Breaking Free from OCD - An Interactional Approach

by Padraic Gibson

If you desire to see learn how to act

(Heinz Von Foerster)

Obsessive-Compulsive Disorder Treatment

This paper sets out a rationale and logic for effective systemic-constructivist intervention in the treatment of OCD and builds upon the outcomes of research in an Irish context. Around the world there are literally millions of people suffering from Obsessive-Compulsive Disorder (OCD), with 50% of cases falling into the severe category. OCD is characterized by the presence of persistent thoughts and/or repetitive behaviors significantly interfering with the individual's daily routines, work, family or social life, then causing marked distress. A wide range of comorbidities is also usually associated with the disease, specifically major depressive disorder. Cognitive–Behavioral therapy (CBT), including exposure and response prevention (ERP) techniques, represents the gold standard for the treatment of OCD. However, individual suffering and functional impairments, as well as the economic cost associated with the disease still remain substantial. Brief Systemic and constructivist therapy for OCD has recently been developed, showing encouraging results (Gibson et al; 2013).

The metaphorical image that best represents the underlying logic of OCD is gleaned from a story told by Paul Watzlawick *"A man claps his hands every ten seconds...and when asked about the reason for this strange behavior, he explains: 'I do it in order to scare away the elephants.' When told there are no elephants present, the man responds: 'well, there you go. See, it works so!''.* Obsessive-compulsive ideas emerge as repetitive fixations which are often unreasonable but from which the client cannot free himself. The typical perceptual and behavioral system of obsessive-compulsive disorders is based from our experience on fear or on pleasure, which in turn drives the patient to repeatedly react by carrying out specific compulsive thinking, formulas or ritualized actions in an attempt to either reduce his fear or to achieve a pleasurable sensation (Gibson et al; 2013, Nardone & Portelli, 2013; Portelli, 2004).

These attempted solutions, give patients an illusion of full control over a specific situation, and it is only over time that individuals start feeling that what seemed to protect them, is actually overpowering the problem. As Samuel Johnson states (1709-1784): *"the chains of habit are too weak to be felt until they are too strong to be broken".* People usually only ask for help or seek therapy when they begin to lose the power to control their own actions and thoughts and the problem becomes diffused, affecting most aspects of their life. As with our action research project for developing effective systemic treatments of the other main pathologies, (Gibson et al., 2014) we noted that in the case of OCD it carries its own specific commitments and unique phenomenology. There are no simple cases of OCD for a clinician

because their initial port of call is usually the medical route, which can in the initial phases reduce the symptoms. However many also drop out of CBT treatment and due to the lack of optimism from professionals in the outcomes for OCD and the lack of knowledge about the effective systemic treatment for this problem, many do not seek further help and suffer in silence.

Fear runs along a spectrum from pure fear (monophobia) to Fear with control (OCD) to pure control (Obsession). OCD patients are usually the type that only seek help from the specialist and therefore the clinician must bear this in mind when working with them. They are looking for confidence in the therapist and someone who has the tools to help them, these problems are notoriously resistant to change using rationalistic explanations. In order to resolve these complicated problems it is important that therapeutic success be built on the use of ***a non-ordinary logic***. In order to re-orient the symptom towards its self-annulment it is necessary to first convey to the patients ***that what they think and do makes sense, but then we must give them the illusion of holding a more efficacious way to manage the situation***. In other words, therapists need to follow the logic that underlies the patient's ideas and actions (Gibson and Portelli 2013, 2014, Gibson and Ray 2014, Portelli, 2005) to change it and to avoid any inherent resistance. These are after all patients that have sought control and found it as far as they are concerned, so if you are going to remove their solution, you'd better be confident in the option you are providing.

