

A clinical developmental perspective on the understanding and treatment of obsessive-compulsive disorder

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Summary

A chronic sense of insecurity is pointed out as playing a major role in the acquisition of the disorder. Obsessive compulsive symptoms are seen as a way of striving to gain some sense of inner hold on managing daily tasks, which have become a major challenge. Since rituals usually have to be conducted despite knowing that they are unnecessary or exaggerated, OCD patients suffer from the well-known shame or guilt of not being able to resist the urge to ritualise. This means a permanent undermining of self-esteem. From a clinical-developmental perspective, trajectories of different themes of insecurity will be described and how they combine into a sense of insecurity. A developmental stance is proposed as leverage to underpin cognitive-behavioural treatment methods. Attention must also be given to general self-esteem as an ongoing focus throughout treatment to provide a base for a lasting treatment effect. Two case vignettes illustrate the inclusion of a developmental perspective into the cognitive-behavioural treatment.

Keywords: *obsessive-compulsive disorder, cognitive-behavioural therapy, clinical-developmental psychology, acquisition of obsessive-compulsive disorder.*

Riassunto

Una prospettiva clinico-evolutiva per la comprensione e il trattamento del disturbo ossessivo-compulsivo

Un senso cronico di insicurezza riveste un ruolo centrale nello sviluppo del disturbo. I sintomi ossessivo-compulsivi possono essere visti come una modalità per ottenere un senso di «presa interna» nell'affrontare i compiti quotidiani, che costituiscono una sfida impegnativa. Poiché i rituali di solito devono essere compiuti nonostante siano ritenuti inutili o esagerati, i pazienti soffrono di vergogna o di colpa per non essere in grado di resistere all'impulso del rituale. Ciò comporta una permanente minaccia all'autostima.

Partendo da una prospettiva clinico-evolutiva, il contributo fornisce una descrizione delle traiettorie dei diversi temi di insicurezza e di come essi si combinano in un senso di insicurezza. Viene proposto un punto di vista evolutivo come base dei metodi di trattamento cognitivo-comportamentali. Una particolare attenzione è posta alla autostima generale, che dovrebbe rappresentare un focus durante tutto il trattamento, al fine di rendere durevoli i risultati. Sono descritti due casi che illustrano l'inclusione di una prospettiva evolutiva nel trattamento cognitivo-comportamentale.

Parole chiave: *disturbo ossessivo-compulsivo, terapia cognitivo-comportamentale, psicologia evolutivo-clinica, acquisizione di un disturbo ossessivo-compulsivo.*

INTRODUCTION

In more than 40 years of working with patients suffering from obsessive-compulsive disorder, I have always been impressed by two features; the common characteristics of OCD — that is the many facets of the disorder that follow the same logic — and, secondly, the uniqueness of each individual case. Over the years I have come to believe that at the core of the disorder we can always find a chronic sense of insecurity in people suffering from OCD — rituals being a way of striving for a sense of security. From a therapeutic point of view, I would single out the need for patients to develop a profound interest in themselves, their lives and their future as the rubicon each patient must cross in order to achieve a lasting change through treatment. This «interest in oneself» can be shaped by the building of self-esteem as one element and a new and deeper understanding of the biographical learning history.

About two decades ago, I began to add a developmental perspective to behavioural and cognitive-behavioural theory and practice, motivated by my puzzlement over those patients who had not been able to benefit from previous treatments. In particular I was concerned about those who reported having been in Cognitive Behaviour Therapy but who had not received lasting help. I felt I needed more information on the patients' interest in their own life story and future and might thus gain a fresh perspective on understanding their individual disorder.

Fascinated as I was by the results of longitudinal studies on risk and development, in particular the construct of resilience, I began to return to stage-models of development like those of Piaget (1954), Erikson (1959), Kohlberg (1984), and related research like that of Loevinger (1976), Gilligan (1982) and Kroger (1989; 2007). There were also newer models of ego-development to be found, which linked affective and cognitive development in constructivist models of meaning-making (Kegan, 1982; Noam, 1988). These seemed to me to come full circle with cognitive models of the acquisition of depressive (Beck, 1967) or obsessional thinking (Salkovskis, 1985).

With certain reservations in mind about stage-models of development perhaps being too rigid and normative, I discovered that those more recent models of ego development placed more emphasis on transition phases, and an ongoing gain of seeing the self and the world from a wider perspective, rather than on the stages as such. The idea of a developmental underpinning of the process of meaning-making seemed convincing. I saw possibilities for a fruitful use of these models in clinical work, both to take a developmentally based look at the acquisition of the disorders and to use the move towards a wider perspective along with cognitive-behavioural methods in treatment as leverage in the difficult process of overcoming fears and insecurities.

