prescribe you medicines accordingly and explain the potential side effects if any.

IV. Regarding psychological theories, I would say that there are many theories of

psychology like psychoanalysis, cognitive theories and behavioral theories which can be invoked to explain and manage your problems. Each theory has its own merits and applicability. Each therapist has his/her own preference and choice of therapies. Now-a-days Cognitive Behavior Therapy (CBT) is being used extensively. I am practicing and formulating Cognitive Drill Therapy and finding it useful, hence, I would be considering this therapy for your problems.

V. In Cognitive Drill Therapy, I consider the problem in two layers. A top layer consisting of the objects of fear such as dog, picture of dog, toy dog, dog on TV etc, body-mind reactions such as accelerated heart, breathing difficulties, danger perception and the measures of safety behavior like avoidance of encounter with dogs. The bottom layer consists of imagined feared consequences such as dog can bite etc.

VI. Then I would point out the presence of Future Tense in imagined feared consequences. I will emphasize that under conditions of anxiety and fear, the mind is focused on future orientation which is reflected in sub-vocal speech consisting of future tense. Since the beginning of the problem, the mind is engaged in future oriented thinking.

VII. Then I will explain the concept of ABC as it is used in drill therapy. I would say that there may be specific tense correlates in the brain. When mind is using past tense, the information goes to the centers in the brain dealing with past tense; for which the notation 'A' can be used. The information of present tense goes to the brain area related with present tense for which a notation of 'B' can be used. For future tense and their brain correlates a notation of 'C' can be used.

VIII. Due to the condition of fear your 'C' centers in the brain remain overactive. If we could cool down the overactive brain center 'C' through psychological methods, the fears would subside. Fears do not belong to 'A' and 'B' centers.

IX. For cooling down the activity of 'C' centers I would ask you to verbally repeat the statements of feared cognition by converting them into past like dog has bitten me.

X. With repetitions, initially there may be an activation of fear reactions. With continued repetition it will get dissolved. It will lead to a bell shape like graph called as anxiety curve. The fear will rise from low to medium to high and then it will begin to decline from high to medium to low to minimal or zero.

XI. The problem lies inside the mind. That is, why mere verbalization of drill statement activate body mind reactions. Verbalizations will escalate the fears and continued verbalizations will dissolve the fear within a few minutes.

XII. Under conditions of fear, you are already experiencing lots of pain and suffering. There will some distress and fear during drill which you need to bear to dissolve it. If there is escalation of fear to very high level during drill, I will be giving you pauses so that your mind gets enabled to process the activated fear.

XIII. I will recommend you to procure a diary and record all your problems, my lessons, your learning and progress in that diary on a day to day basis. The diary will be immensely useful for revising the sessions and monitoring the progress.

XIV. I will also prescribe you some home work of drill and daring. You will learn the drill therapy from me and apply it in your real life situations. Most therapy happens between

sessions. You will be required to do daring to expose yourself to real situations to the extent bearable to you. Before daring, perform the drill and continue to do the drill during daring and exposure to real life situations.

XV. The affected person may become scary of repetitions and think that by repeating the problems, it can get deposited in subconscious mind and the feared consequences can certainly happen. A sort of magical thinking, that mere repetition can cause external physical events. I would clarify it by saying that mere repetitions cannot cause a physical event in external world. If I place an object on the table, and keep on repeating it that the object is flying, object is flying; nothing will happen even if I keep on verbalizing it for years.

XVI. I also point out to the concept of Universal Probability. I would say to the affected person that all of us have more or less probability of experiencing accidents/adverse circumstances. It can happen to anyone at any time. This Universal Probability applies to everyone. If I am not a dog phobic, I am passing through a street and a dog can bite me or anyone else if there is such a stray dog. That is, part of the Universal Probability.

XVII. Given the allowance for Universal probability, the repetitions will not increase the chances of dog biting. The idea that mere repetition of dog bite, would increase the probability of dog bite is untenable. Through verbal repetitions, we are not depositing the idea in the subconscious mind, instead we are bringing it to the surface conscious awareness.

XVIII. I will also highlight that over the years he/she is managing his/her problems by avoiding the objects of fear. This avoidance gives temporary relief. The transient relief obtained through avoidance creates an illusion in the mind that avoidance is the only solution. To secure avoidance an affected person may go at length.

XIX. Instead of avoidance, exposure is the solution. The exposure should be done for both the objects of fear and the imagined feared consequences. The exposure to underlying fear structure is most important.

XX. I would also give an example of darkness phobia. If a child is scared of darkness and keeps avoiding the dark place; his problems will continue to exist. Somehow, he must learn to expose himself to the darkness in divided doses to overcome this fear. He would be required to dare and enter the dark places. With repeated daring the fear will subside.

XXI. The imagined feared consequences lie in the mind. They have universal probability of occurrence. But the mind in imagination is multiplying the fear manifold. Most of the persons are operating in this world within the framework of Universal Probability.

XXII. Through drill therapy, we do not remove fear emotion from your system. You will continue to experience the fear as and when there is a real danger. Phobia is an irrational fear whereas fear is emotional reaction to actual danger. For example, if there is a snake in this room, most people will get scared and would try to ensure safety either by removing the snake or removing oneself. Since there is a real danger, it is called fear. But when a person sitting in the room sees a poster of snake in the room and get scared and try to remove either the poster or oneself, it would be irrational fear because actual

snake is not there. Drill therapy normalizes the fear. It does not exclude the fear from the personality. Fear is an essential emotion required for survival. But the irrational fear is an obstacle and a problem in the life which needs to be corrected.

XXIII. I will clarify most questions and concerns raised by the affected person and his/her family members and then proceed to the application of drill therapy. I also use guidelines from other therapeutic approaches, my common sense and intuitive understanding to clarify the concerns and questions of the affected person.

XXIV. At the end of the treatment, the objects of fear will remain as such in the environment but those objects would fail to elicit fear reaction or there would be minimal reactions in response to the distress.

XXV. Through drill therapy we do not aim at cure of the condition. Instead, the condition will become manageable and you would be able to face the objects of fear and they would either not disturb you or produce minimal distress.

XXVI. In case of obsessions, those obsessive ideas may come to the mind but would not elicit prominent distress. They would get normalized.

XXVII. Research studies show that all kinds of obscene/filthy thoughts can occur in the mind of healthy persons. They tend to ignore them and do not give any importance.

Formulation of Drill Statement: It is the most important, easy and readily comprehensible technique. From the two layer structure, focus on the feared cognition of future tense in bottom layer and convert the tense of the future oriented cognition. The future tense should be converted to past or present tense preferably past tense. For example,

Feared Cognition in Bottom Layer of Dog Phobia:

A. Dog can bite
B. I can catch rabies
C. If dog bites, there will be injury to muscles
D. I shall have to take anti rabies injections
E. Pain shall be inflicted due to injections
F. I may die due to rabies

Tense Conversion of Feared Cognition:

A. I am bitten by a dog
B. I have caught rabies
C. Dog has bitten me, my muscles are injured
D. I am taking anti rabies injections
E. I am experiencing pain due to injections
F. I am dying due to rabies

Drill Execution: Drill is executed in a sequence. All statements are not processed simultaneously. For application of drill two things are required: (a) Object of fear (2) Tense Converted Feared Cognition. The object of fear can be in imagination or in real time an actual object. The first priority is for holding the mental representation of object of fear. If mental representation fails to elicit the body-mind reactions, then actual object is considered. Having settled upon the nature of feared object and feared cognition; the drill is applied in following

manner:

Ask the affected person to hold mental image of the object of fear and verbally repeat the tense converted feared cognition

For example, hold a mental image of scary dog in your mind and repeat I am bitten by a dog. Repeat, Repeat and Repeat.

Body-Mind Reactions during Drill: When an affected person commences repetitions of drill statements, he/she may experience no reaction, a mild reaction, a moderate reaction, or a very severe reaction. Moment to moment monitoring of body-mind reactions is required. Drill adaptation is required based upon the feedback received during moment to moment monitoring of the distress. This monitoring is done every 30-60 seconds. If the stirred body mind reaction is low or medium the drill is continued. If it escalates to high level; the drill may either be continued or a pause of 1-2 minutes may be given depending upon the distress bearing capacity of the affected person. If the distress escalates to very high level; invariably pause must be given to 1-2 minutes or longer depending upon the resolution from the very high level. When it returns to medium or low level; then only the drill is resumed.

Pauses during Drill: Giving pauses during drill is extremely helpful in processing the overwhelming emotions stirred by the drill. Pauses are given when the distress of body-mind reaction escalate to high or very high level. A pause is a must when distress rises to the level of very high on moment to moment monitoring of subjective distress level. During the pause, a silence may be maintained or any topic other than the fear can be discussed. Usually a pause of 1-2 minute is sufficient, however, a longer pause may be required if distress persists. It is speculated that the brain takes some time to the processing of activated overwhelming emotional response. During the periods of pauses, brain adapts itself and becomes enable to process the emotional data activated by imaginary/verbal exposure to the objects of fear/feared cognition.

Drill Dilution: This is an important technique in drill therapy. When distress shoots up rapidly to very high level upon 2-3 drills, in that case drill dilution must be considered. In drill dilution the drill is broken into low doses so that the activated body-mind reactions remain in manageable limits. There can be a variety of method for drill dilution. I am enumerating the approach to drill dilution adopted by me. Any of the following or creative solution to drill dilution can be adopted.

I. I will tell the affected person that I will be doing the drill for me, just listen. I will continue to perform the drill until resolution of distress due to listening.

II. I will break the drill statement into parts and will ask the affected person to do drill of the part statement. For drill statement ‘dog has bitten me’ I may break it into following parts (a) dog (b) bitten. First I will ask the person to drill the word ‘dog’ and after resolution of the distress, I will ask for drill of ‘bitten’ and upon resolution of distress to this, I will ask the drill for full statement; ‘dog has bitten me’.

III. I will choose any other drill statement from the list which is less anxiety provoking.

Pass Criteria for Drill: When to switch over to other objects/cognition during the application of drill is a decision to be taken by the affected person or therapist. I follow a simple rule. When a drill fails to activate body-mind reactions upon three consecutive repetitions; then I switch

over to other object of fear/feared cognition. By following this rule, I continue to pass on to other objects of fear and the feared cognition.

Managing Hanged Distress: At times, the distress due to drill may get hanged at high or medium level. When the distress persists beyond five minutes, I consider it as hanged. To release the hanged distress, I recommend for giving pauses or asking the affected person to introspect and tell me what else is running in his/her mind. I look for feared cognition which get activated in response to drill statements. I will keep a record of such activated feared cognition. To melt the hanged distress, I may switch over to those feared cognitions that run in the mind. For example, when drill is being performed 'dog has bitten me' and the distress get hanged. I will ask what else is running in your mind. If the affected person say that 'help will not be available' then I will ask him/her to drill 'help is not available'. The drill of such concurrent feared cognition dissolves the hanged distress. It is speculated that distress gets hanged in response to concurrently active feared cognition. The drill of such cognition dissolves the hanged distress.

Drill Compounding: After a couple of sessions of drill therapy, I may execute processing of multiple feared cognitions in a single drill. I call it as drill compounding. When two or more feared cognitions are combined in a single drill statement, it is labeled as compounded drill. For example, 'dog has bitten me' is a single feared cognition. 'Dog has bitten me, I am having pain' is a compounded drill containing two feared cognition 'bitten' and 'pain'. 'Dog has bitten me, I am having pain, I am feeling helpless' contains three feared cognition; hence compounded drill. Drill compounding is done when the affected person becomes enabled on single statement drills. After a few sessions, brain starts processing the emotional data in bulk.

Imagination vs. Reality (Soch vs. Sachai): The terms soch vs sachai, shared by Dr. Richa appealed to me and I included it in my working. It is a powerful concept to clarify the distinction between objective fears and irrational fears. When a person says that on a street a stray dog may bite him/her and he/she can catch rabies. A simple question is asked is it in your imagination or a reality. The goal of this enquiry is to impress him/her that the fears are being held in imagination (soch) and imaginative fears are to be corrected.

Multi-sensory Involvement: All sense modalities – eyes, ears, nose, skin, mouth, process emotional data and can become associated with objects of fear and feared cognition. Any single or a combination of sense modalities can be used in drill therapy. I recommend to use as many sense modalities as possible for faster procession of emotional experience at brain level. While performing the drill, I may show picture of dog, ask the affected person to attend to the dog barking and then perform drill 'dog has bitten me'. Multisensory involvement is a better way to process the fears in drill therapy.

Outcome Expectancy: An affected person may harbor an expectation of complete cure of his/her problems. This expectancy of cure should be regulated through psychoeducation. I would say to the affected person and family members, that through drill therapy, the irrational fears will come under control. About 10-20% fear may remain in the system but that would not interfere in the life that much. Also drill therapy cannot heal each and every case of phobia/OCD. There may be some cases who would show minimal response to drill therapy. In those cases, other approaches of psychiatric and psychological treatment may be tried.

Session Duration and Session Frequency: A session of drill therapy may last from 60-90

minutes. The sessions may initially be conducted every day for a couple of days then to alternate days. When most objects of fear/feared cognition get processed, the follow up schedule can be implemented. One or two follow up sessions may be conducted on weekly basis, then every 15 days, one month, three months and at six month. Some booster sessions may also be required to process the objects of fear and feared cognition that may emerge later on.

Use of YouTube and Google Images: All situations and objects of fear cannot be simulated in therapist's room. Google Images/YouTube can be a good choice to expose the affected person to his/her objects of fear. I expose the affected person to this content and require him/her to perform drill while exposed to this content. I have tried this exposure in fear of skin disease, dog phobia and other conditions.

Enhancing Generalization: For promoting generalization of acquired gains through drill therapy, I promote generalization by recommending the affected person to do drill and daring in as many real life situations as possible. For a dog phobic, I would recommend the person to go to the street, go in proximity of dogs and perform the drill. This real life exposure will enhance self-efficacy of the affected person and he/she would be able to face the situations with confidence. This will boost the sense of mastery over fears.

Ignore, Ignore, Ignore: The persons having obsessions keep on dwelling into the mental content of obsessions and worries for hours in a day. They get involved into it and try to solve by reasoning and finding some solutions. This solution finding quest consumes lots of time. I say to the affected person that this solution finding thinking itself is an OCD. The best way is to ignore, ignore and ignore it. Get out of your mind, involve yourself in some physical activities. The mind will get distracted and feel liberated by engaging in other activities. Give NIL importance to your OCD thoughts. The idea of giving Nil importance can work like magic in some cases.

Non-cooperation Movement: The persons affected by OCD feel compel to get involved in covert or overt activities due to OCD. The best approach to deal with this compelling quality of OCD is to adopt a non-cooperation movement. Do not co-operate with your OCD compulsion. Refuse to comply with the demands of OCD in executing compulsions. Initially, the OCD in mind will shout louder and louder, show imaginary threats but if you can persist in ignoring and not complying with OCD demands, the OCD compulsion will begin to fade away.

Drill, Daring & Distraction: The three components can produce major changes in the life of affected persons. Drill is the repetitions of tense converted statements of feared cognition. Daring means exposing oneself to the objects of fear in real life, and distraction means getting oneself busy in work be it occupational, academic or domestic. Application in this manner will enhance the probability of positive results from this approach.

Attribution to OCD: The persons with OCD attribute obsessive thoughts to their will. They think that thoughts are under their direct control. Which thought should come to the mind and which not can be controlled by exercising will power. Their such thinking is grossly wrong. Obsessive thoughts get hanged in the mind due to the disorder; a disturbance in chemical functioning of the brain. It is taught to the affected person that he/she should dissociate from these thoughts. Every time the thoughts come, they should say in their head that these thoughts are due to OCD. They are not healthy thoughts. With continued treatment, the

quantity and the importance of thoughts will fade away.

Co-therapist: To encourage the affected person to carry out home work, practice of drill in real life setting, we need to train any family member who can act like a therapist in real life situations. The co-therapist is educated and demonstrated the procedures of drill therapy. They are also educated not to promote avoidance and compulsive behaviors of the affected person. The induction of co-therapist in the drill therapy program can accelerate the progress and the generalization of therapeutic effects.

Responsibility Appraisal: The persons with OCD have an inflated sense of responsibility for the feared consequences. If a person has abusive thoughts in his mind towards god, he/she may think that god may punish him or his family due to these thoughts by causing accidents, deaths and disability. If any such things happen then he/she would be held responsible because these thoughts originated in his/her mind. To deal with such thinking the concepts of magical thinking and multiple determinants of an event are discussed with the affected person.

Thought-Action Fusion: The persons with sexual OCD think that having such immoral thoughts in the mind is equivalent to the actual act. They equate thoughts with action. To clarify this pattern, the idea of soch vs. sachai can be helpful in explaining that thoughts are thoughts and acts are acts. Both are not the same thing. If I think in my mind that I have killed an ant, that does not mean that I have actually killed an ant.

Stress Induced Relapse: Upon remission of irrational fears/OCD, it may surface in response to stressful life situations. If a person comes with relapse after drill therapy, then presence of stress in his life should be explored. If it is present then a therapist should help in resolving the stress which lead to the relapse. After successful management of stress factors, the relapse condition will get rolled back. Drill may or may not be required in such cases.

Exposure to Unprocessed Trigger: During the course of drill therapy an attempt is made to identify and make a comprehensive list of the objects of fear/feared cognition. All recorded objects/feared cognition are processed in the therapy sessions. Upon termination of therapy, additional objects of fear/feared cognition may become apparent to the affected person. Since no drill was performed to these unprocessed objects/cognition; the body-mind reactions are likely to get activated during exposure to those objects/cognition. For example, a person has 10 objects of fear and 5 feared cognition. All got processed in therapy sessions. None was left. The affected person showed substantial improvement. Therapy terminated. After some time, an 11th object of fear or 6th feared cognition may become apparent to the affected person. This 11th object or 6th feared cognition was not drilled during the treatment. Since it was not drilled, the body-mind reaction is attached to the object/cognition. This newly identified object/cognition should be drilled to detach the body-mind reaction.

Here I make a distinction between relapse and the unprocessed object/cognition. Relapse means activation of body-mind reaction to those objects/cognitions whose body-mind reactions were detached through drill but resurfaced. That is, drilled objects/cognition activate body mind reactions. But when non-drilled objects/cognition activate body-mind reactions, it is not relapse because these objects/cognitions were never processed in drill therapy.

This phenomena of activation of body-mind reactions to non-drilled objects/cognition, favors the position that spontaneous generalization across objects of phobia/cognition does not occur spontaneously. Hence, train and hope approach to generalization does not work here.

Each identified object/cognition has to be drilled. There are few cases where generalization across objects/cognition can occur spontaneously.

Periodic Lapse: Despite successful resolution of body-mind reactions to certain objects/cognition, there may be instances of occasional activation of body-mind reactions to drilled objects/cognition. If it is not persistent, it can be ignored considering it as lapse. If persists, the bottom layer should be identified and drilled once again.