Obsessive-Compulsive Disorder (OCD) is an anxiety disorder characterized by recurrent or persistent thoughts, impulses or images that are experienced as

"The chains of habit are too weak to be felt until they are too strong to be broken". (Samuel Johnson)

intrusive or distressing (obsessions), and repetitive behaviors or mental acts (compulsions) often performed in response to an obsession (M. Keeley & Storch, 2008). Epidemiological studies report a lifetime prevalence of 1-4% in the general population (J. S. Abramowitz, Taylor, & McKay, 2009; Foa, 2010; Karno, Golding, Sorenson, & Burnam, 1988), equal for men and women, although the disorder is most commonly found in boys than girls (J. S. Abramowitz et al., 2009; Geffken, Storch, Gelfand, Adkins, & Goodman, 2004). Co-morbid psychological disorders associated with OCD include major depression (Doron, Moulding, Kyrios, & Nedeljkovic, 2008), additional phobias, panic attacks, generalized anxiety disorder (M. L. Keeley, Storch, Merlo, & Geffken, 2008) as well as severe occupational, social and family dysfunction (J. S. Abramowitz et al., 2009; Nardone & Portelli, 2013; Storch, Abramowitz, & Goodman, 2008). However because of the subtle nature of the disorder and because of the seemingly common sense logic that underlies these rituals, many patients go undiagnosed with OCD. (For example: health anxiety, general anxiety-patient here)

Just Stop it! Exposure and ritual prevention

In cognitive and Cognitive-Behavioral Therapy primary processes used for the treatment of OCD are Cognitive Restructuring (CR), rational emotive behavior therapy or Beck's cognitive therapy and self-instruction training (van Oppen et al., 1995). In order to interrupt the vicious circle that maintains the problem, widely used CBT techniques are also Exposure and Response Prevention (EX/RP or ERP) strategies (J. S. Abramowitz, 2006; Doron et al., 2008; Meyer, 1966), which essentially lead the person to systematically face the feared stimuli and to experience anxiety without performing any rituals (Lewin et al., 2011). CBT including EX/RP was found to be effective in a number of clinical trials, both in adults and children suffering from OCD, obtaining best outcomes in comparison with other forms of psychotherapy and placebos (J. S. Abramowitz et al., 2009). Also, findings from several studies have shown CBT improving OCD symptoms more than pharmacotherapy, as well as being especially durable after treatment withdrawal and efficient in providing safety (J. S. Abramowitz et al., 2009; Geffken et al., 2004).

However, although ERP techniques have demonstrated good follow up rates of success, they often provoke anxiety in individuals and about 25% of people drop out or refuse the treatment (J. S. Abramowitz et al., 2009; Storch et al., 2008). Also, from the other 75% who continue receiving the intervention, only 25-40% reach some recovery, while most of the subjects remain symptomatic even after the full therapy course (Storch et al., 2010). Similar results have been found in a meta-analytic review of 16 studies with EX/RP in OCD patients, with 48% of them having symptom reduction (M. L. Keeley et al., 2008) as well as in another review study examining the efficacy of CBT for pediatric OCD, revealing that 50-75% of receivers remain somewhat symptomatic (Boileau, 2011). Also

You can avoid doing it at all, but if you do it once, you must do it no more and no less than five times.

when we strip back the jargon and professional language used in CBT we are essentially left with the naked fact that EX/RP is essentially telling the patient to 'stop it' which is nothing short of what the patient has tried unsuccessfully to do most of his/her life. Moreover from our study in The Bateson Clinic we can see the paradoxical effect of using this type of rational advice, it actually increases the ritualized behavior. Who hasn't gone on a diet only to discover that what we were avoiding is even now more attractive? So we can see that OCD lies within a completely different type of logic to common sense or rational language and this is where Bateson (1973) and Watzlawick et al. (1967) come to our aid, with their work on paradoxical interventions. Another factor predicting poorer outcome is family invlovement, and specific treatment forms have been developed, like cognitive-behavioral family therapy (Doron & Moulding, 2009; M. L. Keeley et al., 2008; Storch et al., 2007). The involvement of the families of children with OCD has been shown to have a beneficial effect (Barrett, Farrell, Dadds, & Boulter, 2005).