I want to stress that, where overt rituals are present, I rely strongly on exposure and response prevention methods in treatment. The potential effects are manifold, there is the possibility of habituation, and a change in expectations with respect to danger and fear

BOZZA ERICKSON

responses, as well as biographical recall of what provoked the search for more security through rituals (Röper, 2001; Zaudig, Hauke and Hegerl, 2002). Following successful confrontation with the feared situations, many cognitive changes take place both with respect to the perceived dangers as well as one's own sense of mastery or self-esteem.

First I will go through some of the themes covering age and stage-salient development and point out where, for the later OCD-patient, things go wrong for a person who ends up with crippling symptoms. In other words I will be looking at acquisition. Secondly, I will point out where, and how, the developmental perspective can underpin cognitive restructuring.

Developmental stage models talk about transition phases as intensive periods of learning, periods of reconstructing the understanding of one's own perceptions, a process to which Piaget (1954) gave the name «accommodation phases». I will focus on the constructivist-developmental model of Kegan (1982) and will place more emphasis on transition phases than on the various individual stages.

According to Kegan (1982) the process of meaning-making is both cognitive and affective in nature, and driven by two major factors strivings: the yearning to belong and the yearning to be independent. Kegan (1982) describes five stages, four of them centred on one of the two basic strivings with the fifth as a mature stage where the two different strivings have been integrated into one epistemology. When one of the two strivings is at the core of the self-and worldview, there is a clear-cut life philosophy and a sense of knowing how to interpret the world and other people. Since the wish to belong and the wish to be separate are diametrically opposite, each transition phase requires a complete re-construction of the self-and world-view. This reconstruction process can move forward stepwise but also through a major crisis. Due to socialisation influences, girls and women tend to arrive earlier and remain longer in the stages favouring inclusion, with the same tendency being found for boys and men in the stages favouring separateness. For an age salient development to take place, the embedding culture, that is the family in the first instance, and then also friends partners and colleagues, should ideally fulfil three major roles: holding, letting go and remaining available, when asked for support.

Outlining Kegan's (1982) model of affective-cognitive ego development, I will bring into focus, those characteristics of the transition phases which appear as the breeding ground for a tendency towards obsessive-compulsive disorder. To illustrate his model, Kegan (1982) uses the graphic of a helix, representing an upward spiral, with the stages of belonging at the extreme right outward point and the stages of separateness at the extreme left. The spiral shows an arrow at the top, indicating that development is only described up to this point but will, for some people, move beyond. Prior to the five stages and their transition phases he describes stage 0 — the *incorporative self* — which is positioned in the middle as the first phase of life where affective-cognitive development is waiting to set in and a choice of wanting to belong and wanting to be separate is not yet possible. Transition phases are characterised by opportunities and challenges of learning, where the constructivist process of meaning-making will establish a wider perspective of understanding. However, each learning step comes at a price: a more complex view of the self and the world means the loss of illusions of security. Therefore the developmental

path entails both growth and loss along the way. In addition, the embedding culture faces the challenges of providing differential support that favours ongoing development and not stagnation. Where collaboration between the self and the environment fail to attune, obsessive compulsive tendencies may be formed throughout at any point along the path of affective-cognitive development.

The first transition phase on the road to the *impulsive self* represent the first two years of life when, ideally, according to Erikson (1959) a sense of «basic trust» is formed. At the same time attachment patterns and «inner working models» (Bowlby, 1988) are formed that will shape the style of relationships in the future. Motor development enables the child to interact more and more actively with the environment. Objects removed from sight, while initially becoming non-existent, can soon be looked for. Growing physical competencies (from crawling to walking) enable more powerful expression of will and spontaneously emerging impulses.

The opportunity and challenge of learning in this phase is centred on the theme of «searching and finding». Negotiating the tension between searching and finding is a major challenge. The specific vulnerability of this transition consists of the child not yet being able to construct probabilities of if, and when, the caregiver will return. The loss of an important person is, therefore, existentially threatening. Learning that the other is separate from the self, means giving up the illusion of being protected through union. Separation anxiety has the quality of feeling is completely abandoned. The task of the embedding culture is thus sensitive attention towards feelings of anxiety. Patients' reports indicate that many were brought up according to strict rules with little room for changing and different requests.