Handling Relapses: Each lapse is not a relapse. Whenever, a person presents with body-mind reactions to objects of fear after successful mastery of phobia/OCD, following must be considered: (a) Examine if the body-mind reactions got activated to already drilled objects of fear. If it is so, enquire if the affected person is still using the drill, if not, then he should do it. Examine, if he was on medication, if he/she has stopped medications even for a few days. If yes, encourage him/her to take medication. Examine if he/she is undergoing any stress currently and the activation is associated with stress. If yes, opt for stress management procedures. Examine if any new feared cognition has emerged. If yes, do the drill. Relapse should also be handled through drill therapy. If drill is not successful then only opt for any other psychological treatment methods. (b) Examine if the affected person got exposed to undrilled object of fear. If yes, it is not a relapse and it should be drilled as usual. Relapse means activation of body-mind reactions in response to already drilled objects of fear.

Quest for Magic Formula: OCD patients keep on thinking and thinking to find out a master formula which could solve their problems magically and instantaneously. This quest for magic formula should be clarified and stopped. There is no such magic formula. The affected person can spend years in search of such formula. They are encouraged to adopt drill, daring and distraction in place of the search for magic formula. The relief from drill therapy itself can be a magic.

Drill Meditation: For generalized patterns of worry and apprehension, a drill meditation of about 30 minutes daily can be prescribed. Sit in the meditative posture, monitor one's thought stream and capture the feared cognition and perform the drill on the spot. This can be continued on regular basis. This can lessen the generalized patterns of fears.

One effective approach to do drill meditation is that a comprehensive list of underlying feared cognition should be prepared and recorded on a piece of paper or mobile. Sit in meditative posture for 30 minutes and read each of the recorded feared cognition in low speed by giving pauses of a few seconds between reading of two statements. Read the list as many times as it can be read within 30 minutes. Any statement can be read more than one time if you feel it.

Use of Patient's Language: When formulating drill statement, the patient's own words and language should be used. The body-mind reactions are tied with the words and phrases which are used by the patients. Synonym or translated words of other language may not elicit body-mind reactions, hence prove ineffective.

Associated Depression and Psychosis: Secondary depression due to OCD/Phobia may uplift upon resolution of phobia/OCD. Psychotic condition may or may not resolve. In cases of associated psychiatric problems of this nature, proper psychiatric evaluation and treatment should be recommended.

Refrain from Avoidance: Avoidance of the objects of fear and feared cognition either in real life situations or in mind does not help in resolving the irrational fears. An affected person is told not to use any tactic to avoid the objects/cognition during the practice of the drill. The avoidance should be converted into exposure patterns. Expose, Expose and Expose is the key to successful resolution of fears.

Future Pacing: Future pacing is the imaginary projection of one's condition in distant future. This technique is used after resolution of the fears. The affected person is asked to imagine a future time may be six months or more and report the condition of the problem. If he/she sees a problem in future time, further drill is required. If no such fear is perceived then it should be reinforced verbally.

Social Relations: The persons with OCD and some with phobia tend to avoid their social relations. They stop talking to their friends and family members. This reduction is social network aggravates the problem. The affected person is encouraged to reactivate his/her social connections in real time and in social media. If the affected person reports any problems with social interactions, that can be clarified, handled with drill therapy or any other supportive psychotherapy including Cognitive Behavior Therapy.

Risk Taking: The persons with phobia/OCD tend to take low risk and try to ensure maximum safety from objects of fear. They are encouraged to dare and increase their risk taking behaviors to actually monitor if the events perceived as risky actually occur or not. They should keep themselves in experimental/trial mode. They should refrain from avoidance and face their fears to see if the risk is authentic and true. In most cases, the risk is in imagination or within the limits of Universal Probability. Repeated observations of oneself in the situations of perceived risk will reduce the risk perception and enhance exposure and coping with the threatening situations.

Support for OCD with Minor Evidence: Some persons with phobia/OCD may support their fears by citing some minor evidence which support their fears. This should be clarified by asking questions and clarifying their apprehensions. Drill can be used to overcome the feared consequences which might have been perceived due to removal of phobic/OCD behaviors.

Basis of Fear in Real Experience: At times, the affected person would cite a past experience when he/she actually had some traumatic experience with the objects of fear. This traumatic experience may antedate the development of phobia/OCD or such experiences may occur during the course of the problem. Or he/she may cite a traumatic experience of some other person which may or may not be known to him/her. We operate in the world of Universal Probability. Any traumatic experience can happen with any of us at any time quite unpredictably. However, it does not justify the persistence of exaggerated fears as these fears cause limitations in his/her life and may interfere in normal adaptive functioning. Cognitive Drill Therapy can normalize the persistent reactions which originated in actual or observed traumatic events.

Rational Coping: Positive affirmations and rational coping statements may be prescribed to the affected person after resolution of fears after a few sessions of drill therapy. Inspirational quotes, motivational statements, healing stories, auto-suggestions, and positively worded suggestions may be prescribed for practicing. The repetition of coping statements would provide cognitive strength and an affected person would be able to continue with the cognitive

drill and make faster progress. I am providing examples of some such statements. An affected person should select only 1-2 such statements. (a) My problem is getting solved (b) I can handle my OCD with cognitive drill (c) Every day I am getting empowered with cognitive drill (d) I can now solve my problems (e) Day by day I am getting confident in solving my problems (f) I am now developing a positive life attitude (g) someone is there to help me out (g) I can think about my OCD later, there is no urgency to think right now (h) I need not argue with irrational thoughts (i) I do not have to be perfect, OK. (j) It is OK to make mistakes (k) I am becoming capable to take risk of imagined feared consequences (l) danger lies in my head, it is not there in outside world (m) I am now doing my best to deal with my irrational fears.

Role of Hypnosis: Hypnosis can be used to implant positive suggestions after drill therapy. When successfully deposited in the mind through metaphors or direct suggestions, the person will begin to emit behaviors in response to the suggestions.

Reassurance Seeking: Some OCD patients consult a therapist and repeatedly try to seek reassurance for their condition. They may feel compel to tell a list of events to the therapist. They should be clearly told that reassurance of OCD behavior is not the treatment. Instead it maintains the OCD behavior. Reassurance seeking behaviors should be discouraged.

21 Days Rule: An affected person may be prescribed drill for 21 days. He/she may be told that he/she should practice drill in their home and real life situations at least for 21 days. The application for this period would help in mastering the fears. It is said that the replacement of a habit takes about 21 days. If it is so, this prescription for 21 days could help in releasing fears and maintaining the gains of drill therapy.

Writing Drill Statements: The affected person may also be told to write the drill statement on a piece of paper 25 times daily for 21 days. The therapist may help in formulation and selection of drill statement for writing. He/she may also be told to record the drill statement 25 times daily on his/her mobile.

Viewing YouTube on Phobia/OCD: I may recommend the affected persons to view YouTube videos on phobia and OCD. There are stories of the people who successfully handled their phobia/OCD. An affected person may pattern his/her approach based upon the successful handling by others. Also, it will boost the optimism that these problems can be handled successfully.

Stories of Successful Persons: There are several stories on the internet of the persons who successfully handled their phobia/OCD. These stories may be read by the affected persons. Their stories usually provide detailed descriptions of their methods of dealing with phobia/OCD. It can add to the insight for dealing with such problems.

Self-help Groups: There are many self-help groups available on the internet like facebook, Google Groups, Yahoo Groups, Whatsapp Groups which deal with the problems of phobia/OCD. Joining these groups will make the affected person aware of the quantum of people who are having similar issues and their problems. They also discuss the remedial methods for dealing with these problems.

Skype Sessions: Drill therapy can be implemented over video conferencing through any app like Skype. There are affected persons who cannot visit a therapist due to their circumstances. The possibility of skype sessions can be explored. The techniques and the procedures are the

same as for the live face to face personal sessions. There are therapists who are already using Skype sessions for successful implementation of drill therapy.

The affected persons may also come up with many more creative solutions to their problems of phobia/OCD. They should be encouraged to generate creative solutions for application of drill therapy. The creative solutions can hit the goal quickly and efficiently.

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13
SELF-HELP TIPS FOR OCD

In this chapter, I am compiling various tips for dealing with phobia and OCD from various sources. However, I am not copying them as such. I am adding my own insight into these tips. Interested person can browse the internet for learning more about such tips. These tips can be helpful in dealing with phobia/OCD and changing the perspective towards objects of fear and imagined consequences.

i. The affected person can encounter objects of fear at any place even in those situations where he/she thinks that those objects would not be present. I recommend that an affected person should always be prepared to utilize the opportunity of drill in surprise exposure to the objects/cognition. On the spot drill can cool down the activated body-mind reactions quickly.

ii. An obsessive mind can generate endless questions and doubts in the mind. Questioning and analyzing these thoughts can lead to an obsessive trap. This trap should be recognized early and measures should be taken to deal with them as early as possible. Consider drill or just learn to deprive them by ignoring and not paying any attention to them.

iii. Sometimes, obsessive thoughts can become overwhelming and nothing may seem to work even the drill. In that case, simply opt for distraction and stop thinking about the obsessive thoughts by distracting to other leisure or occupation related activities.

iv. Get out of your mind. All obsessive thoughts run into the mind. An affected person becomes inner directed and his attention remain focused on obsessive thoughts. Get involved in external environment. You may take a walk, a pleasure giving activity. When mind gets focused on other things away from the mind itself; you will feel the calmness and freedom from obsessive thoughts.

v. The surge of obsessive thoughts is temporary. It may come like a tide wave in the mind. Instead of getting involved into it, you should remember that this tide wave is temporary. It will fade away if mind is disengaged from obsessive thinking.

vi. You need to become neutral to your obsessive thoughts. Don't argue, condemn or fight with the thoughts. The idea of giving Nil importance to such thoughts is extremely useful.

vii. An affected person tends to compare himself/herself with other friends who are progressing well or who seem to enjoy their life. A feeling of inferiority develops. Considering the law of Universal Probability, any disorder can develop in any person. Overcoming from the disorder is the first priority. When you get out of the disorder, your mind will get liberated and may be you will once again progress at a faster rate.

viii. After recovery from phobia/OCD, some persons become sad for the years lost in the disorder. Instead of becoming sad, one should thank the almighty that you could come out of it and now you can take up more responsibilities in your life.

ix. Persons affected with phobia/OCD may find that their family members and friends are not able to appreciate their problems and the suffering. To them it appears to be a

trivial issue. It is OK because those persons are not trained in psychology and do not know how a sufferer feels. Do not allow your mind to be affected by their ignorance or adverse comments.

x. An affected person or his/her family member or friend may think that it is an issue of will power. If the affected person has strong will, he/she would be able to deal with the situation. I would like to assure you that these problems are not linked with will power. Mere act of will power is unlikely to resolve the issue. It needs systematic and scientific handling. The idea of controlling these problems through will power can injure your self-confidence. Consider these problems as a disorder of emotions and deal them with the approaches described in this book.

xi. Blaming Self or Parents: An affected person may blame oneself or one's parents for their phobia/OCD, as if it is caused by their faults. Phobia/OCD have multiple determinants. The role of rearing by parents is minimal if any. But your own attitude towards parenting and life events is of much more importance. You need to modify your own perspective to get rid of these problems.

xii. An affected person may consider that some paranormal activities by someone is being done to him which is causing these problems. Due to this idea of paranormal influence, the affected person may visit religious places and priests to get away the paranormal influence. In most cases of phobia/OCD these measures are a wastage of time and money. Also such concepts in the mind interfere in getting proper treatment. If an affected person cannot get rid of the idea of paranormal influence, he/she should not leave medical and psychological treatment. With persistence in psychological methods, the results are bound to come in most cases.

xiii. Homeopathy remedies can be an useful adjunct to deal with some phobia/OCD. The persons who are familiar with Homeopathy may consider adding those remedies by consulting a trained practitioner. This should be considered as an add-on component unless homeopathic remedies remove phobia/OCD by themselves.

xiv. A person affected with OCD may at times get confused whether a given thought or act is normal or an obsession. When such a doubt occurs in the mind, the affected person should consider it as obsessive thought because the healthy part of the mind by itself sends alert signal to the mind that an obsessive stream of thoughts is getting originated in the mind.

xv. Drill diary should be reviewed periodically. The reading of drill diary from time to time will keep the memory fresh for the recorded strategies for dealing with OCD.

xvi. In OCD the mind is perturbed by imaginary fears. An affected person should realize and label imaginary fears as imaginary. When imaginary fears are considered as real fears, the problems and OCD patterns sets in. Hence, develop a realization of imaginary fears.

xvii. In OCD, the mind becomes absorbed in itself and the content of thinking. This inward orientation of mind should be changed by engaging the mind in activities in external environment such as music, TV, social interaction, occupational activities, domestic activities and so on.

xviii. A person affected with OCD thinks those obsessive thoughts should not come to his/her

mind. Because appearance of these thoughts in the mind causes distress. In order to reduce the distress he/she keeps on eliminating the obsessive thoughts from the mind. Also keep on developing strategies that could push them away. This is a faulty pattern. The correct approach to obsessive thoughts is that they should be given nil importance and be ignored. It should be kept in mind that these thoughts may continue to come in the mind in more or less quantity even after improvement. The only difference will be that these thoughts will not cause distress and you will be able to ignore them easily and effortlessly. Hence, the goal of treatment is to enable yourself for effortless ignorance of obsessive thoughts. When you will begin to ignore these thoughts, they may use more power to drag you in their trap. With your boldness and persistence in ignoring and ignoring will cut the pushing energy of obsessive thoughts and you will be able to deal with them easily.

xix. Daring is extremely important. When you are faced with a choice of avoidance of OCD situations vis-à-vis facing it, you should opt for daring and facing the situations and perform drill as per requirement. Your repeated choice of daring will substantially reduce the fears in dared situations. The situations in which you fail to dare may continue to disturb you.

xx. You should keep on reminding yourself that your mind has become habitual in generating obsessive thoughts. You should acknowledge it. Once you accept and acknowledge this fact, it becomes easier for the mind to deal with obsessive patterns.

xxi. Compulsive acts are the culprit. The temporary reduction of distress due to compulsion creates an illusion in the mind that compulsive acts are the solutions to the problem. In this illusion an OCD person keeps on doing compulsions endlessly. To come out of the trap, the compulsive acts shall have to be stopped. When compulsions are stopped, the imaginary fears will escalate in the mind, perform the drill and the distress will begin to fade away. With persistence, the objects of fear would stop to activate body-mind reactions and then there will be no need for compulsive acts.

xxii. OCD can transform you into a cleaner. You keep on cleaning your mind from filthy thoughts or keep on cleaning your hands, body, area of living and the objects. This cleaner role is not a rational choice of yours. Instead it is forced on you by OCD through creating imaginary fears in your mind.

xxiii. The imagination of an OCD person can create a mental picture of fear of God's punishment if religious objects are touched with dirty hands, sexual or aggressive thoughts towards god/goddesses. The affected person may even think that this punishment may come in next birth cycles. Such a person should realize that these thoughts are produced by OCD, a disorder of mind. It is not the product of their healthy choice. Even God knows how these thoughts are running into your mind. Take proper medical and psychological help in overcoming these fears.

xxiv. In OCD, there exists an exaggerated and magnified perception of danger. The imagination of the affected person goes to the extremes and usually perceives some kind of threat to life and survival. We are living in the world of Universal Probability. Anything can happen to any person at any time. We need to operate on this fundamental principle of nature. OCD thinking or compulsions do not modify this probability. Hence,

the affected person should realize the imaginativeness of danger perception in irrational fears and normalize the danger perception.

xxv. Keep on filling your time with some productive activities and cut the OCD thinking and compulsion time to the minimum. Also keep on postponing the OCD thinking and compulsions.

xxvi. Keep on monitoring your distress during OCD spikes and when the OCD is calm. At the time of spike it seems too terrible but when it cools down it does not threaten.

xxvii. Try to acknowledge and accept that your mind generates obsessive thoughts and compels you to get engaged in compulsions. As soon as OCD thinking/actions get initiated become aware of them.

xxviii. During activation of OCD spike, an affected person seeks isolation to think through the OCD thoughts. This approach of thinking it through is not helpful. Instead, the affected person should get involved in others and activities.

xxix. Avoid multi-tasking. Some persons do multiple tasks simultaneously. This approach of doing tasks builds up stress. The persons affected with OCD should do one task at one time. Rushing though the tasks also creates stress. Try to be a bit slow and firm in doing various tasks.

xxx. If thinking multiplies the fears. Take care of 'if' thinking and convert it into 'if not' thinking. For example, 'what if the door of the house remained open' replace by 'what if the door is not remained open'.

xxxi. Dwelling into cause finding thinking. An affected person may spend hours, days, months and even years in finding the causes of OCD thinking and actions. This cause finding thinking can spoil lots of time and still the question would remain as such. The cause of OCD thinking and action is changes in the brain functioning as well as the threatening meanings assigned to the obsessive thoughts and actions. Stop thinking too much about the causes.

xxxii. An affected person may get into endless reassurance seeking behaviors. Whenever, the affected person perceives a danger, he/she tends to seek reassurance from family members, friends and even the therapists. Reassurance works transiently. Stop seeking reassurance and realize the imaginativeness of the danger perception.

xxxiii. Re-activate your lost passions and social interactions. Connect with people and share.

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14
THEORETICAL FRAMEWORKS

I am considering multiple theoretical frameworks in this seemingly easy and straightforward approach to dealing with phobia and OCD. The theoretical frameworks may appear to be a bit overwhelming to the persons who are not into the field of psychology/psychiatry. The exposition of theoretical frameworks would facilitate the grounding of the concepts of drill therapy and would further stimulate the creative mind of the readers to think more and more about the role of drill therapy in dealing with emotional disorders, phobia and OCD in particular. I am invoking three primary theoretical mechanisms in explaining the basis of drill therapy. (a) Principles of Classical and Operant Conditioning (b) Linguistics (c) Cognitive Appraisal.

Classical Conditioning: Also known as Pavlovian Conditioning and Respondent Conditioning was developed by Ivan P. Pavlov, a Russian Physiologist in last decade of 19th century. He also earned Nobel Prize in 1904. I am elaborating an experiment based on the principles of classical conditioning for comprehension of the mechanisms involved in drill therapy. I will also introduce some of the concepts of this conditioning to make the task comprehensible. The interested readers should read the work of Pavlov in detail.

A stimulus is any object which produces a response/reaction. For example, when a needle is pricked in a finger, there will be a withdrawal response of finger/hand. Here, the prick of the needle is a stimulus; and the withdrawal of finger/hand is a response.

A stimulus can further be categories into two types (a) Neutral Stimulus (B) Natural Stimulus. A natural stimulus has inherent properties of eliciting a natural response. Needle prick is a natural stimulus for eliciting withdrawal response. Neutral stimulus does not naturally elicit the natural response. It is an artificial stimulus. For example, sound of an alarm cannot naturally elicit a withdrawal response of finger/hand. Alarm sound is a neutral stimulus for this response.

Classical conditioning is the procedure through which a neutral stimulus can be made to behave like a natural stimulus. A neutral stimulus can be 'magnetized' or 'charged' to act like a natural stimulus. Through the principles of this conditioning, the alarm sound can be 'charged' in a manner that it can elicit withdrawal response of finger/hand.