Rigorous But Not Rigid Interventions

Our model of brief systemic and constructivist therapy (BST), has shown effective outcome results in treating many forms of psychological suffering when compared to CBT, (Gibson et al., 2014; Nardone & Portelli, 2005). One of the significant differences that exist between the two approaches is that CBT derives from learning theory, whereas the traditional systemic approaches as explained here, base themselves on the assumptions on the theory of change (Watzlawick et al., 1967). In other words, while a cognitive-behavioral therapist guides the patient through a process of awareness and voluntary effort to learn how to fight and handle the disease, the systemic therapist should adopt ad hoc therapeutic interventions in therapy that create a corrective emotional experience, that is accompanied by a felt sense of change. This intervention should transform how the person perceives and reacts to his own reality, thus allowing the individual to later acquire awareness of the problem and the ability to prevent it reoccurring. However, the systemic approach also results in a more efficient, intervention leading to faster healing and reducing relapses long term (Gibson 2014).

Communication is Essential. The Problem of Evidence Based Practice

We live in an era of evidence based practice (Wompold, 2007) and one of the major problems of evidence based therapy or medicine is an orientation towards a belief that the active ingredient in treatment is the 'technique' and therefore many doctors and evidence based therapy models place less emphasis on the relationship and communication.. Differentiating the two models above is also the type of language adopted during clinical dialogue, as well as the language used in the therapeutic prescription phase of the treatment for OCD. In fact, cognitive-behavioral approach is traditionally characterized by a logical-rational communication, a language that is typically one of explanation. On the contrary, systemic therapy outlined here is based on language that is injunctive and performative (Austin, 1962), aimed at making the person *feel* differently before acting differently, *through the use of metaphors, anecdotes and stories and questions with the illusion of an alternative* (Erickson 1971).

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To explain it more clearly; if we wished to describe a chocolate cake to someone who had never tasted it we may run into a specific problem; that of descriptive language. It is very hard if not impossible to enable someone experience something by describing it. If however I avoid the sweet, salty, buttery, spongy description and instead provide the other person with a recipe for a chocolate, then they can create and experience it. It is then and only then after experiencing it, can they gain insight into chocolate cake and their experience of it. This is essentially what we are asking practitioners to consider, to give the client access to some actual experience of change, to which they can then refer and reapply to future change.

Systemic Therapy's Helpful History:

Through the use of suggestive and persuasive forms of communication (Gibson 2013 and Gibson and Nardone 2014) (Nardone, 2003; Nardone & Watzlawick, 2005) derived from communication theory developed by Gregory Bateson in an anthropological context and the constructivist developments of the cybernetic theory of Von Foerster and Glaserfeld and Watzlawick et al., and from Milton Erickson's studies on hypnosis and suggestion we now have an effective model of systemic therapy for OCD. Also from the more recent past, we have applied the work of the Palo Alto School (Mental Research Institute – MRI) who first formulated the Brief Therapy model, further developed by Giorgio Nardone, who together with Paul Watzlawick developed

an advanced form of therapeutic technology, presented for the first time in the book entitled ***The art of change*** (Nardone & Watzlawick, 1990) and more recently in ***Winning without fighting*** by Padraic Gibson, Mateo Papantuono and Claudette Portelli (2014).

How Obsessive-Compulsive Disorders Evolve

From our research we can define five reasons that trigger compulsive thoughts and actions: ***1) the doubt that generates the need for reassuring answers; 2) an excess of ideological rigidity as well as extreme moral respect or religious belief; 3) an excess of rational reasoning processes, leading to complete unreasonableness; 4) an extreme health prevention that turns into phobia and 5) the attempt to reduce anxiety and distress generated by a trauma*** (Gibson et al., 2014;Nardone & Portelli, 2013).