Characteristic for the end of this transition phase is impulsive expression of changing moods.

The path towards obsessive compulsive tendencies may be paved by an inclination to search for security and avoid insecurity. Striving for security will henceforth be characterized by a quality of impulsivity, including a non-negotiable urge to perform whatever means of reassurance will be chosen.

The stage of the *impulsive self* is the first stage favouring inclusion. Close connection to the caregivers is the sole base from which to look at and deal with the world. From the child's point of view parents are there to tend to its needs. The self is his or her perceptions; all wishes have to be expressed.

The opportunity and challenge of learning in the second transition phase towards the *imperial self* includes the birth of the role. The child learns that people have different roles, tasks and plans of their own. That renders them uncontrollable. The ability of magical thinking helps to negotiate the larger environment. The child can now express anxiety verbally, and the parents' reaction to the child's anxiety is crucial. The task of the embedding culture is to give time and attention to the child's fearful moments. If the focus lies on taking away the anxiety it includes the message: whatever causes anxiety ought to be avoided. Parents may be addressing the anxiety or holding the anxious child. In continuing the path towards obsessive compulsive tendencies, this provides a breeding ground for obsessional thinking and ritualistic behaviour. This transition phase entails the beginnings

of a tendency to build a seeming security by creating rituals. The fear of the unpredictable and uncontrollable is taken from here and remains a permanent characteristic. Cognitive schemata are formed that include magical thinking — schemata that will be hard to challenge with rational argument.

The stage of the *imperial self* is the first one that favours independence. The child is now part of a new embedding culture, in school and in a circle of friends. The child has a concept of his or her abilities and compares himself with others. The principle of cause and effect is understood and the mechanics of how things work and function is of principal interest. Friendships have rules and are judged according to their usefulness. Impulses can now be controlled. The importance of personal wishes and needs has taken their place, although their fulfilment can be postponed in expectation of later rewards.

The opportunity and challenge of learning in the third and next transition phase towards the *interpersonal self* is entering the world of emotions — understanding and reflecting one's own and those of others. Growing out of complete identification with one's own needs and coordinating different needs, including those of others, is a related task to be tackled. Self-esteem depends on valuing through other people. The task of the embedding culture is to teach reliability on the bases of mutual agreements. Following patients' reports of the time period of their adolescence and the description of the family atmosphere, it seems that there was often little room for the expression or explicit verbal exchange of emotions. Descriptions of family life entail many common characteristics. Family life is organised around rules and with respect to societal traditions of the world around. Parents are often hard-working and aspiring to gain financial security and the respect of neighbours and colleagues. Children are looked after well; they have to function and do well, and gain the parents' recognition through achievements. Giving attention to the child's individual characteristics and talents is not commonly found.

During this transition phase the path towards obsessive-compulsive tendencies is continued by constructing understanding of the self predominantly at the emotional level. Entering the world of emotions is experienced as threatening. General rules of «right» or «wrong» do not provide the same compass as earlier. There is a personal conscience that creates new duties and commitments. A personal sense of responsibility gives rise to anxieties about making mistakes. The component of readiness for feelings of guilt is added. When left alone with mastering emotional turmoil, fear of possible negative consequences of one's actions leads to overvalued ideas of responsibility. This implies alertness towards specific dangers. When ill intentions count, not only when discovered by others, guilt takes on a new quality. Fantasies of others knowing about one's ideas lead to fantasies of their reactions. «Bad thoughts» can result in feelings of shame and guilt. Responsibility is taken on for one's thoughts; harsh judgements about the badness of one's character are inferred.

The stage of the *interpersonal self* favours inclusion. Self-esteem is dependent on the attention and recognition of others. A sense of self-worth is suspended, so to speak, between the self and friends or members of the family. Ambivalences cannot be negotiated within; different emotionally held views are attached, and belong to, one group or another. Relationships can have the warm and safe quality of unity with a strong sense of belonging.

The description using Kegans's (1982) model of ego-development ends here since the essential learning steps of the path of developing obsessive-compulsive disorder have occurred in these three transition phases, where the following characteristic schemata have been acquired:

1. searching for security and avoiding insecurity;
2. avoiding the uncontrollable and the unpredictable. Dealing with reality by magical thinking;
3. overestimating personal responsibility, developing a scrupulous conscience.

When exploring a patient's biography, including the learning history of the symptomatology, keeping an eye on the developmentally relevant themes of the transition phases helps to understand where general insecurities and lack of trust in one's own judgement were picked up.