Let me now mention the technical terms used for natural stimulus; neutral stimulus and the responses in classical conditioning. (1) Unconditioned Stimulus (UCS): Any stimulus which naturally elicits a natural response. UCS is a natural stimulus. (2) Unconditioned Response (UCR): It is the natural response to the UCS/natural stimulus. (3) Conditioned Stimulus (CS): A neutral stimulus which gets 'charged' in a way that elicits a natural like response. (4) Conditioned Response (CR): A response to the conditioned stimulus. These terminologies can conveniently be understood through following example:

The Experimental Situation: A researcher designed an experiment in which he/she prepared a special cage in which a dog is tied. One of the leg is connected with a wire which can circulate electricity in one of the leg of the dog; as and when the dog withdraws the leg, the circulation of electricity stops. Also, the researcher took a bell for raising alarm. Before commencement of the conditioning, the researcher tested the withdrawal response of the dog to the electricity circulation (UCS) and the alarm sound (CS). Naturally, the dog displayed a withdrawal

response (UCR) to the electric current (UCS) but did not show any leg withdrawal response to the alarm sound (CS). Having tested in this manner, the actual training in conditioning commenced.

For training the researcher presented two stimulus in following sequence – alarm sound (CS) and electric current (UCS). Two stimuli were presented repeatedly in this sequence, and every time withdrawal response (UCR) was seen. With repeated presentations in this manner the researcher observed that at the end of the conditioning, the dog started showing withdrawal response (CR) only to the alarm sound (CS) even when no electric current (UCS) was presented. Now the alarm sound (CS), originally a neutral stimulus got 'magnetized' and started behaving like 'electric current' (UCS) for eliciting withdrawal response. CS CR connection is formed through conditioning and represent the essence of classical conditioning.

There are many concepts involved in classical conditioning. It is seen that the stimuli which are similar to the conditioned stimulus (CS) also tend to elicit the similar response, leg withdrawal in above experiment. This process is known as Stimulus Generalization. Multiple similar stimuli elicit the same response.

CS-CR connection can best be explained in terms of predictability. With repeated pairing of CS-UCS, the CS tends to predict the upcoming UCS. Since, CS reliably predict UCS, a response gets triggered to CS alone. If this predictability is not established or lost; then CS would not lead to CR. For example, alarm sounds (CS) are raised intermittently without electric current (UCS); the CS-CR connection will not be formed because electric current (UCS) comes both in the presence and absence of alarm sound (CS). The predictability between CS-CR will not be formed.

When, CS-CR connection is firmly established through conditioning, it can be broken by destroying the predictability of CS-UCS. To break this predictability, only alarm sound (CS) can be presented to the dog repeatedly in the absence of electric current (UCS). Sooner or later, the dog will realize that now only alarm sound (CS) is coming and no electric current (UCS) is following. The dog will cease to show withdrawal response (CR) to alarm sound (CS). This cessation of response to the CS, is called extinction. Conditioned Stimulus (CS) once again become a neutral stimulus and get 'demagnetized' or 'discharged' for eliciting the Conditioned Response (CR).

But here is a catch. As soon as the alarm sound (CS) is presented without electric current (UCS), the dog will withdraw the leg. There is no opportunity left to realize whether UCS is coming or not. To make the dog realize, the leg of the dog will have to be tied/held temporarily when alarm sound is presented so that a realization develops. When the leg is tied/held and alarm sound (CS) is presented there would be signs of discomfort reflected in the attempts to withdraw, barking and so on. Since, electric current (UCS) will not be there, these body reactions would cease to occur after sometime. The dog will have to bear temporary discomfort to get rid of the withdrawal response to alarm sound (CS). But it will happen.

Operant Conditioning: Also known as Skinnerian Conditioning. It is developed by B.F. Skinner in 20th Century. Interested readers should read his work in detail. I will be introducing only some of the concepts of operant conditioning, particularly avoidance conditioning.

A researcher conducted an experiment in which he/she developed a box having two compartments partitioned with a low hurdle. Two Compartments are labeled as Compartment

'A' and Compartment 'B'. The compartment 'A' contains a grid in which electric current can be circulated and Compartment 'B' is a safe compartment which does not contain any electric grid. A neutral stimulus of electric bulb is also attached in the box. A rat is placed in compartment 'A'. The bulb is switched on. Nothing happens. Within moments, electric grid is switched on. The rat will show random movements of jumping, running here and there and would accidentally crossed the hurdle and would come to compartment 'B' which is a safe zone. The experiment is repeated in this manner for several trials. Place the rat in compartment 'A'; switch on the bulb; switch on the electric grid. This will lead to cross over to the compartment 'B'. After training, the rat will begin to jump to the compartment 'B' immediately as soon as the electric bulb is switched on. Now, the neutral stimulus of electric bulb leads to the jumping behavior. Following processes could be delineated in this experiment:

I. A neutral stimulus becomes a cue for upcoming electricity circulation in the grid which leads to pain and discomfort. That is, a neutral stimulus becomes predictor of the painful consequences.

II. The rat is not terrified of the neutral stimulus (electric bulb) but the painful stimulus of electric current which is likely to follow the neutral stimulus. The distress is caused by the expectancy of the painful stimulus.

III. Jumping to the safe compartment 'B' in response to the neutral stimulus (electric bulb) results in avoidance of the possibility of experiencing painful stimulus. By jumping in compartment 'B' the rat no longer experiences the electric current.

IV. When the researcher redesigns the experiment and removes the electricity circulation in the grid from the experiment; the rat will still continue to jump to the compartment 'B' in response to the electric bulb. Since, there is no electric current involved in the experiment now, the false predictability is held by the rat. Due to this false predictability, the rat continues to emit the jumping behavior in compartment 'B'.

V. This false predictability can be destroyed by further modification in the experimental situation. Compartment 'B' is blocked. The rat no longer can jump to compartment 'B'. The electric current from the grid is removed. When rat is placed now in compartment 'A' and bulb is switched on the rat will engage in jumping behavior towards the wall erected between two compartments. There will be visible signs of discomfort in the behavior of the rat. Since, electric current is not there, the distress will initially escalate and then begin to resolve. With repeated exposure to the electric bulb in this manner without presentation of electric current, will destroy the false predictability held by the rat and the neutral stimulus (electric bulb) will again become neutral.

In conditions of phobia/OCD, the objects of fear are usually neutral stimuli which falsely predict painful experience. Our task as a therapist is to destroy the predictability of false outcomes due to the exposure to the neutral but 'charged' objects of fear. The affected persons with OCD/phobia do not work on destroying this false predictability. Instead, they keep on avoiding the charged neutral objects of fear. Face the fears. Face the objects of fear continuously for sufficient frequency and duration can make them realize the falseness in the objects of fear. Cognitive Drill Therapy is an efficient form of intervention that aims at destroying the false predictability of the objects of fears.

Cognitive Appraisal: The appraisal theory of emotion proposes that emotions are extracted

from our evaluations, interpretations, explanations and the meanings ascribed to the event. In the context of phobia and OCD, the activated feared cognitions correspond to the appraisals. When touched by a dirty object, following feared cognition may get activated in the mind of the person affected with OCD:

I. I may spread contamination to other objects.
II. Most objects will become dirty
III. The germs can spread through this contamination
IV. I may touch religious objects with dirty hands, which can lead to punishment by god.
V. Something may go wrong with family members, and I will be held responsible for spreading the contamination and leading to fatal consequences.

Technically speaking, the person affected with phobia/OCD is not scared of the objects of fears instead he/she is scared of the underlying imagined feared consequences. Objects of fear act as trigger or cue which falsely predict the danger to life and survival. The goal of the treatment is to make the affected person realize the falsification in the imaginative feared consequences. After treatment, when exposed to the same objects of fear, the objects fail to elicit the underlying feared cognition and also the body-mind reactions which emerge due to faulty danger perception. The task in therapy is to neutralize and normalize the objects of fear by correcting the 'distorted appraisal'. Cognitive Drill Therapy relies very heavily on the identification and correction of faulty appraisal of danger through exposure as opposed to through an appeal to the reason.

Linguistics: The usage of the concepts of linguistics in drill therapy is purely my speculation which may or may not hold true from the perspective of the theories of linguistics and the brain correlates. But I am quite comfortable in using them and they are serving my purpose effectively hence, I am continuing to use them. This is an area open to sophisticated researches which I intend to do sometime.

There are three tenses corresponding to three time frames of (a) past (b) present and (c) future. More than the tense, the time frame involved in the explicit or sub-vocal language is important. For these time frames, three notations A-B-C can be used. A means a time frame of past; B means a time frame of present and C means a time frame of future. Also, it is hypothesized that three time frames have their corresponding neural correlates in the brain. Let us use the same notations for neural correlates that are associated with time frame. 'A' for neural correlates of past; 'B' for neural correlates of present and 'C' for neural correlates of future. Anxiety and fears essentially have future orientations. Under conditions of anxiety and fear, the neural correlates responsible for future time frame get overactive. If this time frame can be switched over to past or present in internal as well as interpersonal dialogues during the condition of anxiety/fear then the overactive brain centers of future will get cool down. The brain activity will switch over to past or present. The brain activity of past and present are not associated with anxiety/fear. Under conditions of fear, a person affected with phobia may use following time frame in his/her internal dialogue:

I. I may be bitten by a dog (dog has not yet bitten him/her; there is a probability at some point in future).
II. If bitten by dog, I may catch rabies. (dog has not bitten yet; rabies has not be

caught yet; these events may happen at some point in future).

The repeated usage of this future time frame is associated with fear. If in the internal/interpersonal dialogue this time frame is switched to past or present, the brain activity will also get switched to the neural correlates of past/present. This can be done in following manner:

I. Dog has bitten me
II. I have caught rabies.

When a person is required to drill (repeat in bulk within a short time span above time frame converted statements) the brain correlates will also get switched over from future to past/present. The neural correlates of past/present are not associated with fear reaction. The repeated verbalizations of time frame converted statements provide an opportunity for the realization of falsification in the danger perception ignited by the objects of fear. This results in an experiential learning. The fear emotion hanged on the objects of phobia get processed and released from those objects resulting in rapid relief from phobia/OCD.

Since, the keywords involved in the fear reaction are emotionally charged, the exposure and repeated verbalizations shoot up the fear reactions to verbalizations to low to high or even very high level. Words are recognized as higher order conditioned stimuli. The repeated verbalizations produce an extinction of fear reactions associated with the objects of fear.

Other theoretical frameworks may also be involved in Cognitive Drill Therapy. I have identified above and may add more if I come across during the course of my development and refinement of the conceptualizations in Cognitive Drill Therapy.

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15
PSYCHOSOCIAL ISSUES

An issue which can be the focus of attention of the therapist or the affected person for healing is classified under psychosocial issues. Most of us have issues in various domains of life that need sorting. In the course of case history taking and assessment these issues become apparent. Some of the issues become explicit during the course of treatment. It may happen that the affected person presented with problem 'A' but in fact he has problem 'B' which need be corrected. The study of psychosocial issues in the life of the affected person would clarify such a situation and also would provide a comprehensive list of the issues faced by an affected person in his life. First a comprehensive random list of the problems is prepared and then it is classified into domains. For example, an affected person came with following issues in his life:

1. Phobia of darkness
2. Difficulties in running business
3. Phobia of height
4. Persistent sadness after demise of a family member
5. Marital discord
6. Problems in intimacy with spouse
7. Feelings of inadequacy
8. Insecurity for spouse and his son
9. Lack of meaningful engagement in life
10. Financial difficulties
11. Hopelessness
12. Worries over academic performance of his son.

All of these problems do not fall in the category of phobia and OCD. Instead these problems spread over multiple domains of life. The problems can be classified in following domains. Other domain may be added as and when required.

Domains of Psychosocial Issues:

1. *Emotional Issues*: All kinds of personal emotional problems of the affected person would be listed here. It would include the problems of phobia, OCD, jealousy, depression, and the like.
2. *Interpersonal Issues*: All relationship problems related with other persons in the life including parents, children, spouse, friends, fellow workers would be listed here.
3. *Occupational Issues*: Non-interpersonal problems in occupational functioning and related matters will be listed here.
4. *Other Issues*: Any other problems in life will be listed here.

The problems enumerated in above examples can be classified into domains of psychosocial issues as under:

Emotional Issues:

(i) Phobia of darkness
(ii) Phobia of height
(iii) Persistent sadness after demise of a family member

(iv) Feelings of inadequacy
(v) Insecurity for spouse and his son
(vi) Hopelessness
(vii) Worries over academic performance of his son

Interpersonal Issues:

(i) Marital discord
(ii) Problems in intimacy with spouse

Occupational Issues:

(i) Difficulties in running business
(ii) Financial difficulties

Other Issues:

(i) Lack of meaningful engagement in life

A comprehensive listing of the psychosocial issues and their classification provides a holistic view of the problems faced by an affected person in his/her life. This enables a therapist to keep a watch on what is happening in the life and how the affected person is progressing. When specific problem of any domain is taken up for treatment, problems of other domains may show changes. Most of the time it is not that only the specific problems need be handled; instead attempts shall have to be made to make the life of the affected person adjusted and harmonious. During the course of treatment issues of multiple domains may have to be targeted through appropriate psychotherapies.

In above case following problems of emotional domain may be targeted through Cognitive Drill Therapy:

(i) Phobia of darkness
(ii) Phobia of height
(iii) Insecurity for spouse and son
(iv) Worries over academic performance of son

Any emotional problem may contribute its portion in the severity of other problems. When specific problem is resolved, it results in deduction of the severity level from other problems too. We need to be alert and open to examine to what extent a given problem is addition to other problems and when specific problem is resolved, to what extent other problems improves. The resolution of the problems of phobia and insecurity in above example might results in partial or total improvement in following problems too:

(i) Feelings of inadequacy
(ii) Insecurity for spouse and his son
(iii) Hopelessness
(iv) Marital discord

Domains of psychosocial issues create a global picture in the therapist's mind for the range of problems being faced by the affected person and his/her family. It may be possible that the assessment of psychosocial issues may point out to the need for handling a problem other than phobia on priority. Other problem may be more problematic and pressing than the phobia/OCD. In that case, CDT may be postponed until resolution of the pressing problem. That problem may call for a treatment other than drill therapy.

OCD is a chronic and debilitating condition in some affected persons. Despite best

applications of drill therapy or even any other forms of psychotherapies are unlikely to produce significant gains in the condition of the affected person. Since, there are less chances of substantial improvement in the condition of the affected persons, there may be a temptation to give up the case totally. In such circumstances, the affected person may seek the help of other therapist or simply cease to seek further help.

I am proposing a tested idea that in the cases when the problem of OCD/phobia cannot be healed significantly and directly; in that case, a therapist should look into the other domains and problems which are likely to respond to psychological input. For example, along with the problem of OCD, a person has serious marital discord at the verge of divorce, in that case, instead of OCD; the marital discord can be prioritized for psychological treatment. Remember, resolution of any problematic psychosocial issue unburden the affected person to some quantity. An affected person carries the mental load of multiple psychosocial issues. The unloading of even a single issue will result in reduction in the mental load caused by so many issues. Each issue has its own mental load; which can be additive or multiplicative with other issues. I have seen changing the lives with extraction of associated psychosocial issue where the primary issue was unresponsive to the psychological input.

For clarification of identification and classification of the problems into various domains, I am citing more examples from real case studies. A person presented with following picture:

An adult person presented with the problems that he is not able to take up lifts as he feels that he may get suffocated inside the lifts. He avoids visiting his family members who stays in multistory apartment. He can't bear to full close the door glasses in the car because of the fear that he may get suffocated. For the same reasons, he would avoid caves, sitting on the back seat of the car and other closed places. He also becomes irritable if somehow he is caught in a closed place. Also he cannot stand on high rise building and look downward. He feels dizziness when looking down from the rooftop of high rise building. He feels shy when he is required to give any presentation related to his business. He also becomes self-conscious when he speaks with persons in authority. He is having problems with his wife who does not take proper care of his old parents.

The psychosocial issues depicted in above case study may be classified as under:

Emotional Issues:

1. Claustrophobia
2. Acrophobia
3. Social Anxiety

Interpersonal Issues:

1. Problems with wife

Occupational Issues: None reflected in the case study

Other Issues: None reflected in the case study

While classifying psychosocial issues in various domains, it should be remembered that as far as possible the issues are identified at the syndromal level. Each phobia/OCD has its own symptoms like dizziness, sweating, breathing difficulties, danger perception and so on. In classification, each of these symptoms are not listed instead the issue represented by these symptoms is listed. This is done, because Two layer partition will include all these symptoms of

the issue. Also, we are not supposed to treat the individual symptoms of the issue involved. For example, in a case of phobia, we are not going to treat directly any of the following symptoms individually: breathing difficulty, dizziness sweating etc. These symptoms will automatically go away because of the corrections in bottom layer.

The exercise in classification of psychosocial issues, is extremely useful in dealing with the problems of the affected person holistically and heal him/her to the maximum extent possible. Also, it can point out to the need for combining multiple psychological treatment approaches other than Cognitive Drill Therapy in the effective management of the affected person and resolution of his problems.

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16
ADDITIONAL IDEAS IN DRILL THERAPY

Outcome of CDT: Drill therapy produce three primary outcomes (a) Extinction/Habituation (b) Enhanced Self-efficacy (c) Re-appraisal.

By repeated verbalizations of feared cognition, the emotional charge associated with objects of fear gets dissolved. After successful application of drill, the objects of fear no longer activate body-mind reactions of discomfort which are called as Extinction/Habituation. For example, a person with dog phobia, used to feel rapid heartbeat, breathing difficulty, trembling by seeing a dog; after drill therapy he/she will no longer experience these symptoms and would remain neutral and calm by seeing the dog.

Secondly, during phobic condition, a person feels that he/she will not be able to face the objects of fear; and if somehow would get exposed to the objects of fear; he/she will not be able to handle the overwhelming body-mind reactions. He/she may feel hopeless and helpless in the situations involving excessive fear. By doing drill and experiencing reductions in body-mind reactions, the confidence of the affected person in his/her capabilities gets boosted. He/she comes to believe that he can handle the situation with reasonable comfort and even begin daring which is called enhanced self-efficacy.

Thirdly, during the condition of phobia, an affected person harbors thoughts of danger perception. In case of dog phobia, the thoughts of danger perception may consist of that dog may bite, if it bites there will be pain, he/she may get rabies and even die. After successful practice of drill therapy, these feared cognitions get modified. The person may think that it is a rare event that the dog would bite, even if bites, he/she can get the treatment. He need not be afraid to this extent.

When all the three outcomes are achieved with drill therapy, then it could be concluded that the affected person has achieved the goal of treatment and he/she is no longer is having an issue of phobia. The active treatment may be shifted to maintenance mode with follow up advice and practice of drill as and when required.

Drill Failure: The application of drill usually produces some changes within three days. If there is nil positive outcome within three days of application of drill therapy, then it essentially calls for a revision of the assessment of the condition of the affected person. It is observed that sometimes, the objects of fear and body-mind reactions along with corresponding feared cognition is sitting on the top of some other problem which should be addressed prior to handling of the phobic condition. The other condition which may need be understood include problems in the personality, interpersonal relationships, any chronic physical illness, real traumatic events in the life and the like. A person presented with issue of social anxiety and drill was initiated. When drill did not produce positive gains or even aggravated the body-mind reactions; re-analysis was conducted. It was found that this person had issues of personality traits. He was sensitive to interpersonal criticism and rejection since his early days. Also, he was having frequent experiences of criticisms and rejection on regular basis in his family. So it was considered best to opt for cognitive restructuring and training in coping skills prior to addressing the feared cognition through drill therapy.