For each of these reasons the purpose may be to ***prevent or repair*** something that "might" happen or "has" happened as well as to ***propitiate or ensure*** things continue to go well. After having discriminated whether the basis of the compulsion is ***phobic or non-phobic***, we then set out to interrupt the dysfunctional equilibrium that is self-reinforcing the disorder. At this stage our model focuses on the patients' attempted solutions, which in the case of a person suffering from OCD are typically represented by:

a) *Avoidance of situations that cause anxiety;*
b) *Request for help or reassurance from others in the form of delegation of tasks or in seeking assistance for avoiding contact with fearful stimuli;*
c) *Implementation of specific rituals to manage the situations (Gibson et al., 2014; Nardone & Portelli, 2013)*

Other important discriminations to be made are whether the compulsion is represented by ***repetitive visible actions or by mental rituals***, then whether the ritual ***follows or not*** a specific sequence, either ***numerical*** or ***analogical***.

Depending on the structure of the ritual an essential and unique aspect of our work is we have devised several counter-rituals specifically prescribed to fit the different typologies of compulsive symptomatology (Gibson and Portelli 2013; Portelli, 2005). These counter rituals, when adopted by the patient, paradoxically break the usual behaviors extremely rapidly, as reported in this journal previously in a case of treatment for self-harm, by one of my colleagues (Boardman, 2014).

Similia, Similubus, Curantor: Prescribing The Problem

Changes we experience in our everyday life (that is spontaneous change) occur when our perceptions, relationships or emotions are called into crisis thus leading to some form of growth or maturity (Watzlaiwck 1987). We generally accept such change as valid or appropriate and our training programmes aims at helping psychotherapists to wait for such spontaneous, non-instructive change (Hoffman 1993). However what is to stop us from finding ways to bring this about actively in our work with those that suffer for many years in silence with such problems, with little other hope of treatment?

In the treatment of OCD change is something of real importance, as these patients tend to drop out very quickly if they do not see change. Moreover, this type of complex problem is not based primarily on the relationship with self and others, but with the relationship with self and self; it is a closed system (Maturana, 1987). What is usually perpetuating this problematic system is the logic that the client is bringing to solving the problem. This self-sustaining, self-referential feedback loop maintains the problem, and the solution is achieved by the recognition of the systemic nature of the problem and by a systemically informed therapeutic response.

Counter rituals, when adopted by the patient, paradoxically break the usual behaviors.

What this means is that the client's apparent ***'solution'*** is his problem and his ***problem is at the same time the only solution***. If we try to rationally explain this we will achieve very little. If we attempt to discuss aspects of the client's life not related to solving their OCD, we will soon find ourselves widening the focus of enquiry without success, increasing the client's sense of hopelessness and our own when the client asks at the end of the session what to do about the problem behaviour. Therefore we believe we must introduce a tangible experience of change to the system via an intervention that creates a corrective emotional experience (French and Alexander 1967; Satir, 1977). This is something that will change how the client feels' about their problem, that will create change in how he thinks and acts. In the case of a patient suffering from Obsessive-Compulsive Disorder, for example, using reason to convince him to stop his pathological rituals will not necessarily lead to any result, however a prescription based on the same logic underlying the problem will turn the force of the

This form of systemic approach is essentially aimed at creating a corrective emotional experience, transforming the way in which the person perceives and reacts to his own reality

symptom against the disorder itself, breaking its perverse balance.

With OCD treatment the following prescription is one we regularly use, ***"every time you enact one of your rituals, you must repeat it five times, exactly five times, no more, no less. You can avoid doing it at all, but if you do it once, you must do it no more and no less than five times"***, the injunction to ritually repeat the ritual paradoxically leads the person to construct a different reality from the one characterized by uncontrollable compulsions. We can then request that they can consider the possibility of not performing the ritual, since not uncontrollable spontaneous anymore, but prescribed voluntarily (Gibson et al., 2013; Nardone & Watzlawick, 2005). The logical structure of this apparently simple prescription helps to avoid the usual resistance that comes with this problem typology. If the individual needs to perform the ritual once, he has to do it five times. Therefore it is therapist suggesting how many times he is to repeat it, thus taking control of the symptom and giving to the patient the injunctive permission to avoid doing the ritual. Usually we find that following the prescription literally at first, clients usually suspend the ritual after a few days, not being able to explain why. It is also true that the way the prescription is communicated is fundemental and we must do it is by the use of a redundantly repeated, hypnotic linguistic assonance and of a posthypnotic message expressed in a more marked tone of voice (Erickson 1974).