We will now turn to the second use of this developmental model, where cognitive behavioural work can be underpinned by placing cognitive restructuring in the context of stage-salient learning. This means paying attention to the stories of concrete experiences in the patient's current life-situation with two aims in mind. First, we want to understand a self-diminishing or unrealistic interpretation of the situation and, secondly, what is the patient telling us about his or her attempts at ongoing meaning-making? The latter perspective means looking more at structure than content, in other words: how does the person currently construct understanding of a social situation? For example: is the patient hurt because a friend refuses to help, although he or she has been helpful recently — or does the hurt have more to do with emotional disappointment of a relational kind? When a constructive-developmental perspective is being applied, it is useful for the therapist to link several stories of a similar content together in order to extract the ongoing developmental move. This way the patient's pain over repeated conflicts, which to the therapist may also seem like the same story over and over again, begins to make sense in terms of the developmental transition.

Many of the obsessive-compulsive patients I have seen or came to know through supervision began treatment in the transition between phases two and three. The home atmosphere they described from their childhood and adolescence indicated that both parents, or the more dominant one, seemed to have lived in a stage two world, where family life was organised around functionality, strict rules and expectations towards the children. In those cases the move towards the following epistemology is particularly hard to traverse. First, there is no model for emotionally determined commitments in interpersonal interactions; secondly loyalties towards parents are at stake when moving into a life philosophy that is different from their parents' world view (Noam, 1992).

TWO CASE-VIGNETTES

The following case-vignette illustrates how the developmental perspective was included in a cognitive-behavioural treatment approach in order to provide encouragement when steps towards improvement were slowing down and motivation appeared to dwindle.

BOZZA ERICKSON

Günther, aged 34, was a successful insurance broker. In the first intake-session he revealed his reason for seeking treatment as the necessity to be cured of his fears, which were in the way of achieving his life goal to become hard and brutal. Being a tall strong man of rigid facial expression and bodily posture, his outer appearance underlined his words impressively. I explained how important it was that patient and therapist agree on the treatment goals and that I needed to understand first, what his definition of hard and brutal was and how he had come to choose this as his life goal. His problems centred on a fear of impending doom and numerous rituals to avoid an unfortunate fate of severe illness and early death. He was unable to use streets that passed hospitals and cemeteries, clothes that had been worn on a day when he had heard of other people's serious misfortune had to be taken to the cleaners, and long showers with excessive use of soap followed. There were also unlucky numbers to be avoided, for example in addresses, phone numbers, sums of money to be paid or the numbers on bank notes. He feared that bad thoughts about other people could harm them, which, in turn, would lead to God's punishment. There were also problems with his relationship to his family. He had had a number of short relationships with women, who had all, more or less, complained about a lack of warmth and sensitivity on his part while he, sooner or later, had always become angry over their laziness in not doing chores for him.

Prior to laying out a cognitive-behavioural treatment plan addressing his symptomatology, a joint understanding of the overarching treatment goal had to be found. A deeper understanding of the patient's biography was needed.

The central event of his family's history was his father's early death when the patient was seven years old. He had been born as the middle child with an older sister and a younger brother. In his memory his father had been very proud of his firstborn son. He had been a lively and cheerful man, while his mother had always been serious and very strict in her upbringing of the children — with the exception of her youngest. The parents had run a small pub type restaurant; the family's home had been in the same house. The father had not been feeling well for some time, when one day he was taken to hospital and died a few days later. According to his mother, his father had to die, because he had not been seen by the best doctors of the hospital. What stood out in Günther's memory of this day was that his father had asked him to go downstairs and get him a fresh draft beer; he had got distracted by friends playing in the yard and saw his father being picked up by the ambulance. So he had failed to fulfil his father's last wish. He was visibly moved when relating the events of this day. When asked, he was unaware of feelings of sadness. What was noticeable to him was deeply felt anger towards the doctors who had not saved his father's life. His father's death came up in a series of sessions with emotions of anger, coming closer to sadness, with visible attempts to avoid these more «threatening» emotions. When clarifying what he understood by the terms «hard and brutal», it became clear, that most of the examples discussed could also be understood as «normal» assertiveness.