Accessing Sub-conscious Mind: During drill, a person may access the experiences stored in subconscious mind. While accessing subconscious experiences, the person can land upon the

first experience that led to the development of phobia/OCD. Access to such an experience immediately enhances the understanding of the affected person and it can initiate a process of re-evaluation of the objects of fear and danger cognition. A person with social phobia was exposed to the drill. She showed severe body-mind reactions to the objects of fear related to social situations. Her age is 50 years. She accessed the first experience of her life during her teenage on stage in which she was not able to make a presentation. A couple of persons in the audience were waving their hands indicating her to come down the stage. This imagery of waving hands got hanged in her mind. On subsequent presentations, she used to get this imagery of waving hands. The access to this experience immediately led her to link with her current problem in performing on the stage.

Drill and Hypnosis: Hypnosis can be conveniently integrated with drill therapy. Hypnosis can be used to conduct assessment for drill therapy. An affected person can be put to hypnotic trance and additional objects of fear and danger cognition can be identified. The mind in hypnosis becomes much more focused which can help in eliciting danger cognition which is not readily accessible to conscious mind. Also, hypnosis can be utilized to review life experiences related with the problem. Age regression can be conducted to identify first life experience associated with the problem. Hypnosis is more useful for this kind of assessment then conducting drill during hypnosis. The drill in waking state is much more effective than the drill during hypnotic state. Posthypnotic suggestions can be integrated effectively with hypnosis. Following types of suggestions can be given to the affected person during hypnotic trance. (a) with every verbalizations of drill, the association between objects of fear and body-mind reactions will get weaker and weaker (b) the emotional charge associated with objects of fear will get drained very fast effortlessly and smoothly (c) while performing drill, subconscious layer of your mind will keep on generating and consolidating helpful and effective ideas about the objects of fear and the reactions (d) while practicing drill at home and real life situations, you would feel tempted to daring by repeatedly exposing yourself to the objects of fear (e) during the course of drill therapy you are likely to have a series of pleasant surprises. (f) every homework would inspire you to keep on doing the homework and record your experiences and success in drill diary.

Extension of Drill: The drill therapy is applicable in stimulus bound anxiety. The primary conditions being dealt with so far include phobia and OCD. However, drill could be explored in any emotional condition that involves underlying fears such as stress induced disorders, substance abuse, envy and the like. The drill can be used to address underlying feared consequences in such conditions. The remaining component of the problems can be dealt with other therapies like CBT.

Other ideas that converge well with drill therapy can be used. These ideas may come from principles of psychology or even from medical disciplines such as homeopathy.

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17
FAQS

I am responding to some Frequently Asked Questions (FAQs) on Cognitive Drill Therapy. The questions raised so far are being addressed here. In the course of further development of Cognitive Drill Therapy, I may encounter more questions, which would be incorporated as and when they are raised and opportunity of their inclusion arises.

1. *Why Cognitive Drill Therapy? We already have many forms of psychotherapies like systematic desensitization, flooding, graded exposure, implosion, exposure response prevention and Cognitive Behavior Therapy, then what is the need for other therapy?*

ANS: Science is not static. It keeps on advancing. The availability of effective therapies does not mean that the search for newer forms of therapies should cease. More and more newer forms of psychotherapies are coming up including meta-cognitive therapies. There are at least two unique components present in drill therapy (a) verbal exposure (b) Tense conversion. Since, this therapy make departure from the existing models of therapy and in case studies it is repeatedly producing positive results, hence, we consider that pursuing the cause of Cognitive Drill Therapy is legitimate, scientific and promising which is opening up new areas of research in clinical psychology.

2. How CDT is different from ERP?

ANS: ERP (Exposure and Response Prevention) is the most recommended form of behavior therapy in cases of OCD. Both CDT & ERP utilize the principles of Exposure to deal with OCD particularly compulsions. Verbal exposure through tense converted statements is the unique feature of CDT which is not present in ERP.

3. How many days/sessions are required for CDT?

ANS: No specific duration of treatment can be specified. In cases being worked out by us it is seen that in cases of Phobia it acts very fast within 2-3 sessions, there can be substantial improvement. OCD takes quite longer about 10-20 sessions or even more.

4. What are the chances of relapse after CDT?

ANS: Relapse can occur with any form of therapies and medical treatment. In phobic conditions, we have case feedbacks of several years duration in which therapeutic gains are maintained. Relapse do occur which can conveniently be handled with a few sessions of CDT during relapse.

5. Can I apply CDT on myself?

ANS. I recommend a few sessions guided by the CDT therapist. Later on you can apply it on yourself with minimal supervision from the therapist. It is very easy to learn and apply.

6. Are there any side effects of CDT?

ANS: It has the same side effects profile as Exposure and Response Prevention albeit in reduced quantity and severity. Till now, I have not seen any side effects of CDT. In some cases, the distress due to exposure may persist for a few days.

7. Is it safe to use CDT?

ANS: CDT can elicit overwhelming traumatic memories. If any person has cardiac vulnerability for traumatic memories, I do not recommend this procedure. Instead, cognitive restructuring and systematic desensitization can be considered which elicit minimal emotional reactions. Apart from that CDT can be a good choice specifically in phobias.

8. I am a therapist. How can I learn CDT?

ANS: You may conceptualize and practice CDT by reading this book. If you need supervised training then you can join us in any of our workshops on Cognitive Drill Therapy. It takes about 2-3 days to learn theoretical and practical aspects of drill therapy.

9. Can I discontinue my medications after improvement with CDT?

ANS: Being a psychologist, I do not advise on medications. The decision to continue, reduce or stop your medications rest with your treating psychiatrist. You need to consult your psychiatrist for the same.

10. How can I know if CDT is effective for my condition?

ANS: I recommend CDT trial of at least three days for making a decision whether it is working. If there is some improvement in three days applications of CDT, then it can be continued for further improvement.

11. Can I combine CDT with other psychotherapies?

ANS Certainly. CDT can conveniently be combined with other forms of psychotherapies like CBT.

12. If I combine CBT and Medicines with CDT, how do I know whether CDT is beneficial for me?

ANS: You can easily make it out. As and when you get spikes of fears, apply CDT on the spot for 5-10 minutes. If it reduces your fears, then consider that it is working for your problems.

13. How much time I spend on CDT per day?

ANS: During active therapy phase, I recommend approximately one hour application of CDT which may be divided in 2-3 applications of about 20-30 minutes. Gradually, you would feel a need of less duration of application.

14. Is CDT scientific?

ANS: Yes. CDT is based on scientific principles of exposure and appraisal theories. The component of linguistic need be investigated scientifically. CDT mostly utilizes existing and tested principles of psychology.

15. Is CDT an evidence based therapy?

ANS: CDT is being developed and applied on many cases. So far we are able to generate case studies. In the course of time, we shall conduct large scale scientific studies to gather evidence base for drill therapy.

16. Is CDT recognized internationally?

ANS: The principles of exposure are already recognized internationally. CDT is based on the principles of exposure. As we reach out the world and conduct more researches, we

hope, it should be very much acceptable to the scientific community. There are many variants of exposure therapies like Prolonged Exposure in PTSD which are recognized worldwide. This may happen with CDT too.

17. Is CDT covered in standard textbooks/journals of psychiatry and clinical psychology?

ANS: Since it is a novel form of treatment which is still being developed, we hope that with accumulation of scientific database, it may appear in the textbooks and journals.

18. What are the indications of CDT?

ANS: CDT can be considered for most phobias except blood-injury type phobia and OCD. More effective in phobias and partly effective in OCD. In other emotional conditions like envy, feelings of inadequacy etc it can be explored. CDT is not applicable for positive emotions like joy.

19. What are the contra-indications and non-applicable conditions for CDT?

ANS: We are not using CDT for psychosis, organic conditions, intellectual disabilities, cardiac vulnerability.

20. Who are the affected persons on whom CDT is unlikely to work?

ANS: CDT is applicable when a person feels anxious/fearful by imagining or verbalizing the objects of fears/feared cognition. In the person, who do not feel anxious while exposed to the objects of fear, this therapy is unlikely to work. Also the persons who are extremely sensitive and intolerant of elicited distress due to exposure, CDT may not be feasible. The persons who fail to comply with home work assignments and continue to have symptoms in real life situations despite improvements in therapist's chamber are unlikely to be benefitted with drill therapy.

21. When CDT therapy should be terminated?

ANS: When an affected person has cleared most objects of phobias and feared cognition through drill therapy and no longer feels anxious then therapy can be terminated.

22. What is the session duration and frequency of CDT?

ANS: A session of CDT usually lasts 60-90 minutes which can be conducted daily or on alternative days.

23. Is there any age criteria for CDT?

ANS: It can be applied from childhood onwards. If a child is able to comprehend the task and practice the drill, it can be considered.

24. Does CDT has any applicability in students of various education systems?

ANS: Very much applicable. Apart from specific phobias, the students have social anxiety and examination anxiety which can be addressed through CDT.

25. If CDT is not working on me, then what should I do?

ANS: Re-analyze your problems and see if you are doing it properly. If there is any gap in its application, then you may re-apply it after corrections. If still it does not work after three days application, then go for other therapies including CBT and psychiatric consultations.

26. CDT requires verbalizations of a few statements. How mere verbalizations can heal my condition?

ANS: See, it is not simple verbalization, it is backed by convergence of multiple theories and technically framed. If you can feel fearful merely by repeating the statements, then with continued repetitions that fear state will subside.

Many more questions may arise in the mind of users, therapists and researchers. I would request all of them to submit me the questions on my email ID so that I can respond to those questions in next revision of the book.

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18
MEDIA COVERAGE

I participated in a National Seminar on Crime Against Women: Issues, Challenges and Intervention organized at my alma mater Digamber Jain College, Baraut (Baghpat) on 1-2 November 2015. I happened to meet my well wisher Dr. Anurag Mittal at Baraut. He has been supporting my passion of hypnosis and past life regression for a long time. He is aware of my recent interest in Cognitive Drill Therapy through social media. When we met, I introduced the concepts of Cognitive Drill Therapy to him. He could immediately conceptualize it and even encouraged me to work on Claustrophobia too. He related an instance where he had to accompany one of his acquaintances to MRI scan because of claustrophobia. He impressed me with the limitations imposed on claustrophobic person while undergoing such examinations. He in turn introduced me and my work to the Correspondent of Dainik Jagaran News Paper Meerut Issue. With a cool mind, we three persons discussed and clarified various concepts, theoretical framework and extensive scope of cognitive drill therapy. A featured coverage appeared on 7th November 2015; the first media coverage on Cognitive Drill Therapy.

भय का भूत भगाने में नहीं होगी परेशानी

नवीन विकारा, बड़ौत

प्रतिभा के विकास में असफलता का डर सबसे बड़ी चुनौती है। भविष्य के प्रति आशंकित होना एक सामान्य प्रक्रिया है, लेकिन जब भय का भूत बन जाए तो जीना दुश्वार हो जाता है। भविष्य के प्रति भय को दूर भगाने में मनोविज्ञान की कोगनेटिव ड्रिल थेरेपी काफी कारगर सिद्ध हुई है, जिसमें भविष्यकाल के भय को भूतकाल में परिवर्तित कर दिया जाता है।

दिगंबर जैन कालेज में आयोजित राष्ट्रीय सेमिनार में शिरकत करने आए मानसिक स्वास्थ्य संस्थान एवं चिकित्सालय आगरा के वरिष्ठ चिकित्सक मनोवैज्ञानिक डा. राकेश जैन थेरेपी पर प्रकाश डालते हुए बताते है कि इस थेरेपी में केवल मनोवैज्ञानिक तरीके से मस्तिष्क के विभिन्न केंद्रों को संदेश देकर भय को दूर भगाया जाता है।

विशेष दैनिक जागरण

कैसे काम करती है विधि

डा. राकेश बताते हैं कि भय का सीधा संबंध भविष्यकाल से होता है। मसलन, भविष्य में होने वाली दुर्घटना, परीक्षा में असफलता, कारोबार डूबने, अपने प्रियजनों से बिछुड़ना आदि का डर। इस विधि में मनोवैज्ञानिक तरीके से मस्तिष्क के भूतकाल, वर्तमान काल और भविष्य काल के उद्दीपन केंद्रों को प्रभावी ढंग से तालमेल में लाया जाता है। मनोवैज्ञानिक उच्चारण व कल्पनाओं के माध्यम से भविष्य के भय को भूतकाल में ले जाया जाता है, जिससे रोगी भयमुक्त हो जाता है।

- कोगनेटिव ड्रिल थेरेपी से आई आशा की किरण
- भविष्य को डर को भूतकाल में कर दिया जाता है परिवर्तित

डा. राकेश जैन।

प्रकाशित हो चुके हैं जर्नल

डा. राकेश द्वारा विकसित कोगनेटिव ड्रिल थेरेपी पर इंडियन जर्नल आफ क्लीनिकल साइकोलाजी, एसआइएस जर्नल आफ साइकोलाजी प्रोजेक्टिंग साइकोलाजी एंड मेंटल हेल्थ में जर्नल और केस स्टडी प्रकाशित हो चुकी है।

भय के प्रकार

1. भगवान से डर : रोगी धर्मस्थल पर जाना छोड़ देता है।
2. सामाजिक डर : व्यक्ति भीड़भाड़ व समारोह आदि में जाने से बचता है।
3. अगोरा फोबिया : इस डर में व्यक्ति घर से बाहर अकेले जाने से डरता है।

इसके अलावा बंद जगह, काकरोच, ऊंचाई व गंभीर रोग होने आदि के डर शामिल है।

Drill therapy can be made popular so as to reach as many affected persons as possible in the world. I am using following methods of spreading the awareness of common anxiety disorders and efficient applications of cognitive drill therapy. The mission is to help people recover from their phobias and OCD.

1. Formation of Whatsapp group and in-depth discussions with members on different aspects of drill therapy.
2. Periodically, broadcasting messages of drill therapy on broadcast lists of Whatsapp
3. Facebook group to allow thousands of interested persons and keep posting content relevant to anxiety disorders and drill therapy
4. Posting relevant content on facebook wall
5. Posting messages in a number of facebook groups related to anxiety disorders, professionals and support groups
6. Posting content on LinkedIn
7. Delivering lectures on cognitive drill therapy in colleges, universities and institutions

8. Conducting workshops on cognitive drill therapy for professionals
9. Delivering talk on anxiety disorders and drill therapy on FM radio
10. Encouraging treated patients to inform other persons who are having similar problems
11. Encouraging workshop participants to take up similar awareness activities
12. Forming support groups on Whatsapp for the persons affected by various anxiety disorders
13. Publication of case studies in scientific journals
14. Online circulation of cognitive drill therapy manual free of cost
15. Encouraging mental health professionals to take up scientific researches on the role of cognitive drill therapy in various anxiety disorders.
16. In due course, we could have an International Association on Cognitive Drill Therapy and may take up annual conferences and publish a journal dedicated to Cognitive Drill Therapy

We need to reach the mass with the technology of Cognitive Drill Therapy for helping them out to deal with phobic conditions. There can be many ways to reach them.

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19

EMPOWERING PROFESSIONALS

For a few years, I have been contemplating for conducting a workshop on Cognitive Drill Therapy for professionals. I was not getting appropriate conceptualization for the workshop. How it would be delivered? What will be the content and the methodology? The idea of a simple PowerPoint presentation and lecturing was not fitting well into my mental representations. So the idea remained dormant until October 2015. With an open mind, I invited some of my students to join me in the path breaking and historical event where I would be transferring my concepts and skills of doing cognitive drill therapy. We 10 persons assembled. I did not have any formal outline or pre-determined outline for proceeding and without any such formal preparation; I was destined to spend three days and about 15-20 hours with this learned group of psychologists and professionals. I had already asked them to read my write ups on Cognitive Drill Therapy and Somatic Charge Therapy including two published works. Spontaneously a structure of workshop got formed in my mind and proceeded to deliver it.

Day-1: Sharing of my cases and core concepts:

On Day-1, I opened with a brief detailing of the purposes and objectives of this workshop. I smoothly moved to the sharing of the case of Mr. Chand in detail. In the context of this case, I explained following concepts:

1. Pavlovian Conditioning
2. Stimulus Generalization
3. Extinction
4. Spontaneous Recovery
5. Role of tense in anxiety and cognitive drill
6. Exposure & Response Prevention
7. Thought stopping
8. Role of hypnosis

Outcomes of Cognitive Drill Therapy: Any kind of exposure therapy including cognitive drill, results in (a) habituation/extinction of conditioned response (b) increased self-efficacy; the patients with OCD and Phobia think that they cannot cope with the fearful situations. Hence, they keep on avoiding it. Through this therapy, they develop a sense of self-efficacy where they come to believe that they can face the fearful situations with ease and comfort or little distress. (c) Cognitive reinterpretation; the patients during anxious states have bias of interpreting stimuli in threatening manner. Through this therapy their interpretation of events changes to adaptive ones. A cognitive restructuring happen naturally.

Experiences with Claustrophobia: I also shared experiences of a professional with Claustrophobia. He was having fear of using lifts. An underlying fear structure of suffocation was detected. He was required to practice the drill for a few minutes, may be 15 minutes. The protocol of drill was “imagine yourself in lift and keep on repeating ‘muje suffocation ho chukka he” (I am suffocated). The SUD units indicated the bell shaped anxiety curve and when he was at ease, he was taken to the lift and was required to use the lift by his own. He was able to use the lift within a few minutes. Also, he was required to practice the drill daily for a few minutes and try to use lifts as Homework. He has improved proportionate to his application of

drill therapy.

Most Severe Case of Contamination OCD: I emphasized that in OCD, a combination treatment is a rule rather than exception. All cases of OCD should receive psychiatric medications. I had a case who was having OCD with secondary depression. He had a long term history of OCD for more than 08 years. He had received proper treatment and still continued the same. He was well versed with the medications he received so far and their therapeutic effects and role of neurotransmitters. He had acquired this information from internet. He even consulted for gamma knife and made initial preparing for undergoing this treatment. He was having contamination OCD; while moving even on bike, he would think that important business papers have fallen and he would turn and look back while driving causing accident risk and when sitting on floor he would think that he has killed aunts and he would be cursed by them. I implemented cognitive drill therapy on him. He learned it well and consciously applied to many anxiety provoking situations. He had lost his business for three years. He was not touching his family members for fear of contamination. Now he has restored his business, now he is able to be with him family members, he can comfortably touch them. He is continuing his medication. His improvements are maintained even on a follow up of 04 years.

Standalone Medical Treatment: I have seen extra-ordinary improvements in a few cases who were put only on psychiatric medications. They were not responding to Cognitive Drill Therapy. I remember at least two cases; one lady with severe contamination OCD having secondary depression with suicide wish. She responded quite well and within a span of two months most of her symptoms subsided. She is continuing her medication and she should continue to do so. Another case was of Obsessional doubts and checking. He also responded quite well to the medicines. CDT was not working on him too. He improved considerably and established his business.