Conclusion

Results obtained from the empirical-clinical research carried out by the 4 year study at the Bateson Clinic Dublin (Gibson and Casltenuovo et al., 2013) and over 15 years at the Centro di Terapia Strategica (CTS) of Arezzo, Italy have shown Brief systemic constructivist therapy having good outcome results in treating Obsessive-Compulsive Disorder, allowing the systematization of specific treatment protocols (Gibson et al., 2013). Data have shown that even the most obstinate of obsessions and compulsions are usually won over by redefining the situation and by setting up a series of concrete corrective emotional experiences that free the patient from his rigid self-feeding perceptive-reactive system. Despite both CBT and systemic constructivist approaches having been proven to be effective with regard to the cure of this particularly hard-to-treat symptomatology, follow up data have revealed the strategic approach also resulting particularly efficient, leading to faster healing and reducing relapses long term.

Focusing on the individual "attempted solutions", then understanding what maintains and worsens the problem, this form of systemic approach is essentially aimed at creating a corrective emotional experience, transforming the way in which the person perceives and reacts to his own reality. Through the use of ad hoc therapeutic interventions and in-session injunctive and performative language this therapy bypasses the individual's usual rational mechanisms, leading to the self-destruction of the logic that imprisons the mind, then the vicious cycle maintaining the problem quickly comes to be interrupted.

References

Abramowitz, J. S. (1996). Variants of exposure and response prevention in the treatment of obsessive-compulsive disorder: A meta-analysis. . *Behavior Therapy,* 27, 583–600.

Abramowitz, J. S. (2006). The psychological treatment of obsessive-compulsive disorder. [Review]. *Can J Psychiatry,* 51(7), 407-416.

Abramowitz, J. S., Franklin, M. E., & Foa, E. B. (2002). Empirical status of cognitive-behavioral therapy for obsessive-compulsive disorder: A meta-analytic review. Romanian Journal of Cognitive and Behavioral Psychotherapies, 2, 89–104.

Abramowitz, J. S., Franklin, M. E., Zoellner, L. A., & DiBernardo, C. L. (2002). Treatment compliance and outcome in obsessive-compulsive disorder. [Research Support, U.S. Gov't, P.H.S.]. *Behav Modif*, 26(4), 447-463.

Abramowitz, J. S., Taylor, S., & McKay, D. (2009). Obsessive-compulsive disorder. *Lancet*, 374(9688), 491-499. doi: 10.1016/S0140-6736(09)60240-3

Austin, J. L. (1962). *How to do things with words.* . Cambridge: Harvard University Press.

Barrett, P., Farrell, L., Dadds, M., & Boulter, N. (2005). Cognitive-behavioral family treatment of childhood obsessive-compulsive disorder: long-term follow-up and predictors of outcome. [Research Support, Non-U.S. Gov't]. *J Am Acad Child Adolesc Psychiatry,* 44(10), 1005-1014. doi: 10.1097/01.chi.0000172555.26349.94

Boileau, B. (2011). A review of obsessive-compulsive disorder in children and adolescents. [Review]. *Dialogues Clin Neurosci,* 13(4), 401-411.

Doron, G., & Moulding, R. (2009). Cognitive behavioral treatment of obsessive compulsive disorder: a broader framework. [Review]. *Isr J Psychiatry Relat Sci,* 46(4), 257-263.

Doron, G., Moulding, R., Kyrios, M., & Nedeljkovic, M. (2008). Sensitivity of self-beliefs in obsessive compulsive disorder. *Depress Anxiety,* 25(10), 874-884. doi: 10.1002/da.20369

Essays UK. (2013). Treatment Of Obsessive Compulsive Disorder Psychology Essay. Retrieved from *http://www.ukessays.com/essays/psychology/treatment-of-obsessive-compulsive-disorder-psychology-essay.php?cref=1.*

Foa, E. B. (2010). Cognitive behavioral therapy of obsessive-compulsive disorder. [Historical Article]. *Dialogues Clin Neurosci,* 12(2), 199-207.