At the beginning of treatment, he had begun the transition towards the interpersonal self, while still remaining closer to the imperial self. He was angry with his mother, who had asked him repeatedly to provide financial support to his younger brother who was unemployed and, in his view, simply lazy. While spending some time on biographical work

in each session, behavioural experiments were conducted and planned for times between sessions. He conquered visits to parts of town previously avoided; with time, long cleaning rituals after hearing stories connected with illness or death were reduced. He saw progress and was pleased with it. While he had opened up and become freer in communicating with me, he seemed to freeze up again and I was wondering whether anger towards me was building up. He suggested that he needed another therapist preferably a man, with both of us there for him at each session. He emphasised that he had enough money to pay for two therapists and that he needed the best possible treatment. Over a few sessions I tried to discourage this unusual idea but then felt that he perhaps knew better than I why he needed a male therapist in the session. In the first session he asked my colleague: «If I tell her how angry I am with her, will you tell her, that I don't mean it?». Two joint sessions with this colleague created a situation which helped the patient to venture into noticing and expressing emotions. For this he had obviously needed the support of the far less problematic father figure. In the treatment period that followed, along with pursuing work around his symptomatology, any reported interaction with family, a new girl friend or colleagues was used to pay attention to a growing need to understand the emotional underpinnings of communication with other people. A new dimension of deeper trust and more open interaction was noticeable in the patient therapist relationship. Treatment regained momentum.

Support for the transition phase between the *interpersonal self* and the *institutional self* is often appropriate in psychotherapy in general. Kegan (1995) criticises humanistic and also cognitive therapies for demanding of the patient to operate within the epistemology of the *institutional self* rather than helping the patient to cross this passage. In a re-analysis of the famous video-series «three approaches to psychotherapy» (Shostrom, 1965) of Perls, Rogers and Ellis working with a patient named Gloria, he gives many examples of all three therapists failing to understand Gloria's plea for support in moving towards more independence — while she is not there yet (Kegan, 1995).

A second case-vignette is used to illustrate the process of fostering development in the next transition phase. Maria, aged 31, was a PhD Student of veterinary medicine. She feared passing on contamination as a result of being afflicted with tape-worm herself. Recently she had given up food-shopping for fear of contaminating the customers in her super-market. Her mother lived with her in her one room apartment during the week, to provide food.

For her PhD research she had to visit cowsheds where she feared mutual contamination. Excessive decontamination procedures for shoes and clothes had become necessary. All clothing was washed and rewashed, which she had to do every time she noticed a white mark on any item. As part of her morning routine she checked her excrements with a Q-tip for specks of white, a procedure that took up to half an hour. A long showering routine followed. All her clothes were extremely worn because shopping for clothes had become impossible. She had given up driving her car for fear of harming other people, but bus rides were also problematic, since she scrutinised all upper windows or roofs, in case there was a suicidal person in need of being rescued.

Maria was born as the last child of four. There was an older sister and two brothers. The family had a small farm; the father was also employed in a factory. Family life revol-

ved around mother's rules, she was very strict and ambitious for her children and sought upward social and financial mobility for the family.

There had been no time for play for the children, the patient had begun cleaning the house and washing floors at the age of five, when the other family members were working in the fields. The patient described herself as having been in a permanent state of fear of her mother's disapproval. One «misdeed» could result in the mother not speaking to any of her children for days. When Maria was 17, one of her brothers committed suicide. She had been particularly close to this brother and was the last person he had spent time with before going to his student house to jump off a 12 storey building. It had been clear, that the brother had been depressed for some time, but the family had been unable to ask about his low mood — nor did they exchange feelings after his death. This event had fallen at a time when Maria was well into the transition phase and close to the stage of the interpersonal self, when themes of responsibility and reliability have a prominent place. Extreme guilt feelings for not having rescued her brother had been the result.

Within the first intake-sessions she told me that she had been in conflict over applying for a treatment place with me for nearly three months. She had been in psychoanalysis for one year while she continued to get worse. Her brother had read a book on OCD for patients and their family, where the author had described cognitive-behavioural methods (Hoffmann, 2000). They both agreed that the effect of this treatment sounded promising. She talked to her therapist about her considering this kind of treatment. Her therapist warned and advised against it. Her brother kept pushing for a change of treatment and after she had spoken to him, felt drawn to risk a change of therapist, only to change her mind during the next session of psychoanalysis. This process of being torn without being able to come to a conclusion continued until her psychoanalyst eventually agreed for her to seek treatment with a cognitive behaviour therapist. Being unable to solve a conflict of opinions of one's own accord and relying wholly on the advice of others is typical for the stage of the *interpersonal self* and the following transition phase, only to change in the stage of the *institutional self* or at least close to it. Similar conflicts showed up at work, with the family and few friends with whom she had managed to maintain contact. Each such story was used in therapy to strengthen ideas of voicing her own opinion or trusting her own ideas.