Treatment Failures: There are some cases who could not improve despite standalone psychiatric treatment or even combination of Cognitive Drill Therapy or any other kind of psychotherapy. These are the cases, who are disturbed to the extent that they fail to conceptualize the psychotherapeutic work and the cognitive drill therapy formulation. I have seen a few such cases whom I could not help through Cognitive Drill Therapy or any other kind of psychotherapies.

Lack of Generalization: I have seen a few such case where I was able to produce significant changes through Cognitive Drill Therapy in my office but there was little or insignificant generalization. I am still trying to find out how I could help such persons and design the homework so that they can take up and execute the homework. Homework is the primary key for promotion of generalization of the effects to real life situations. Some patients are not able to gather the courage to do homework and promote generalization. Their psychology of not doing homework and lack of motivation for generalization of improvement to real life situations needs to be studied.

Fear of Relapse: During the course of Cognitive Drill Therapy most patients will sooner or later come up with fear of relapse. They will say, now they are feeling better but after some time their OCD or fear will bounce back. This fear of relapse is also a fear and need be drilled in the same manner. “relapse ho chukka he’; “relapse ho chukka he’; “relapse ho chukka he’ (My condition has relapsed). Initially, this drill causes a surprise reaction. But it is a quite powerful

drill for dealing with fear of relapse. It gives a pleasant 'ah' experience.

Fear of Drill: When I introduce the idea of doing drill and the reaction it activates; initially it can frighten not only the patient but also the therapist. They may think that by doing the drill; repeating the fear related words, holding feared images would worsen the condition and the fear or OCD will aggravate. Barring the exception, the drill is an exposure which is bound to produce extinction. It does not aggravate the condition. This fear dissipates rather quickly as after performing a few cognitive drills, the therapist and the patients come to realize the power of drill in reducing the fears. This fear of drill can be prominent when there is activation of severe anxiety response during the application of the drill. Instead of fearing the drill, simply give a gap of few minutes and resume the drill protocol. This way the anxiety and fear will show a declining pattern.

Disbelief in Cognitive Drill Therapy: The learner therapists and the patients initially have serious doubts regarding effectiveness of drill therapy in overcoming OCD and Phobia. 'mere repetitions of a statement can give relief in extreme fear and anxiety reaction' just impossible, ridiculous, quackery or just a new method to impress, fraud, placebo. These may be the reactions. So, to the patients, I say that let us not evaluate the outcomes until one week. We shall collectively examine after one week if the application of drill therapy is useful. By the end of one week if there are therapeutic gains, then drill therapy should be continued else it should be switched over to other models of psychotherapies.

Despite my verbal persuasions, the participants continue to have disbelief. They would say 'me apni aankho se dekhu to manu' (I shall believe if I see it happen before me). Over the years, I realized that the population of the believers just by listening or reading is less. There is a tendency just to discard or reject such novel ideas because it does not fit into their existing cognitive structure. It is good for them for protection of their cognitive structure. Nothing should be believed blindly. One should have direct exposure and experimentation to the satisfaction of one's own curious mind. There is only one problem of 'concluding on the basis of insufficient data'. The success rate is not 100%. If it is not 100%, that means there are failures. If you take up one case for demonstration and it turns up as failure, you should not conclude merely on the basis of a few observations. Just keep on doing it. I recommend that before forming any opinion of the effectiveness or usefulness of Cognitive Drill Therapy, you must apply and monitor at least 30 cases. A sample of 30 cases is quite reasonable to form an opinion of its efficacy.

On Day-1, I mostly shared my experiences, understanding and concepts of Cognitive Drill Therapy. I had never thought that I would be devoting first day to these topics. But it was a smooth flow of sharing.

Day-2: Sharing of participants' cases:

Day-2 spontaneously got structured. I encouraged the participants to share their cases. One of the participants had already learnt cognitive drill therapy individually from me. She had applied it on a child with stammering. She got objectively verifiable improvement in social anxiety of that child. She also reported that there is little improvement in stammering. He was not interacting with authorities and participating fully in other social activities. But now this child is involving himself in interaction with authorities and social interaction with support of Cognitive Drill Therapy. I responded that for stammering problem the option of speech therapy

should also be considered. The drill therapy is unlikely to change the stammering but it can reduce the social embarrassment and anxiety due to stammering.

Other participants also shared some cases of OCD and phobia. In the process, I emphasized how the case history and other relevant information should be gathered. I educated the participants on the components of history taking and psychological assessment.

I demonstrated case history taking on one of the participants. She was having a specific fear of performing on stage from rote memory. She is into music and required to sing from rote memory without any aide. To manage her fear she had developed a strategy to look towards the judge on the dais and holding some cues. She was getting negative feedback from the audience. She was perturbed with this scenario. While demonstrating case history taking I proceeded in following manner:

1. I simply enquired with an open ended question. Give me a detailed history of your problems. She told that she is not having any fear of social situations as such. She can effectively deliver lectures and other presentations on podium. The only specific component of music performance is the point of concern.
2. How did it originate? She accessed one of her sub-conscious experience that in teenage she was performing on the stage. She got blank. The audience laughed and waved their hands to indicate her to come down from the stage. She reported that she is able to remember this instance after so many years. She was not conscious of this experience. It gave her a sort of insight. She was almost surprised by recalling her experience.
3. She also showed her video clip of her avoidance behavior while performing on the stage.
4. I enquired what scares her while doing singing performance on the stage. She reported following feared consequences:
    a. *I can go blank*
    b. *I will lose trust of other persons*
    c. *I do not want to let down others who have trust in me*
    d. *An imagery that audience is indicating by their hands to come her down from the stage*
5. I partitioned the problem into its (a) surface structure and (b) underlying fear structure.
6. The surface structure consists of performing on stage leading to anxiety reaction and an avoidance pattern by holding cues and looking for reassurance.
7. The underlying fear structure consists of fear of letting others down, fear of going blank and an imagery of people indicating her to come down of the stage.

The live demonstration of this assessment and formulation further clarified the process of collection of relevant information. It raised the confidence of the participants. Still disbelief was persisting. This participant wanted to resolve her issue for getting convinced of Cognitive Drill Therapy.

I say that efficacy of any therapy cannot be contingent upon demonstrations of results in a particular case. But my this point is rarely appreciated until the participants apply my concepts into their practice and see the effects.

I also discussed my published case studies. I highlighted the research potentials of Cognitive

Drill Therapy.

I demonstrated that initially many patients reject the idea of underlying fear structure despite knowledge of psychology and even cognitive drill therapy. This happens because the underlying fear structure is sub-conscious and not readily accessible to the conscious unless specifically attended too. With persistence of the therapist, the underlying fear structure can be discerned.

The focus of the second day was on sharing, discussion on the cases of the participants. We discussed other cases too and I clarified many concepts and repeated the concepts of Day-1.

Day-3: Practical Demonstrations of the Application of Cognitive Drill:

The participants were eager to observe practical applications of cognitive drill therapy. I explained to them how to formulate the drill.

Drill Formulation: The formulation of drill statement is a skill.

1. It consists of overt or covert exposure to the anxiety provoking stimulus. In case of stage fear, 'imagining oneself on the stage'; in case of contamination OCD, putting a contaminated object in the range of sensory field of the patient.
2. Selection of any one specific string of underlying fear structure such as going blank on the stage or fear of rejection or fear of letting down others etc.
3. Changing the tense of the string of underlying fear structure. Such as 'I have gone blank' or 'I have been rejected' or 'other people are let down because of me'.
4. In this instance, following drills were formulated:

    a. (i) imagine yourself on stage without any aid or avoidance
       (ii) repeat to yourself 'I have gone blank'.
    b. (i) imagine yourself on stage without any aid or avoidance
       (ii) 'I have been rejected'
    c. (i) imagine yourself on stage without any aid or avoidance
       (ii) 'other people are let down because of me'

Drill Implementation: I made her to do following drill one by one:

a. (i) imagine yourself on stage without any aid or avoidance
   (ii) repeat to yourself 'I have gone blank'.
b. (i) imagine yourself on stage without any aid or avoidance
   (ii) 'I have been rejected'
c. (i) imagine yourself on stage without any aid or avoidance
   (ii) 'other people are let down because of me'

At the onset of the drill implementation, she started showing heightened emotional reactions characterized by weeping and crying spells. I had to give pauses to manage her severe reactions. Crying, crying and crying, tears into her eyes. I had to persuade her not to resort to mental avoidance. At the end of the drill she felt calm, composed, and even started smiling and laughing.

There was an extinction of anxiety reaction to above stimuli. Her self-efficacy got enhanced. She now felt that she could comfortably be on the stage for music performance without any

avoidance, reassurance or memory aide.

The participants got real feel of what Cognitive Drill Therapy is? How much powerful it could be? What kind of emotional reactions can be stirred during drill applications? These were the divine moments for me and for participants too.

The other perspective what I highlighted was that of 'de-hypnotizing'. Due to conditioning, she used to be in a state of trance while performing music on the stage. The drill therapy could possibly de-hypnotize her from that conditioned state.

Contra-indications: I categorically conveyed that Cognitive Drill Therapy should not be used on the patients having cardiac risk. Also this therapy is not useful on schizophrenic patients.

Indications: CDT is a treatment for stimulus bound anxiety. That is, if you can make out a stimulus- response association in the anxiety state then possibly it can be used. The specific instances where Cognitive Drill Therapy can be used are as follows:

a. Fear of public speaking
b. Sexual thoughts towards religious objects
c. Contamination OCD
d. Agoraphobia
e. Claustrophobia
f. Specific phobia

Psycho-education: The patient should be properly educated prior to the commencement of the drill application. Following specific components should be communicated:

a. Diagnosis of the condition
b. Surface structure
c. Underlying fear structure
d. Theory of extinction
e. Anxiety curve
f. Theory of tense conversion
g. Importance of Homework

Controlling Avoidance: For extinction to occur, it is necessary to prevent the avoidance pattern. Avoidance leads to reduction of unpleasant drive state which is a negative reinforcement and maintains avoidance behavior. I clarify it to the patients through an example of 'darkness phobia'. Suppose a child has phobia of darkness. We want to remove his fear of darkness. The avoidance of darkness gives him a sense of relief but it does not solve the problem. Somehow, he has to expose himself to the darkness. When exposed to the darkness, this child will initially have an avoidance tendency and would display emotional reactions like crying. With continued exposure without avoidance, the phobia of darkness would disappear. Similar approach needs to be adopted.

Multi-sensory Involvement: The patient is encouraged to imagine the anxiety provoking stimulus in as much details as possible. Involve as many sense modality as possible. The multi-sensory involvement would lead to faster results.

Bearing Discomfort: When exposed to anxiety provoking stimulus without avoidance, there would be anxiety and distress in the patient. I tell them to bear some of the pain and suffering of exposure as this discomfort would lead to therapeutic results. There is pain in both suffering

and surgery; but the pain of the surgery is temporary and would ultimately lead to greater comfort.

Recordings by the Therapists: I recommend that case history and details of each session including assessment details should be recorded in any manner with the consent of the patient and be kept safe. These recordings would help in generating research papers, case studies, monographs, books, presentations and lectures. Within a few years each therapist will have sufficient data to add to the pool of database of Cognitive Drill Therapy.

Invitation of Criticisms: I encourage the participants to criticize the concepts of Cognitive Drill Therapy so that I can contemplate and formulate my response to such criticisms. This would help me in refining the theoretical and practical aspects of this novel and effective form of psychological treatment.

Expectancy of Results: I say that no form of therapy of any theoretical framework can cure each and every case of OCD and Phobia. The therapies are more or less effective and useful. I am setting up the perspective that Cognitive Drill Therapy cannot heal all patients of OCD and Phobia; also who respond to this therapy would not be cured 100%. Through this therapy I am able to help some of the patients in a manner so that they can help themselves by managing their OCD and Phobia. I also say that upper limit of improvement is about 70%; a moderate goal. If there is more improvement, it should be celebrated as a bonus.

Role of Hypnosis: Hypnosis can be used to promote adherence to homework. It can also be used to reduce avoidance pattern and enhance vividness of imagination of the anxiety provoking stimulus. Hypnosis can also help in accessing early experiences and initial sensitizing event relevant for OCD and Phobia.

Drill-Daring & Distraction: I recommend drill, daring and distraction in OCD and Phobia. Perform the drill, do daring by exposing oneself to anxiety provoking stimuli and do distraction by keeping yourself engaged in some productive work.

Rationale and Coping Statements: A positive and helpful self-talk is also helpful in managing OCD and phobia. The statements such as 'this is temporary'; 'I can reasonably handle it'. 'Give nil importance to OCD thoughts'; 'OCD is a trap' etc can be identified and practiced by the patient.

Thought Stopping: If worry occupies the mind and there are several strings of thoughts running into mind, the technique of thought stopping can be used. The patient is taught simply to mentally shout 'stop it' as and when he realizes the presence of repetitive or excessive thoughts in the mind.

The workshop was an enriching experience for me as well as the participants. I urged the participants to record their learning from this workshop and share with me so that I could incorporate the feedback in my work. Also, this will be an opportunity for them to revise most concepts of drill therapy.

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PARTICIPANTS' FEEDBACK

I am sharing the feedbacks given by the participants of the workshops. I am reproducing the content mostly as shared with minimal copy editing.

Participants-1:

Cognitive Drill Therapy is a novel therapy specifically designed for patients of OCD and phobia. Structured over three days, the workshop balanced the theoretical and practical aspects of cognitive drill.

Day-1: Majorly focused on two things. Firstly some cases of OCD and Specific Phobias were shared which helped us to conceptualize the chief complaints of the patients. We understood in detail as to how these problems affect the everyday life of such patients and what all attempts are made by them to cope up with their problems. Secondly, the focus was on the basic principles of Classical Conditioning. It helped us to understand the application of underlying principles of classical conditioning in development of OCD and phobia. The distinction between unconditioned and conditioned stimulus could well be connected to covert and overt structures. The surface structure needs to be explored for underlying structures. Response generalization takes place gradually so that each patient develops his own 'umbrella' of causes, meaning that many stimuli elicit the same anxiety response. Day-1 gave all of us enough food for thought and we could appreciate that the suffering of an OCD patient or a phobic might seem very casual to an outsider but it is very genuine for the patient.

Day-2 was power packed as it focused on the implementation. Though individual differences can exist, but on an average, a patient requires about 10 sessions of CDT with daily homework. The important aspects covered on day-2 were as follows:

Case History: The major aim of the case history is to gather detailed background, discovering conditioned stimuli, underlying fear structures, attempts made by the patient to cope with the problem and how the patient's life has been affected by all this. The most pertinent question during this enquiry phase probably is 'what do you think will happen if …….' ?

Assessment: It refers to administration of standardized tools to objectively assess the reported fears and anxiety. Depending upon the requirement one can use Y-BOCS, Fear inventory and any other relevant scale along with a visual analogue scale to get a subjective rating of anxiety felt by the patient.

Psycho-education: This is one of the most important stages of CDT. The patient needs to know the exact diagnosis of the problem followed by the information on the functional nature of the connection between the conditioned stimuli (triggers) and reactions (fear, anxiety). The compulsive actions are a form of avoidance which have been providing a temporary relief to the patient. As a result the problem has persisted and probably worsened over the course of time. CDT works on two basic principles. Firstly, during exposure anxiety follows the pattern of a bell shaped curve which means that it rises, attains a peak and declines thereafter. Secondly, sufficient and repeated exposure to conditioned stimuli tends to reduce its strength.

Cognitive Drill: The final phase is the cognitive drill. The identified triggers are converted into past or present tense and repeated by the patient till a particular triggers stops eliciting the anxiety response. Each trigger should approximately take about 5-10 minutes. Visual

analogue scale is used with each trigger multiple times to assess the intensity of the response. In one session we move on from one CS to another as per the comfort of the patient. The drill is effective when it addresses underlying structures, is multi modality and most important if the patient experiences the anxiety when presented with the stimulus.

Day-2 exposed us to the intricacies of CDT. Detailed case history was demonstrated live and also through reported cases. Information received in case history was kept safe for the final day for drill demonstration.

Day-3 began with live demonstrations of the drill on one of the participants who reported anxiety in a specific performing situation where there was no cue to refer to. The fear of going blank and being embarrassed in front of the audience and associated fears were taken up in the drill. The results confirmed the efficacy of the drill. The procedural issues became very clear on day three.

Over and above the most important take home points that I would like to mention are:

i. The relevance of Classical Conditioning procedures in learning and unlearning fear responses.
ii. The T-R connection
iii. Breaking down of behavior units into surface and underlying structures
iv. The importance of psycho-education
v. The importance of continuing medicinal support
vi. Multimodality and daring in drill

OCD and specific phobias are probably the disorders with the highest rates of prevalence. The three days workshop was an intense training program which completely changed my outlook on these disorders. The highly structured course material and the focused delivery of that course material worked towards enhancing my knowledge. From the first day on to the third day it was an upward graph as far as learning and understanding is concerned. The program strengthened my understanding of theoretical concepts and raised my conviction for the practical application of the basic principles of classical conditioning. Such programs are add-on to the skill repertoire of any professional working in the field of psychotherapy.

The three days of intense learning were really empowering. From theoretical to practical, from other cases to self, I felt more competent in being able to handle the anxiety issues of my clients. Anxiety is such a natural response that one does not realize when and how it becomes attached to so many stimuli to which it is not a natural response. The abreaction and the cathartic responses that I saw in the in-person training was a wonderful negation of my own apprehensions that how can seemingly funny repetitions of a phrase lead to reduced anxiety. The workshop gave me an opportunity to revisit the theoretical aspects of classical conditioning theory, and helped me to learn the power of sufficient and continued exposure of conditioned stimulus in reducing the associated response of anxiety. From interviewing effectively to explore the underlying issues to prepare the drill for various conditions, the learning is magnanimous.

Participant-II:

Workshop on cognitive drill therapy was an amazing learning experience. It was spread into three days, where on day 1 different cases were told to us of Anxiety, Phobia and OCD. We were

taught of different complaints that patients make in different mental conditions. How do they react in such a state? How do these anxiety states affect their personal, professional and social life? We also learned that behind cognitive drill therapy, one of the theories that functions is the Pavlovian Conditioning theory. The functioning of classical conditioning which is mainly about stimulus and response was explained. How anxiety or phobic responses develop in a person and how such anxious responses get strengthened and how can we break this connection with the help of cognitive drill therapy. We also learned that whatever symptoms we are able to see or reported by the patient they are the overt level and it has a covert connecting cause to it. So it's important to identify it.

On day-2, we learnt about the whole process. How should we start the session? So as the person comes with a problem we should take the case history like what all problems he has, since when he has this problem, how does it affects him, what are the disadvantages, what has he done till now to control or treat his problem. Also explore the overt and covert stimulus or causes that create anxiety. During the history taking session we have to identify all the stimuli that cause anxiety in the person and make a list of it so that all the stimuli can be dealt with during the therapy sessions.