Geffken, G. R., Storch, E. A., Gelfand, K. M., Adkins, J. W., & Goodman, W. K. (2004). Cognitive-behavioral therapy for obsessive-compulsive disorder: review of treatment techniques. *J Psychosoc Nurs Ment Health Serv,* 42(12), 44-51.

Geller, D. A., Biederman, J., Stewart, S. E., Mullin, B., Farrell, C., Wagner, K. D., Carpenter, D. (2003). Impact of comorbidity on treatment response to paroxetine in pediatric obsessive-compulsive disorder: is the use of exclusion criteria empirically supported in randomized clinical trials? [Clinical Trial Multicenter Study Randomized Controlled Trial]. J Child Adolesc Psychopharmacol, 13 Suppl 1, S19-29. doi: 10.1089/104454603322126313

Gibson, P, Castlenuaovo, Pietrabissa, Manzoni. (2013). A Pilot Study on the effectiveness of Brief Strategic Therapy in the Treatment of Post Natal Depression.

Gibson, P, Manzoni, M., Pietrabissa (2014) A 4 year Observational Study on the efficacy of BST Treatment for OCD in an Irish Clinic. *Journal of Therapies in Medicine.*

Gibson P., Papantouono, M., Portelli, C (2014) *Winning Without Fighting: A Handbook of Effective Solutions to Social, Emotional and Behavioural Problems in Schools*

Gibson, P., Ray, W. (2014): Family Therapy Pioneers: No:1: Don D Jackson. Analysis of Transcript of Jacksons Therapy as a lesson to us all. (Unpublished)

Gibson, P., Ray, W. (2014): Family Therapy Pioneers: No: 2-John Weakland. The Sublte Art of Doing Nohting: (Unpublished)

Jonsson, H., Hougaard, E., & Bennedsen, B. E. (2011). Dysfunctional beliefs in group and individual cognitive behavioral therapy for obsessive compulsive disorder. J Anxiety Disord, 25(4), 483-489. doi: 10.1016/j.janxdis.2010.12.001

Karno, M., Golding, J. M., Sorenson, S. B., & Burnam, M. A. (1988). The epidemiology of obsessive-compulsive disorder in five US communities. [Research Support, U.S. Gov't, P.H.S.]. Arch Gen Psychiatry, 45(12), 1094-1099.

Keeley, M., & Storch, E. A. (2008). The nature, assessment, and treatment of pediatric obsessive-compulsive disorder Behavioral Psychology 16(3), 535-551.

Keeley, M. L., Storch, E. A., Merlo, L. J., & Geffken, G. R. (2008). Clinical predictors of response to cognitive-behavioral therapy for obsessive-compulsive disorder. [Comparative Study Review]. Clin Psychol Rev, 28(1), 118-130. doi: 10.1016/j.cpr.2007.04.003

Kim, S. W., Dysken, M. W., & Kuskowski, M. (1990). The Yale-Brown Obsessive-Compulsive Scale: a reliability and validity study. [Clinical Trial Comparative Study Controlled Clinical Trial]. Psychiatry Res, 34(1), 99-106.

Lewin, A. B., De Nadai, A. S., Park, J., Goodman, W. K., Murphy, T. K., & Storch, E. A. (2011). Refining clinical judgment of treatment outcome in obsessive-compulsive disorder. *Psychiatry Res,* 185(3), 394-401. doi: 10.1016/j.psychres.2010.08.021

Mahoney, M. J. (1991). *Human Change Process: The Scientific Foundations of Psychotherapy.* New York: Basic Book.

Meyer, V. (1966). Modification of expectations in cases with obsessional rituals. *Behav Res Ther,* 4(4), 273-280.

Nardone, G. (2003). *Cavalcare la propria tigre.* Milano: Ponte alle Grazie.

Nardone, G., & Balbi, E. (2008). *Solcare il mare all'insaputa del cielo. Lezioni sul cambiamento terapeutico e le logiche non ordinarie.* . Milano: Ponte alle Grazie.