With exposure and response prevention treatment she made rapid progress within the first 10 sessions. She did her own food-shopping, had reduced the time spent with her morning routine, given up numerous cleaning and checking rituals at work and increased social contacts. One evening she went out for a meal with a friend. She had seen a small white food item and, later in the evening, began ruminating that this might have been a tape worm. She decided she needed a tapeworm cure. We discussed her fears in one session and I used various means strongly to question her plan.

When she returned for the next session she had given in to her fears. She was distraught and feared she had lost all that had been gained so far. We discussed what she thought of her tape worm cure retrospectively, why she had been vulnerable to her old fears returning on that particular evening, and what impact this setback might have on the overall treatment outcome. She was unhappy about having given in — which she now saw as a mistake. I agreed with her that the tape worm cure had been detrimental to the progress of

her treatment but making such an important decision against my advice was also a major step in learning to listen to her own inclinations. Seeing that one's decision had been a mistake was only part of the learning process. This event did not result in renewal of other rituals and had no additional negative effects.

To conclude, I would like to link the developmental perspective with the cognitive behavioural treatment approach. Indeed, the latter remains the core of the treatment while the developmental perspective is what it says: a way of understanding patients with their life history and their current process of meaning-making. This can help to obtain a clearer understanding of the learning history of an individual disorder and support the patient's process of seeing longstanding fears and problematic convictions in a new light. Fostering affective-cognitive development has often successfully overcome moments of stagnation or even set-backs and strengthened motivation to continue the courageous work of overcoming a crippling symptomatology. Whenever cognitive-behavioural work results in a step-by-step improvement, the developmental perspective may play only a minor role; where stagnation sets in, looking at the developmental struggle in hand, building a bridge for the ongoing process of a transition phase can be the crucial ingredient.

REFERENCES

- Beck, A.T. (1967). *Depression: Causes and treatment*. Philadelphia: University of Pennsylvania Press.
- Bowlby, J. (1988). *A secure base. Clinical applications of attachment theory*. London: Routledge.
- Erikson, E.H. (1959). *Identity and the life cycle*. New York: International Universities Press.
- Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge: Harvard University Press.
- Hoffmann, N. (2000). *Wenn Zwänge das Leben einengen. Zwangsgedanken und Zwangshandlungen. Ursachen Behandlungsmethoden und Möglichkeiten der Selbsthilfe*. Mannheim: Pal.
- Kegan, R. (1982). *The evolving self. Problem and process in human development*. Cambridge: Harvard University Press.
- Kegan, R. (1995). *In over our heads. The mental demands of modern life*. Cambridge: Harvard University Press.
- Kohlberg, L. (1984). *The psychology of moral development*. San Francisco: Harper & Row.
- Kroger, J. (1989). *Identity in Adolescence: The balance between self and other*. London: Routledge.
- Kroger, J. (2007). Why is identity achievement so elusive? *Identity*, 7, 331-348.
- Loevinger, J. (1976). *Ego development: Conceptions and theories*. San Francisco: Jossey Bass.
- Noam, G.G. (1988). The theory of biography and transformation: Foundation for clinical-developmental therapy. In S.R. Shirk (Eds.), *Cognitive development and child psychotherapy*. New York: Plenum.
- Noam, G.G. (1992). Development is the aim of clinical intervention. *Development and Psychopahtology*, 4, 679-696.
- Piaget, J. (1954). *The construction of reality in the child*. New York: Basic Books.
- Röper, G. (2001). Chronische innere Unsicherheit und ihre Bedeutung für die Entstehung der Zwangsstörung – ein klinisch-entwicklungspsychologisches Störungsmodell. In G. Röper, C. von Hagen and G. Noam (Eds.), *Entwicklung und Risiko*. Stuttgart: Kohlhammer.
- Salkovskis, P. (1985). Obsessional-compulsive problems: A cognitive-behavioural analysis. *Journal of Behaviour Research and Therapy*, 23, 571-583.
- Shostrom, E. (1965). *Three approaches to psychotherapy (film and video series)*. Corona del mar: Psychological and Educational Films.
- Zaudig, M., Hauke, W., & Hegerl, U. (2002). *Die Zwangsstörung: Diagnose und Therapie*. Stuttgart: Schattauer.

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