Then after taking the detailed case history, we conduct tests for assessment of Anxiety, Fear, OCD and also use the Visual Analogue Scale to assess the level of anxiety for each conditioned stimulus. After the assessment of the patient next step is to psycho-educate the person about his illness or disorder where we have to tell the person the diagnosis of his problem and how has the problem developed (that can be done by explaining the Stimulus-Response-Avoidance theory). So these three steps case history, assessment and psycho-education has to be done on the first day when the patient comes.

On the second day of the therapy when we have identified all the triggers and reactions we start up with the Cognitive drill therapy in which the person has to keep repeating the statement that has been identified as anxiety arousing in past or present tense. Reason being that anxiety is future oriented and person tends to avoid such stimuli which he assumes will cause him pain so starts avoiding them or do not confront them. Avoiding such stimuli which creates anxiety in the person gives the person a temporarily relief and that becomes a pattern. So in CDT person will repeat the statement in the present or past tense form which as a result will increase his anxiety gradually, will go higher and then gradually will go down(forming the bell shaped curve).This bell shaped curve is also a proof that you are working on the correct stimulus. While doing drill we have to involve lot of sensory modalities like patient will himself repeat the statement that is verbal, therapist repeats the statement and the patient listens to it that's auditory, patient writes the statement down that's kinesthetic.

While doing the drill patient has to visualize the situation as vividly as possible so that he experiences the same anxiety as if it is real. Along with the drill, if possible then we have to dare the patient to either touch the object or to get in close proximity with the feared object. Along with drill and dare we also have to tell the person to distract himself from these anxious thought by getting engaged into his daily activities or social activities because by not doing so person is reinforcing his obsessive or phobic thoughts and giving undue importance to them, So if the person will engage himself into some work or activity will not give unnecessary importance to them. We also have to give homework to the patient for practicing these statements at home. These drill dare and distraction sessions will continue till the time all the

stimulus have been practiced and have lost their anxiety arousing feature and have become neutral.

On day-3 we got a chance to see a live demonstration of CDT, as two of the participants volunteered for working upon their anxieties. One of them was a case of social phobia and another had performance anxiety. So we learned about the practical application of the Cognitive Drill Therapy that we had learned in two days in theory form. Watching a demonstration gave much more clarity to the concepts and brought the realization about the power of this technique. Along with the therapy we also have to encourage the patient to take medication and not to leave it without doctor's consultation. Patient's family members are also to be psycho-educated about the patient's illness and therapist can teach the drill to one of the family members so they can help the patient in practicing at home. The therapy has to be practiced for 10-15 days. It will start showing its effect within this period.

Participant-III: A 3D therapy-Drill, Daring & Distraction:

Dr. Jain is known for his unique expertise of offering, professionals as well as patient friendly therapeutic interventions. He artistically converts complicated therapies into concise therapeutic models, and effortlessly trains his trainees and transforms them into skilled professionals.

Continuing with the trend of presenting complicated therapeutic interventions in concise capsules Dr. Jain has developed a breakthrough therapy 'Cognitive Drill Therapy (CDT)' for the patients with OCD, Phobia and panic attacks. OCD is a chronic disorder and is considered a common psychiatric condition. Treatment of OCD typically involves the use of Psycho-education, pharmacotherapy especially serotonin reuptake inhibitors (SRIs), behavior therapy and cognitive therapy. Cognitive behavior therapy (CBT)/Exposure response prevention (ERP) is considered first line treatment for OCD patients. As Clinical Psychologists across the world know very well that treating OCD, Phobia and panic attacks is lengthy treatment irrespective of the therapeutic model preferred by the professionals, and significant improvement in the illness is also not perceived by some patients which lead to significant dropouts.

Dr. Jain while working with an adult with chronic OCD, had illuminative thought of cognitive drill as therapy. The cases of OCD treated with cognitive drill in combination with pharmacotherapy have been instrumental in establishing CDT as a potentially rapid therapy for treatment of OCD/phobia. He initially prescribes a 10 days course in OCD which can be repeated as per the requirements of the patients. However, in cases of Phobias it usually needs less than10 days course of Cognitive Drill Therapy. He is demonstrating success of Cognitive Drill Therapy in various phobias including social anxiety, agoraphobia and specific phobias. Also it is observed that a simple listening to his approach of Cognitive Drill Therapy, a few patients integrated it into their lives and got improved without explicit and interactive focused sessions with Dr. Jain.

On the first day of the training we were skeptical of success of the CDT in OCD and phobia, social anxiety and panic attack patients per se. We underwent the first day training with skeptical thoughts laden with our own fear of failure to treat OCD originating out of our past experiences with OCD patients. When a larva comes out of its cocoon and converts into an ugly caterpillar no one can imagine that the same ugly caterpillar will transform into a beautiful butterfly. This was the experience of each and every student after completing the three days

training. We were transformed into a confident professionals bubbling with energy and conviction to treat disorders like OCD, social anxiety, panic attacks, phobia in just 1 hour per day for 10 days on an average, depending on severity of the case. The OCD patients however, may need longer time depending upon the severity. Dr. Jain is very clear that this therapy cannot treat 100% patients with equal level of success and no unrealistic claims of absolute recovery from these disorders is claimed. However, the applications of Cognitive Drill Therapy do produce significant improvement rapidly in many cases.

Day 1- Understanding theoretical perspective: On day-1 Dr. Jain oriented us towards new perspective on application of Pavlovian theory of conditioning for extinction of the fear (conditioned responses) with various stimulus of obsession (CS). We were also sensitized that thoughts associated with CS in case of phobia/social anxiety/OCD are originate in brain centers which are responsible for future tenses. OCD patients speculate the consequences of obsessive thought and to avoid the harm and the pain develop various anxiety and fear; and by making a patient do cognitive drill, we symbolically align the patient's brain and in turn get benefited rapidly through following mechanism-

1. Neural pathways of brain (centre of future tense) diminishes responsible for OCD/ anxiety disorder
2. The fear/crystallized anxiety (CR) extinct in absence of UCS stimuli.
3. Patient does cognitive reinterpretation of the fear , underlying themes and attains self efficacy

A few important component of CDT were also elaborated.

1. Anxiety on stimulus can be elicited by its mere mental representation (Covert conditioned stimulus). The process is as follows Covert stimulus covert response (Neural firing & Release of hormone)
2. Emotionally charged words act as conditioned stimulus and has potential to elicit conditioned response (fear/ anxiety). Mere repeating of the conditioned stimulus/word will elicit fear and after a period of time when anxiety (CR) will reach to its peak, it will decline.
3. Therapist needs to identify all possible spectrum of associated stimulus and response (umbrella). And make the patient do drill till the time anxiety (CR) extinct. e.g in case of phobia with dog , the umbrella of CS could be as shown in the picture.

4. There are three systems of anxiety viz cognitive, somatic and affective. This therapy is effective when a patient reports all three systems of anxiety. All systems should be incorporated in CDT.
5. The therapist should prefer all modalities for CDT e.g taking patient to real site, writing, imagining and auditory.

Day 2- Case studies and experiential learning through CDT session on one of the trainee suffering with social phobia: The theoretical perspectives we learned on day-1 were explained by Dr. Jain with supporting case studies. CDT was demonstrated on one of the participants who was having stage phobia. Steps were as following-

1. Taking relevant case history

2. Taking problem statements
3. Identifying underlying themes (umbrella). Make him aware that CDT doesn't eliminate anxiety, but it disconnects the connection between stimulus (feared stimulus) and fears (conditioned response).
4. Identifying three modalities of anxiety viz cognitive, affective and somatic.
5. Psycho-educate the patient about CDT on following aspects-
   A. Meaning of the illness
   B. Three types of anxiety reactions – fight, flight, freeze. We react to feared stimulus by avoidance thereby we avoid.
   C. Fear has many underlying themes/issues which need to be addressed. Identifying the umbrella of stimuli is required. The patient avoids object/stimulus which only give temporary relief from fear, thus real issues are never addressed. e.g A student might be avoiding giving presentation, because he has underlying fear that he may be ridiculed, looked down upon if he makes mistake
   D. Fear has future orientation in brain. By changing the orientation from future to past or present during CDT the neural pathway of fear breaks down in brain.
   E. Fear has its cycle. After reaching its peak fear/anxiety diminishes
   F. Importance of medicine/pharmacotherapy in treatment of OCD. He encourages combination treatment in OCD. Medicine recommendations are invariably made through psychiatric consultations.
   G. CDT is three component therapy- Drill, Daring & Distraction.
   H. Patients should also be told that all existing OCD themes will extinct after therapy but new themes may develop over the period of time, same therapy can be used.
   I. Patients should be psycho-educated for giving NIL Importance to their OCD thoughts and study about OCD as much as possible. He may be recommended to read book 'brain lock' which illustrates OCD is due to thoughts locked in brain.
6. Following test to be taken pre & post CDT
   A. Narration from patient about illness
   B. Visual Analogue Scale
   C. Subjective Reports of Distress
   D. Depending on the case, pre and post CDT tests to administer on the patient. For OCD patients YBOC, Generalized anxiety scale, fear inventory, etc can be used
7. **CDT Session**: Practice session may continue for 10 days (1hr /day plus Home Work). Therapist should make patient perform drill for all stimulus in umbrella using as many modalities as possible (speaking, writing, listening, imagining, and seeing in real). When patient ceases to exhibit anxiety, he should be asked to perform a daring act by facing the feared stimulus in real. If patient doesn't exhibit anxiety; the drill on that stimulus can be terminated as it's the indicator of extinction of anxiety (CR)

A. 1 hour CDT to be done at clinic.

B. Each trigger of anxiety to be given 10-15 min approx. All modalities of stimulus presentation viz. visual, auditory, writing and tactile should be used.

C. Report on level of anxiety to be taken every 30 second.

D. Patient should be given Homework to do CDT at home. He should be advised to keep himself distracted means engaged professionally/socially.

Day-3: Day for skill refinement on CDT: On day-3 feedback was taken from the participant, who had been given the CDT for her stage fear on previous day. It was amazing to witness her cognitive restructuring on her stage fear. It was surprising to notice that she was laughing at her irrational themes of fear. Unbelievably, we also noticed her enhanced self-efficacy. The same participant, who was shivering while narrating her fear, had reframed her thoughts on stage fear. The same participant later reported that after three days she gave a live performance before huge audience without any sign of stage fear

Last day CDT was demonstrated on other participant who was having anxiety for public speaking. Patient of OCD will have many stimulus of anxiety whereas patient of phobia will have limited anxiety.

We all felt skilled and empowered. I also applied Cognitive Drill Therapy by my own and observed extra-ordinary improvement in the condition of the recipients. I am excited to extend its applications as and when I get cases on which this novel and highly effective form of psychotherapy is indicated.

Participant-IV:

After completing a three days workshop on CDT conducted by Dr. Rakesh Jain , First and foremost, I want to say that we Indian psychologists should feel proud on Dr. Jain for developing a new therapy. It is evident that Cognitive drill therapy will prove an excellent therapy for treatment of as complicated disorder as phobias, OCD and anxiety disorders in future. Dr. Jain made it very simple and logical and also taught us in a very effective manner. I personally recommend that it should be learnt by all psychologists as well as psychiatrists. God bless him to keep this sprit for developing other contributions.

Participant-V:

I would like to place on record my sincere gratitude to Dr Jain for giving a soldier an exposure to such a path breaking therapy - CDT which accords an opportunity not only to professionals of this field, but to one and all to make a difference in combating the most common and widespread situation relating to mental health such as OCD and Phobias. The 3 day workshop under Dr Jain's guidance and interaction with wonderful participants was an experience akin to opening of 'chakras'. The uniqueness of CDT motivates us "to go beyond the call of duty" because "If you only do what you can do, you will always remain where you are".

Participant-VI:

All of us are doing well in life but in some areas we are unable to perform to out inherent potential. What limits us is our “Fears”. There are many varieties of fears e.g. fear of enclosed spaces, fear of rejection, fear of failure, fear of success, fear of rats etc. Fear is something about imagined consequences. CDT is a great low-cost therapy that helps us clear our quickly and

efficiently by “facing it”. This therapy destroys the underlying structure totally and completely. As a matter of fact CDT empowers people so that they can clear any new fears they develop in future on their own. CDT reminds me of the famous ad line “DARR KE AAGYE JEET HAI”.

Participant-VI:

Sir, I think that CDT workshop makes us very resourceful in the area of treating phobia and OCD. My own experience as a subject was wonderful. So I am very much assured about its results and now I preferred CDT as my first choice of treatment. Sir, you explain all the concepts of CDT in very easy and simple words. Sir, CDT workshop was really wonderful. I am very thankful to for this workshop.

Participant-VII:

I am proud of being a student of psychology and fortunate to have a 'GURU' like Dr. JAIN SIR. When I heard about CDT, I became eager to know about it. The workshop, organized by Dr. Jain Sir, always attracted me because he has ability to impregnate the knowledge of the topics in our mind in very simple way. I could not resist myself to attend the workshop on CDT. This workshop described systematic procedure of CDT to us, enhanced our therapeutic knowledge to treat the patients by cognitive restructuring and enabled us to make research plans in this area. In this workshop, we could know about hidden, underlying structure of fear. We learned that CDT would help us to treat the patients and we would be capable to enable them to deal with their fear/obsession by 'Soch to Soch' (thinking to thinking) and to get rid of their unnecessary behavior in real life. Thus CDT is a structured way to cope up from fear by verbal exposure. I am thankful to Dr. Jain Sir who is not only my teacher but also enlightened my line of career as a psychotherapist

Most of the participants feel empowered within a span of 2-3 days. They can successfully conceptualize the concepts and applications of Cognitive Drill Therapy and can execute the same on the patients suffering from phobic/OCD conditions.

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21
SHARING CDT WITH EDUCATORS & PSYCHOLOGISTS

I am being invited to conduct workshops on Cognitive Drill Therapy by Institutions, Universities and Colleges throughout the country. Two days workshop is enough to transfer core concepts and skills of drill therapy to the participants. I received an invitation from Regional Institute of Education, Bhopal to conduct one such workshop for 44 trainees of Diploma in Guidance & Counseling Course on 21-22 August 2016. The batch consisted of experienced Educators and Psychologists. I readily agreed to conduct the workshop. My choice was strongly influenced by my concern that the students in educational system have high prevalence of Social Anxiety. Because of this anxiety they feel inhibited to express themselves in classrooms, group discussions, seminars, debates and interviews. Even talented and bright students suffer from social anxiety. This suffering takes a toll on their life style. Because of social anxiety they may begin to use substances of intoxication and even feel depressed. The net outcome of low participation in expressive activities leads limitations on realization of their full potentials, inhibition in creative expressions which taken together results in National loss. Hence, I am strongly convinced that we should empower teachers and counselors working in the schools with the technology of Cognitive Drill Therapy so that they can identify and help the students in overcoming social anxiety. If we could intervene into social anxiety in the formative years of education, then this would result in better achievements, creativity, social relationships, self-esteem, self-confidence, contribution to the society and the Nation.

Usually, it takes a few days to overcome social anxiety to a reasonable level. We need to make students aware of their social anxiety and help them out. Even the teachers do have social anxiety. Because of this anxiety, the teachers may not deliver optimally to their students. This scenario of social anxiety makes an urgent call to the mental health professionals to deal with the condition at massive level. We need to take care of both the teachers and the students in the educational setup so that they can put their maximum to the academic and personal development.

Having oriented to the need and importance of intervening into social anxiety, I introduced Cognitive Drill Therapy to the group by highlighting the concept of Two Layer Structure in phobia. The two layers are (a) Conscious Layer (b) Sub-conscious Layer. The conscious layer consists of three components (i) Objects of fears (ii) Body-mind reactions (c) Safety behaviors. The subconscious layer consists of 'danger perception'. In case of social anxiety, the two layer structure would be as follows:

Conscious Layer:

Objects of Fear: speaking before elders, strangers, known group, in public, authorities, stage, debate, interview etc.

Body-Mind Reactions: When exposed to the social objects of fear, an affected person may experience multiple body-mind reactions such as shallow breath, rapid heartbeat, hot/cold flashes, blushing, dry mouth, butterflies in the stomach, dizziness, blankness, trembling, speech hesitations, becoming self-conscious etc.

Safety Behaviors: In order to overcome painful body-mind reactions and social anxiety, an

affected person may find excuses to avoid social objects of fear, avoid eye contacts, may develop some physical illness prior to participation in social activities, sit on the back, try to hide from the view. Or involve in extensive preparations prior to social encounter and use positive affirmations.

Sub-conscious Layer:

Danger Perception: Usually, the person affected with social anxiety has following kinds of thoughts of danger perception:

i. People will make fun of me
ii. My image will get tarnished
iii. People will come to know about my incompetence
iv. People will reject me
v. People will criticize me
vi. People will begin to ignore me
vii. What others will think of me?
viii. People will judge me

A person with social anxiety remains trapped into conscious layer and keeps on dealing with the components of conscious layer. Rarely, he/she work on the subconscious layer of danger perception. Since, the subconscious layer remains intact, the person continues to experience social anxiety for years until effective resolution. The goal of treatment is to make corrections in the thoughts of subconscious layer.

A perusal of the thoughts of subconscious layer would quickly reveal the future perspective. Anxiety looks into future. Under conditions of anxiety, a person tends to use future tense in his/her sub-vocal speech. There are three tenses – Past, Present and Future. We can use notations for three tenses – A=Past; B=Present; & C=Future. Also, I am speculating, there might be three areas in the brain that process three tenses. We can use the same notations for brain areas corresponding to three tenses. A=Past; B=Present; & C=Future. The idea is that anxiety is associated with future tense. If we could modify the anxiety related statements into past or present; then those statements would not trigger Centre 'C' in the brain. For this simply change the tense. The statements after tense change would appear as follows:

i. People have made fun of me
ii. My image got tarnished
iii. People have come to know my incompetence
iv. People have rejected me
v. People have criticized me
vi. People have begun to ignore me
vii. Others have thought of me
viii. People have judged me

Over the period of time, these evaluative and inference judgments of other people's thinking and reactions become associated with fear reactions. In accordance with the principle of habituation, if these statements are repeated for sufficient frequency and duration; then it would produce habituation. Hence, in cognitive drill, a person is required to repeat, repeat and repeat the tense converted statements.

Initially, imaginal and verbal exposure is implemented in following manner. “imagine a social situation, and repeat above statements”. Keep on repeating. If verbalizations of these statements activate body-mind reactions to a high level, then a pause of 1-2 minutes is given for natural reduction in distress. When the distress, is reduced to medium or low, the drill is resumed. To monitor, the pattern of reactions, every 30 second, a report of distress is obtained from the person. He/she may report it out of 100 or as low, medium or high. Visible changes are expected within 3 days application of drill therapy. However, I recommend a usage for 21 days. Homework assignment of the same drill is given to the affected person. He/she is to practice drill for 60 minutes which can be broken into two sessions of 30 minutes. A drill diary is to be maintained for recording the experiences with the drill and the problems of social anxiety including any other issues in the life. The goal of imaginal and verbal practice is the normalization of body-mind reactions to verbal and imaginal exposure. The affected person may express disbelief in the power of drill therapy. He/she need be assured that the effects of drill will be perceptible within 3 days. If not, then other methods could also be added.