Nardone, G., & Portelli, C. (2005). *Knowing Through Changing: The Evolution of Brief Strategic Therapy.* Glasgow: Crown House Publishing.

Nardone, G., & Portelli, C. (2013). *Ossessioni Compulsioni Manie. Capirle e sconfiggerele in tempi brevi.* Milano: Ponte delle Grazie.

Nardone, G., Verbitz, T., & Milanese, R. (1999). *The Prisons of Food: Strategic Solution-oriented Research and Treatment of Eating Disorders.* London: Karnac Publishing.

Nardone, G., & Watzlawick, P. (1990). *The Art of Change: Strategic Therapy and Hypnotherapy Without Trance* San Francisco, USA: Jossey - Bass.

Nardone, G., & Watzlawick, P. (2005). *Brief Strategic Therapy: Philosophy, Technique and Research.* Lanham, Maryland: Jason Aronson.

Portelli, C. (2004). Advanced Brief Strategic Therapy for Obsessive-Compulsive Disorders. *Brief Strategic and Systemic Therapy European Review, 1.*

Portelli, C. (2005). Brief Strategic Interventions for Obsessive Compulsive Disorders: acquiring the maximum with the minimum in the first session. *Brief Strategic and Systemic Therapy European Review, 2.*

Rosa-Alcazar, A. I., Sanchez-Meca, J., Gomez-Conesa, A., & Marin-Martinez, F. (2008). Psychological treatment of obsessive-compulsive disorder: a meta-analysis. [Comparative Study Meta-Analysis Research Support, Non-U.S. Gov't]. *Clin Psychol Rev,* 28(8), 1310-1325. doi: 10.1016/j.cpr.2008.07.001

Storch, E. A., Abramowitz, J., & Goodman, W. K. (2008). Where does obsessive-compulsive disorder belong in DSM-V? *Depress Anxiety,* 25(4), 336-347. doi: 10.1002/da.20488

Storch, E. A., Geffken, G. R., Merlo, L. J., Jacob, M. L., Murphy, T. K., Goodman, W. K., & Grabill, K. (2007). Family accommodation in pediatric obsessive-compulsive disorder. *J Clin Child Adolesc Psychol,* 36(2), 207-216. doi: 10.1080/15374410701277929

Storch, E. A., Larson, M. J., Muroff, J., Caporino, N., Geller, D., Reid, J. M., . . . Murphy, T. K. (2010). Predictors of functional impairment in pediatric obsessive-compulsive disorder. [Multicenter Study]. *J Anxiety Disord,* 24(2), 275-283. doi: 10.1016/j.janxdis.2009.12.004

Tek, C., Ulug, B., Rezaki, B. G., Tanriverdi, N., Mercan, S., Demir, B., & Vargel, S. (1995). Yale-Brown Obsessive Compulsive Scale and US National Institute of Mental Health Global Obsessive Compulsive Scale in Turkish: reliability and validity. *Acta Psychiatr Scand,* 91(6), 410-413.

van Oppen, P., de Haan, E., van Balkom, A. J., Spinhoven, P., Hoogduin, K., & van Dyck, R. (1995). Cognitive therapy and exposure in vivo in the treatment of obsessive compulsive disorder. [Clinical Trial Comparative Study Multicenter Study Randomized Controlled Trial]. *Behav Res Ther,* 33(4), 379-390.

Wang, Y. P., & Gorenstein, C. (2013). Psychometric properties of the Beck Depression Inventory-II: a comprehensive review. [Research Support, Non-U.S. Gov't Review]. *Rev Bras Psiquiatr,* 35(4), 416-431. doi: 10.1590/1516-4446-2012-1048

Woody, S. R., Steketee, G., & Chambless, D. L. (1995). Reliability and validity of the Yale-Brown Obsessive-Compulsive Scale. [Research Support, U.S. Gov't, P.H.S.]. *Behav Res Ther,* 33(5), 597-605.

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