When, body-mind reactions get normalized to verbal & Imaginal Exposure, we need to move forward for daring. In daring, an affected person is to expose himself/herself to the real social situations and express himself/herself. During exposure to actual situations, the drill should be continued. The drill is to be done sub-vocally in social situations. While with the therapist or alone, drill verbalizations can be done.

Cognitive drill breaks the functional connections between stimulus and response. Objects of fear are the stimulus and fear is the response. It means the objects of fear usually remain unchanged but lose their power to activate fear reaction. Stimuli get neutralized. Similarly, fear reaction remains in the personality. It cannot be eliminated from the personality. Fear has an adaptive function. It is not possible to kick it out from the system. The secret to change is the successful breaking of stimulus-reaction connections through drill therapy.

To achieve the goal of successful disconnection between objects of fear and fear reaction, we must identify and enlist maximum number of objects of fear in a numbered bullet. For example,

1.Speaking on stage
2.Speaking before known group
3.Active participation in group discussion
4.Participation in debate
5.Oral practical examination
6.Selection interview
7.Speaking to Head of the Institution
8.Speaking to teachers
9.Speaking to elders
10.Speaking before unknown group
11.All other similar situations to be recorded specifically

The drill should be done for each identified object of fear. If any listed or unlisted object of fear is left out from the drill, it might continue to have fear evoking potentials. The drill will break the connection between drilled object of fear and the fear reaction. An expectancy that reduction of fear from one object will spontaneously reduce the fear in undrilled object may not hold true. Hence, aim for drilling as many objects of fear as possible. Also, it is seen that an

undrilled object of fear is encountered after a gap of a few months. The exposure to such undrilled object will elicit fear reaction. If it happens so, drill should be performed for newly identified object of fear.

Similar is the case with the thoughts of danger perception. As far as possible, all thoughts of danger perception should be identified and listed in a numbered bullet. For example,

1. People will make fun of me
2. My image will get tarnished in people's mind
3. People will come to know that I do not know anything
4. My deficiencies will be exposed to others
5. People will have a surprise expression that I do not know even such a simple thing
6. People will humiliate me
7. People will begin to ignore me
8. People will judge me negatively
9. People will have a negative impression of me
10. All such similar thoughts of imagined feared consequences should be identified and listed

To implement the drill, imagine first object of fear and verbalize entire list of the thoughts of danger perception by converting them into past or present. When it gets normalized, then take up next object and so on. Perform drill in imagination with each object of fear and the list of thoughts of danger perception. When complete list is normalized, then daring is recommended. In daring, face the objects of fear in real life and perform the drill sub-vocally. Continue to do it until reduction of fear in real life situations.

Apart from verbalizations, following methods can also be used to perform the drill:

1. Record the converted drill statements in your mobile and listen to them for about 30-60 minutes daily
2. Write the converted drill statements for 30-60 minutes in a drill diary.
3. Read the converted drill statements for 30-60 minutes daily.

After clarifying the concepts and the techniques involved in the drill therapy, I proceeded to live demonstrations. I asked the group, how many of them are having social anxiety. About 10-15 hands were raised. I invited them one by one on the podium and made them practice the drill for their thoughts of danger perception. On an average, most of them reported significant reduction in their social anxiety within 10-15 minutes. I made following observations:

1. The conceptualization of drill therapy itself empowers the participants to deal with their social anxiety
2. Workshop group is a social context and performing drill before the group is a real time exposure to the objects of phobia which involves inherent daring
3. The participants could freely verbalize their thoughts of danger perception
4. Participants felt comfortable and confident after performing the drill
5. Regular practice of drill was prescribed to each of them

I explained that cognitive drill therapy produce following three outcomes (a) habituation of

fear reaction to objects of fear (b) increased self-efficacy that they can now handle the situation (c) Cognitive Reinterpretation of the danger perception. The danger perception gets modified and now the objects of fear no longer appear to be threatening.

I also enquired about their learning experience of drill therapy. They expressed that they could learn and imbibe the technology of drill therapy. Also they attested to the empowerment potentials of drill therapy. They felt that they are confident enough that they would be implementing this therapy in their classrooms to enable the students to overcome their social anxiety. I am sharing their feedback so that readers could have an idea that this therapy can be easily conceptualized by the participants.

Participant-I:

Thank you Sir for telling me the crux of CDT. I could easily understand the two layered structure - the top layer and the bottom layer. I could also assimilate objects of fear, body-mind reactions and safety behavior or avoiding measures. I could also know the danger perception. I liked the concept of drilling, taking pauses, intervening, checking the anxiety at regular intervals. Thank you so much for transferring these skills to me. Surely, I have been benefitted a lot through your simple but amazingly effective style of handling the sessions. The practical part is absolutely wonderful. Thanks a lot for telling OCD, types of OCD and how CDT can be effectively used to help the person suffering from OCD. Once again, Thank you very much.

Participant-II:

It was a great and unique experience to learn CDT from you. I learnt the top and bottom layer and partition of CDT fear factor, body-mind reactions, safety behaviors and danger perception. As a school teacher I feel it will be of great help for me to reach out to students in their adolescent age and help them out. The best part of this workshop was real life activity and multiple live demonstrations. Thank you very much Sir.

Participant-III:

CDT Therapy developed by Dr. Rakesh Jain, Indian Clinical Psychologist (we are proud of it) basically for Anxiety disorders and phobias. Basis of anxiety lies in future tense. Brain has 3centres A, B and C corresponding to past, present and future tense. Components of CDT

Upper Layer:

a. *Objects of fear*
b. *Mind Body Reaction*
c. *Safety Behaviors*

Bottom Layer:

a. *Danger Perception*

Drill means to change the danger perception from future to past or present. Time to time percent of danger is to be asked. If discomfort level is high then pause needs to be taken. Drilling should be given for home work. To check daring has to be taken.

Participant-IV:

Hello Sir, your CDT session was wonderful and I am sending the feedback of your session

what I have understood. Cognitive Drill Therapy is a therapy which actually confronts the subconscious irrational thoughts and danger perception of the client and make them realize that the objects of fear (perceived threatening event) are not that much threatening---> decreases the anxiety and fear which actually blocks the self expression. Flow chart of fear is as follows: Objects of fear--->develop underlying danger perception--->body-mind reactions---> avoidance behaviors. Actually a distorted relation was developed in the past between the Conditioned stimulus (CS)--->triggers future tense thoughts--->Conditioned Response (CR). Through CDT this distorted relation is restructured by replacing the future tense thoughts with PAST TENSE THOUGHTS. Thank you Sir for your guidance and training session.

I am hopeful that acquisition of Cognitive Drill Therapy skills by Educators and school psychologists and counselors can do larger goods in the domain of social anxiety by intervening at the early stage. Liberating young students from their social anxiety will enable them to a fulfilling life to a greater extent and will provide an opportunity for them to realize their optimum potentials in the activities that require presentations and participation in social context.

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ADDITIONAL CASES

Single session of CDT for Contamination OCD:

An adult female presented with more than 20 years h/o contamination OCD characterized by distress, anxiety, fear and irritability coupled with nausea feelings for contamination in toilets. She keeps her bathroom spotless which is a cause of concern because of time consumed in cleaning and issues with husband and children regarding maintenance of cleanliness. She would ensure clean toilets. Due to the concern over cleanliness, she finds it extremely difficult to use public toilets or toilets of other houses. She would hold herself from using others' toilets as far as possible. She uses specs. While using others' toilets she would either remove specs or would not switch on the lights to avoid noticing any spots, site of hairs, shit and wet soaps. Also, she would try to distract herself from the mental images of contamination or try to eliminate those images from awareness.

In her teen age, she had to use extremely dirty public toilet which precipitated her problem. Also she was in NCC and did a course in mountaineering where she got exposed to dirty places. Quick Cognitive Drill Assessment revealed following fear structure (imagined feared consequences)

1.She would not be able to eat.
2.Hairs could come into food items
3.The mental images of shit would dominate her mind and she would not get rid of them
4.She would feel nausea.

She was given psycho-education that she has been avoiding the contaminated objects of surface structure. She never worked on underlying fear structure. The fear structure is responsible for continuation of her problems. If she works on the underlying fear structure then the contaminated objects will cease to elicit the problematic reactions.

Cognitive Drill Therapy was applied on her and she was asked to form mental images of shit and repeatedly verbalize feared consequences in past or present time reference. Initially she felt visibly anxious, defensive, hesitant and tried to avoid mental images of contamination. The drill continued with pauses for 30-90 seconds as and when the SUDs were medium to high. After 20 minutes of the application of Cognitive Drill her reactions significantly subsided to imaginal and verbal exposure. She was then taken to others toilet as a behavioral test. She did not feel anxious however, because of the fear of anxiety activation she took 2-3 minutes to come near the gate of the toilet. She was not forced into this exposure. She felt comfortable to stand near the gate of the toilet.

After one hour of this application she comfortably took her lunch even when the bathroom door was open within her vision. It was recommended to her that she should continue practicing the drill and it is likely to reduce her OCD significantly.

Another Case of Contamination OCD:

A young adult was having contamination OCD for several years. He has being receiving regular treatment. But his contamination OCD was still persisting. He would feel severe distress when exposed to dirty objects. It was noticed that he was having more discomfort particularly in wet contaminated objects and the places where white ants were present.

Beneath this surface structure he was having fear of "inhalation of germs". For processing of his fear of germs; I asked him to do drill in imagination and at verbal level for the germs. He was required to imagine wet contaminated objects and verbalize "germs inhale kar chukka hun"; "germs inhale kar chukka hun"; "germs inhale kar chukka hun" (I have inhaled germs).

When he felt comfortable with imaginary drill, I exposed him to wet contaminated objects and places of white ant in real. He demonstrated severe discomfort to this exposure characterized by itching sensations in the body and perceptible body tremors. I told him that he need not touch these wet contaminated objects. He need to just keep his palm over it and keep on verbalizing "germs inhale kar chukka hun"; "germs inhale kar chukka hun"; "germs inhale kar chukka hun". Because of severe discomfort, I had to give extended pauses in between. I also prescribed the same exposure to him as homework. He performed this drill at his home also. Within a few days of this exposure and drill; he is now having negligible discomfort to wet contaminated objects and places of white ants.

Spider Phobia:

A young girl reported a phobia and disgust for spiders. Following objects/situations of fear were identified:

1.Exposure to spider
2.Spider on the body
3.Big size spider
4.Distance of spider
5.The texture of spider

She had typical body-mind reactions of fears characterized by accelerated heart beat, rapid breathing, startle reaction, dilated pupil, goose bumps, nausea and so on. The safety behavior was quite prominent. She would either run away/withdraw from the place or remove the spider with a long stick. The thoughts of underlying danger perception were as follows:

1.If it falls on my body I would become unconscious
2.Spider would crawl on my body
Following cognitive drill was formulated and practiced for 15 minutes:
1.Spider has fallen over my body, I have become unconscious
2.Spider is crawling over my body

She performed above drill in imagination. Then she was taken to a point where a spider was visible on the ceiling. She performed drill by seeing the spider on ceiling. Then she was shown images of spider. Again the drill was practiced during exposure to images. Having done this, she was asked for daring by hitting the spider on ceiling with a tiny object. She threw the object on spider and stood below that so that if spider falls, it would fall over her body. The rise and falls in body-mind reactions were observed in during drill and daring. Within minutes, she could overcome the body-mind reactions by continued drill.

Monkey Phobia:

A young girl reported phobia of monkeys. She had following danger perception that monkey could attack on her and she may die. She was prescribed following drill "monkey has attacked me". Within a few minutes she was able to overcome severe body-mind reactions to a normal level. She needed drill dilution because she was having very high distress when drill was

initiated. She continued the drill and overcame her fears and body-mind reactions. Then she was shown images of money which were apparently dangerous. She could drill and minutely inspect the images with no discomfort. Instead, the entire topic of monkey became the point of amusement.

At times, drill can act very fast specifically in cases of phobia. The only thing is that we need to identify the thoughts of danger perception and drill those thoughts by imagining the objects of phobia or real-time exposure to the objects/situations of phobia.

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23
RESEARCH IDEAS IN DRILL THERAPY

Cognitive Drill Therapy has immense potentials of research. There can be so many ideas and areas to work with. I am enumerating my thoughts and vision of research ideas for CDT. There can be many more ideas which can be conceptualized and executed by creative and passionate researchers.

1. **Case Studies**: Since CDT is still in its formative stage, we are contemplating a huge number of case studies that can be worked out using CDT. I am encouraging therapists to maintain systematic record of each case which includes case history, clinical interview, formal assessment of severity, cognitive drill assessment, cognitive drill protocol, session-wise details of work up and follow ups. Each case is a potential case study. I have noted that the cases of pure obsessions, contamination OCD, social anxiety, examination anxiety, specific phobia including lizard phobia, fear of skin disease, fear of germs and agoraphobia are responding to CDT quite favorably. If we can generate good number of case studies, that itself would serve the basis for larger group studies. Also the range of conditions covered in case studies and the responsiveness of CDT would provide a basis for more number of case based studies.
2. **Within Group Studies**: Pre-post and follow up group studies could also be carried out for any of the phobia and OCD. In the beginning, social anxiety and specific phobia of any type can be good starting point for within group studies. Such studies would involve comprehensive baseline assessment, execution of CDT protocol for 10 sessions, post assessment and follow up assessment at 03 and 06 months. The sample size can be anywhere between 10-30 patients in one study.
3. **Between Group Studies**: The comparative studies between groups can be conceptualized in many ways. The simplest study would be pre-post study of two groups (a) CDT group (b) reference group. Identify any specific disorder and implement CDT protocol in one group and the second group does not receive the treatment. I could be wait listed control group. Again the assessments would have to be carried out at three points (a) Baseline (b) Post CDT (c) follow up.
4. **Comparison of CDT with Other Therapies**: More than one group can be recruited where one group receives CDT and other groups receive other forms of treatment such as ERP, Cognitive Restructuring, REBT etc. Such studies would help in documentation of the effect size of CDT and whether it is really useful in comparison to other forms of existing therapies.
5. **Integration of Psychophysiological Parameters**: While conducting any kind of study on CDT, be it a case study or a group study, psychophysiological parameters such as galvanic skin response, heart rate variability can be monitored before, during and after treatment with CDT. This will provide an objective evidence for the efficacy of CDT.
6. **Applicability of Single Subject Designs**: Single subject designs such as ABAB Design, Multiple Baseline Design, Changing Criterion Design can provide an excellent design framework for evaluation of the efficacy of CDT. Until, group studies takes up, I would recommend the researchers to consider this design for conducting robust studies on CDT. There are several good resources which can be used to become familiar with single

subject designs.

7. **Brain Imaging**: If someone can take up high-tech researches, it could do wonders in the understanding of CDT. What happens in the brain when a person is performing cognitive drill and what changes take place in the brain upon completion of the drill and reduction/ elimination of fears.
8. **Extension of CDT**: I have been applying CDT in cases of phobia and OCD. Other therapists are taking it beyond these conditions. Researches can be conducted to explore to what extent CDT is useful in the conditions like envy, depression, PTSD, anger management and the like.

With increasing application of Cognitive Drill Therapy, more and more researches will be undertaken by the researchers. Since CDT is based on scientific principles of psychology, it is bound to get a boost in due course of time.

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24
RECOVERY FOCUSED BEHAVIOR THERAPY

The persons affected with OCD and Phobia remain struck in habitual behaviors of avoidance for ensuring safety. In their mind they have a mental picture of their phobic and OCD behaviors. The mental picture that represent phobia can be termed as "Phobia Image' and the mental picture that represent OCD can be termed as "OCD Image". The set of behaviors such as changing routes of the street for fear of dog are linked with "Phobia Image" and the set of behaviors such as repeated hand washing are linked with "OCD Image". Such persons also have healthy mental image which does not contain phobia or OCD. Such mental image is termed as "healthy mental image". The affected persons know what the healthy behaviors are.

These persons want to get rid of their 'phobia image' or 'ocd image' and aspire to live in accordance with 'healthy image'. In order to live by 'healthy image' they tend to push away or get rid of behaviors of phobia and OCD. They try to mentally and behaviorally restrain themselves from getting into phobic and ocd behaviors but sooner or later their struggle fail and they submit to the behaviors of 'unhealthy mental image'. The more they try to resist the behaviors of 'unhealthy mental image' more they get into the trap and feel compel to get involved in avoidance and safety behaviors.

This struggle is unnecessary. There is a simple solution to attain the goal. The goal is to live by 'healthy mental image'. To attain this goal, the affected person should get rid of the mental trap of eliminating 'unhealthy mental image'. Instead, they should directly focus on the 'healthy mental image' and emit behaviors that represent 'healthy mental image'. Ignore 'unhealthy mental image' and its behaviors and focus on 'healthy mental image' and its behaviors. I am exemplifying this with real cases.

Case Study-I: A 36 years old female presented with contamination and checking type OCD of six years. She was spending lots of her time in cleaning activities and if things are not cleaned she was getting severe BMR. Most of the time she felt compelled to get into the cleaning activities. Psychiatric treatment was yielding partial and intermittent relief in her. In the first session, I listened to her elaborate story of OCD and then said to her that when she will be fully recovered she will touch all dirty objects, she will have no BMR and there would be no need of cleaning.

I demonstrated before her and touched several objects and told that "when she is fully recovered she will touch all dirty objects as I am touching and there will be no BMR and there will be no need to clean herself". I demonstrated it with multiple objects. She keenly observed my touching of many dirty objects and conceptualized the goal of 'emitting behaviors in accordance with healthy mental image'.

Thereafter, I encouraged her to demonstrate me how she will be touching dirty objects when she is fully recovered from OCD. She too followed the same procedure. Touched several objects and repeated that she will touch the dirty objects and there would be no BMR and no need for cleaning.

Within three days she had an extra-ordinary improvement in her OCD and the sessions were terminated after five sessions.

Case Study-II: A therapist shared with me that she had a person affected with social anxiety. He would not speak before others and felt conscious and feared rejection and ridicule. When he was asked to act on his 'healthy mental image' how would he speak before others when he is fully recovered; he delivered a speech for 15 minutes then and there.

Case Study-III: Another lady was also reported to have issue of contamination. She was asked to show how she would be handling dirty objects when she is fully recovered; she comfortably demonstrated handling of multiple dirty objects without any BMR and need for cleaning.

Case Study-IV: A young adult is having an obsessive issue of skin disease due to applications of soaps. He tries many soaps and uses lots of water and efforts to clean his face to ensure the safety against probable skin disease due to incomplete soap cleaning. He was required to demonstrate the face cleaning with soap when he would be fully recovered. He comfortably demonstrates the face washing with soap without any BMR and repetitive and ritualistic patterns of face cleaning.

The idea is to emit the behaviors in accordance with 'healthy mental image'. You must actually show others may be your friends or family members, how would you perform when you are free from OCD or Phobia.

This simple focus shift can do wonders in some cases.

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25
CBT MANAGEMENT OF OCD

Cognitive Behavioral Conceptualization of the OCD:

For understanding CBT management of OCD a clear understanding of Cognitive Behavioral conceptualization of the OCD disorder is cornerstone of success for both patient and more importantly for any CBT therapist. It highlights the areas on which both are going to work. Without a route a ship in voyage is a terrifying idea.

To start with modern cognitive behavioral conceptualization of OCD, here it means trying to understand more essentially the maintaining factors of the disease than looking out for etiological factors we are mentioning the key maintaining factors of OCD in terms of CBT conceptualization:

a) Negative appraisals or interpretation

b) Faulty maladaptive coping strategies by patients to their symptoms; which is again divided in two ways;

   i) Avoidance behaviors

   ii) Compulsive acts itself

Now to illuminate in brief the above mentioned maintain factors, we will start with Negative appraisals which consists bedrock of Cognitive Model (not Cognitive Behavioral Model). It rests on premise that intrusive thoughts are essentially universal human experience. Rachman & Silva (1978) initially reported that over 90% of a community samples reported occasional intrusive, repugnant, unwanted thoughts, images or impulses. Salkovskis & Harrison (1984) reported that thought of non OCD sample did not differ in content from those experienced by people diagnosed with OCD. However, what did differ was the meaning attributed to the intrusive thought. Non OCD people appraised the intrusive thoughts as having no special significance, whereas people diagnosed with OCD appraised these thoughts as threatening meaning and personally relevant. The threat simultaneously produces emotional distress and the urge to engage in overt or compulsive acts that functions to reduce both threat and distress (Carr; 1974, Mc Fall 1979 & Salkovskis, 1985). For example one thought being affected by disease by seeing a death of someone. A non OCD person would not place any special significance on this thought but a OCD people may appraise the same thought as indicative of future danger and lesson for him to take some firm steps. If he ignores then devastating consequence may happen to him. This threatening appraisal would clearly lead to anxiety and the urge to take necessary steps in order to be contamination free. The threatening appraisal is what initially maintains behavior, without it, the emotional distress would be minimal or nonexistent and the urge to engage in a behavior that functions to decrease the threat would be unnecessary.

Many researchers & clinicians mentioned types of such faulty negative appraisals which are of importance to OCD out of which six are considered highly replicated. Out of these, Salkovskis reasoned Inflated Responsibility appraisals are of central importance. Salkovskis (1996) regards responsibility as “the belief that one has power which is pivotal to bring about or prevent subjectively crucial negative outcomes”. Obsessive Compulsive Cognitions Working Group (OCCWG) has suggested five appraisals domain in addition to responsibility (OCCWG,

2001). The beliefs are;

i) Over importance of thoughts
ii) Control over thoughts
iii) Overestimation of threat
iv) Intolerance of uncertainty
v) Perfectionism

Overimportance of thoughts can be summarized as giving a thought merit because it was experienced (i.e., the thought was important which is why it occurred and it is thought about because it is important). The reasoning behind overimportance of thoughts is circular (Whittal et.al, 2001). An additional concept is thought action fusion (TAF) (Rachman & Shafran, 1998). TAF is thought to be operating when thoughts and action s are inappropriately fused together. There are two suggested component; moral TAF and likelihood TAF. In moral TAF, having the thought and engaging in the action are seen as the same (e.g., having an intrusive unwanted sexual thought is equivalent to carrying out the act). Likelihood TAF entails a higher probability of an event happening because the thought occurred (the probability of diseases increases because of an intrusive thought of contamination). Both cause extreme guilt, shame & severe distress hence one does anything everything which decreases anxiety or such like compulsion or avoidance which are reinforcing in nature.

Control over thoughts, another faulty type of appraisals, is similar to previous domain in which the distress is hypothesized to be produced by the perceived catastrophic consequences if the intrusive thoughts are not controlled (Clark & Purdon, 1993). A typical response to intrusive uncontrollable thoughts is an effort to suppress it, while it actually increases the frequency of such thoughts in more severe form and in result and one more tries to further suppress and so on a escalation in more circular form happens and one becomes more frustrated and distressed.

Another faulty reasoning process of **overestimation of threat** is likely common as in case of other anxiety disorders. This appraisal is highly restructured and dealt in case of both cognitive & behavioral approach of Exposure techniques which we will discuss later.

Intolerance of uncertainty, though mostly associated with generalized anxiety disorder even in case of OCD especially in symmetry based compulsion it is perhaps more stronger. It is usual with OCD patients that they know the behavior (e.g., locking the car) was done. However, because it doesn't 'feel right' or they are not absolutely certain, the behaviour must be repeated. Even a small seed of doubt is unacceptable likely due to consequences associated with it.

Another faulty appraisal associated more strongly with symmetry compulsions are of **need of perfectionism**. It is the "tendency to believe there is perfect solution to every problem, that doing something perfectly (i.e., mistake free) is not only possible but also necessary, and that even minor mistakes will have serious consequences" (OCCWG, 2001). Strive for this escalates compulsive acts which perhaps have no limit.

Now let's understand the other maintaining factors which are more behavioral in nature but further fuels the faulty cognitive part of the patient.

Obsessive thoughts, impulses and images usually concern themes which are personally

relevant, repugnant and build imaginable catastrophic fears. Subsequently when obsessions occur then it is understandingly accompanied by feelings of discomfort or anxiety, the more personally unacceptable the more uncomfortable one becomes on its occurrence. Then the individual tries to find something which is aimed either to decrease such elevated anxiety or distress or to neutralize the imaginary consequences these are attached with. And such acts often take form of either or both compulsion or avoidance.

Compulsions are usually carried in stereotyped or idiosyncratic which brings temporary anxiety relief and the expectation that had these not been carried out then the anxiety has increased or the dreadful consequences would have been inevitable.

Patients also develop avoidance behaviors, keeping away from situations or objects which trigger obsessions. For example patient with contamination fears may avoid public toilets, places; patient with sexual thoughts may avoid looking opposite gender, people with pathological doubt (checking) may avoid shopping and buying things for his own. For patient this acts on a principle that of "prevention is better than cure or for them avoidance is better than cure."

In both the acts, compulsions and avoidance, gives temporarily relief. This "relief" is reinforcing in nature. Imagine a situation in your occupational setting where you are given reward for something. Then it will motivate you do the same work for which you got it. Similarly these temporally relief acts as such reward on reinforcement, so when ever in future obsessions happens the patients uses the method that which gave him success. But he is not aware that these acts of temporary relief strengthen his faulty fears in a long run, hence making the disease stronger on each acts of this.

In summary, "avoidance prevents exposure to the feared thoughts, and compulsions terminate exposure; both types of behavior prevent the patient from confronting (being exposed to) his feared thoughts and situations" (Salkovskis, 1997). Compulsions and avoidance thus prevent reappraisal: if the patient stops these behaviors, he discovers that the things he is afraid of do not actually happen. Thus these two own way of coping the problem by patients makes the disorder more firm and habitual in manner.

CBT Management:

As we have mentioned earlier the first and perhaps most important step of CBT of OCD is understanding and communicating the patient that what are the maintaining factors of their OCD and how their own "coping acts" are maintain the problem and their own role is foremost building block of their success in overcoming it. In short rationale of treatment has to be communicated efficiently i.e., how each of the step is actually going to give them success.

Exposure and response prevention (ERP): For the past 35 years, the psychosocial treatment of choice has been exposure and response prevention. Treatment using this approach involves developing a hierarchy of presenting symptoms, from least fear producing to most, and then guiding the client through exposure to items on the hierarchy until the highest level items are readily tolerated at the same time response prevention is included, whereby the client is asked to refrain from completing the compulsions that would otherwise eliminate the anxiety or distressing emotional reaction (Rowa et al., 2007).

ERP can be delivered in two ways.

In Classical Habituation model, ERP involves exposing the patients to the anxiety triggering stimuli in a graded manner, starting with the item that illicit at least moderate level of anxiety or distress. It should be explained the patient that often people think that the anxiety will continue and becomes intolerable, rather it does not increases to intolerable levels and after subsides more rapidly than they might expect. Sometimes within ten minutes, at times may be half an hour or an hour, but it will. It is also to be explained that they will notice that after they have done exposure two or three times, the amount of discomfort they get at first becomes less and less. This is the best indication of how the treatment is working, as time goes on, they will find that they are able to do the exposure and get no discomfort at all.

Even in a single session, when ERP is about to be started it is advisable to take SUD rating (out of 100) of the patient of how uncomfortable he/she feels at that moment, then after every 10 minutes same can be asked him to re rate out of 100, this should continue till he feels less anxious or score on SUD rating significantly lower. On in a rule of thumb it should last 45 minutes at least. This subjective experience of decreasing anxiety will be counterproductive to his past belief that "anxiety is intolerable and will escalate forever" and also will be self reinforcing in nature.

ERP as Cognitive Restructuring Tool: Aside of using as habituation tool, here what we do is that we invite patient (after rationale and conceptualization) to challenge the obsessions without doing avoidance and compulsions and observe whether their feared anticipatory consequences actually happens or not. For example one involving in repeated washing of hand would be asked to soil his hand deliberately and make him seat without washing 1 hour and observe in 12 hour basis whether he or family has been in any disease, or modification that only immediately wash soiled hand for only one minute and go on touching his family members and see whether in 12 hour check period has any one fallen ill.

On basis of that they are encouraged to restructure the beliefs that repeated washing is not needed or even one minute is enough for it. It's better to demonstrate few ERP sessions with therapist in beginning but key lies in multiple home work sessions to be carried out. We basically involve family member in treatment session so they can push and motivate patient for homework sessions. Another thing it has be to clearly stated that in every session at beginning he will feel intense discomfort and anxiety so he is not to be afraid of.

Some data suggest that ERP is more effective if it includes not only habituation but also discussion of feared consequences and dysfunctional beliefs (Freeston, 1997). The method of delivery is important with in vivo therapist– assisted ERP, in conjunction with imagery, reported to produce the greatest change in symptom severity.

Success rates for treatment completers are approximately 80% (Foa & Kozak, 1996). Treatment gains are typically maintained over the long term (Foa & Kozak, 1996). A similar or slightly higher efficacy of ERP therapy as compared to SSRIs was found in several clinical trials (Mawson & Marks, 1984) and in several meta analyses (Van, 1994; Abramowitz, 1997; Kobak, 1998), having been definitively consolidated as the first choice treatment when rituals prevail and the symptoms have mild to moderate intensity.

Since ERP is reported to be a difficult treatment to tolerate where drop-out and refusal rates range are seen the clinician has to supplement with additional techniques to support his cause for success. What we do is integrate these motivational interviewing methods and supportive

techniques aimed with humanistic orientation. Even on minor success, how trivial it may be, we try to give as practical examples can like, situation of infant when he starts babbling or imitating human speech, does he ever leave that well I will only speak when I master at it? Does he (patient) when started to learn cycle leave it when he fall down while learning?

Cognitive Restructuring Techniques:

The concerns with classical ERP led to the development of alternate theories that would more directly address the changes that were thought to account for a decrease in the severity of OCD symptoms. It was consensually proposed that OCD patients attach a threatening meaning to the intrusions, whereas those without OCD appraise similar thoughts in a more neutral fashion (Carr;1974, Mc Fall 1979, Salkovskis, 1985). It is the appraisal that produces the emotional distress and the urge to neutralize the intrusive thought and these faulty appraisals are distributed in six domains: tendency to overestimate the risk and the responsibility; the importance and the power of thoughts and the need of controlling them; the need of certainty; and perfectionism (Salkovskis, 1985).

The identification of dysfunctional beliefs in OCD patients has led some authors to propose and adapt cognitive techniques for the treatment of OC symptoms (Salkovskis, 1985, 1989, 1998; Rachman, 1997). In parallel, some clinical trials have proven the effectiveness of using cognitive therapy alone for the treatment of OCD (Emmelkamp,1988). Similar efficacy was seen between cognitive and ERP therapies (van Oppen, 1995; Cottraux, 2001; McLean, 2001; Whittal, 2005).

Here, like other CBT oriented methods, after explaining model of the next step is ti discuss the rationale for treatment. Given that intrusive thoughts are nearly universal the obsessions are not the target for treatment. It would be near to impossible to stop thoughts that are normal experience of being human. However, it is reasonable to target the way in which these intrusive thoughts are interpreted.

The insight that the content of thoughts are universal in nature can be encouraged by asking patients to conduct survey of the frequency of intrusive thoughts amongst their friends and/or family members. To accomplish the task list of intrusive thoughts reported by non clinical samples can be given to them (Rachman & de Silva, 1978).

Apart from normalization another important task is make patient learn to distinguish appraisals from obsessions. There has been some disagreement among CBT therapist on when cognitive interventions should be introduced. We are in favor that we may start with cognitive tactics aimed at faulty appraisals and then introduce ERP both as habituation and restructuring techniques because cognitive interventions are usually less threatening than ERP sessions and client can be mentally and cognitively prepared for challenging behavioral work to follow.

Appraisals:

To make client learn to distinguish appraisals from obsessions many authors have suggested that appraisals can be described as “your interpretation of the obsession”, “what the obsessions means to you,” “what you think of obsessions,” or “the importance given to thoughts,” “What makes this a significant thought for you?” “What’s so upsetting about this thought?” “What is that makes it to difficult to ignore you?” (Freeston & Ladouceur, 1997; Whittal & McLean, 1999).

Once a client has explained his view on the importance of the intrusive thought, the therapist must then focus on identifying the different types of faulty appraisals involved in the client's understanding of the importance of the thought. Then therapist can provide required cognitive skills in challenging these appraisals as required.

Challenging Inflated Responsibility Appraisals:

Salkovskis argues that responsibility appraisals, perhaps is central most in OCD. It can be discovered during a downward arrow analysis. Freeston et. al (1996) suggested courtroom procedure where an individual patient takes the roles of both the prosecuting and defence attorneys. This helps client think critically about the reasoning behind their OCD beliefs as they are required to put forward the arguments that are evidence based than emotional based.

Pie chart technique is another technique to directly challenge excessive responsibility appraisals. The client is asked to identify a situation involving personal responsibility and to give a rating as to how responsible he or she felt for causing this situation (e.g., "My cousin in my family got sick. I am 95% responsible because I wore dirty socks, and last time I did this someone also got sick"). The client is then asked to think all possible contributors to this situation. A circle is drawn (i.e., pie chart), and the client is asked to place all of the possible contributions to the pie, with an estimate of the percentage of importance or responsibility of each contributor for the situation. The therapist can then compare the client's initial responsibility estimate with the final estimate represented in the pie after taking all other possible factors. This exercise highlights on drawing attention of the clients' automatic tendency to exaggerate his or personal responsibility, emphasizing the multifaceted and dimensional nature of responsibility, and highlighting the difficulty in portioning overall responsibility for any negative situation because of multiple interacting contributors (Salkovskis, 2003).

Challenging Overestimated Threat Appraisals:

The downward arrow technique can be used to cognitively challenge all the faulty appraisals of obsessions. In this exercise the client begins with the obsessive thought and then the therapist probes with the question. As the client answers responds to each probe, the therapist is able to peel back the layers, to uncover successively more basic dysfunctional appraisals. Once the therapist exposes the core fear, then he can summarize by stating that, "So your fear is that if the obsession is true, then this awful outcome will occur." If at this point the client agrees that the appraisals of threat are biased and unrealistic then the therapist can propose a series of ERP tasks that involve his fears.

If clients are not ready for ERP another approach can be tried to bring more conviction. Double-column evidence gathering technique introduced by Beck can be used. For example, a client having fear of contaminated would be ask how many people have died as they have sat in public places, how many times in past you have fallen ill for it before this OCD started, does similar things happen to your family members when they do such?

Challenging over importance of thoughts:

Over importance to one's thoughts takes a faulty circular reasoning. My having the thoughts means it is important. My having the thought increases the probability of action. Finally, my having the thought and engaging in the action are more equivalent. Examples of circular

reasoning involved in appraising the thought as over important and the process by which it is developed are discussed. Dwelling on thought provides evidence that it is indeed important. Clients here can be told to adapt a come and go style and test it in a behavioural experiment. On alternative days clients are asked to let intrusive thoughts "come and go" and on the other days to engage in their typical "fight and dwell style". The outcome measures that patients are asked to record is the time spent engaging in obsessive thinking. Typically what patient report is lower frequency, intensity, and duration of obsessions on the "come and go" days.

Cognitive interventions for likelihood TAF bias will be very similar to the strategies discussed in regard to overestimated threat because Likelihood TAF involves the erroneous view that the obsession increases the probability that feared outcome will occur. Freestone (1996) illustrates use of downward arrow technique to expose Likelihood TAF associated with harm and accident obsessions. Freestone again recommended similar technique to expose the core dysfunctional thinking underlying Moral TAF (e.g., "that I am an evil person, a pervert for having thoughts that maybe I would sexually touch a child"). "Once the highly critical self judgement is clearly articulated with the client, the therapist proposes to test the view that, "the way we think determines our true moral character". Socratic questioning can be used to introduce doubt in the client's global, rigid, and absolutistic belief that having bad thoughts is the basis of bad character (Clark, 2004).

"Have you ever changed your mind about someone you at first thought were highly moral but now you find is not so moral? What happened that caused you to change your mind? Was it what that person thought or what the person did?" (Clark, 2004). The therapist could give an example from news reports of clergy accused of sexually assaulting children. "If morality is mainly determined by what we think, how many bad thoughts must a person have to be immoral?" "Is one terribly immoral thought equal to 100 slightly immoral thoughts?" These questions are intended to suggest that judgments of morality cannot be rigid and absolutistic and that person's behavior is more valid measure of moral character than his or her thoughts.

Therapist can also explore whether a person's will plays any role in moral value. Consider a person who intentionally runs down a pedestrian versus a person who accidentally runs over someone who has run out in front of traffic. Freeston et al. (1996) suggest that the client can be asked to talk to close friends or family about their strange thoughts as way of normalizing unwanted, even abhorrent, intrusive thoughts. The purpose of this cognitive intervention is to help clients to be aware of when they engage in the faulty appraisal of Moral TAF, to realize that moral value is not primarily determined by our thoughts, and that morality is based on deliberate choice of action.

Challenging Intolerance of Uncertainty or Perfectionism:

Clark summarizes two main aims here that are to demonstrate the negative consequences associated with both types of appraisal and to show that a state of certainty and perfection is rarely, if ever achieved.

Freestone (1996) proposes that both should work on a list of advantages and dis advantages to the high need for certainty and perfection. Clients are asked to recall the most memorable times in which they were certain of a action or decision, or when they acted perfectly. Each certain and perfect incident is evaluated in terms of the advantages and disadvantages of such appraisals. Clients can then be asked to recall important occasions on which certainty or

perfection was not achieved and they had to live with doubt. Again Socratic questioning, the therapist probes the positive and negative consequence of tolerating uncertainty and imperfection. The therapist should explore the frequency with which certainty and perfection are achieved. The cognitive restructuring exercise should conclude with cost/benefit analysis: "Is striving for certainty was worthwhile?" "On balance, do the costs far outweigh the benefits?"

In above discussions we have tried to present the fundamental CBT mechanisms of OCD patients in a nutshell manner for sake of brevity. In addition to these there are many other numerous behavioral experiments and works which are supplemented with these description of all those in a single chapter may not do a proper justice, in order to get detailed overview of it readers are encouraged to go through CBT specific books on OCD.

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