The Role of Inconsistent Parenting and OCD in Children: A Clinical Case Study

Angana Mukherjee*, Dr Vani Kulhalli**

* Consultant Clinical Psychologist, Mumbai,India
** Psychiatrist, Mumbai,India

Abstract- The present case report highlights the role of inconsistent parenting in causation and maintenance of psychopathology of a 17 year old boy, referred here as "Anil", diagnosed with Obsessive Compulsive Disorder.The case report also puts forward the Psychiatrist's and the Clinical Psychologist'sreflection, focussing mostly on the treatment outcome. Pharmacotherapy and Cognitive Behaviour Therapywere the treatment of choice for Anil where Cognitive Behaviour Therapy was being modified according to the developmental needs and family context. The case report also puts forward the significance of early attachment and parenting (Guidano and Liotti,1983, Safran,1990) and the role they played in the development and maintenance of the dysfunctional beliefs (Bhar and Kyrios,2000).

Index Terms- Obsessive Compulsive Disorder, Cognitive Behaviour Therapy, parenting

I. Introduction

Obsessive Compulsive Disorder (OCD) is a psychiatric condition first described more than 100 years ago (Westphahl,1878) . Obsessive Compulsive Disorder or complex repetitive rituals, isolated obsessions and compulsions might be collectively grouped into a form of a spectrum of psychological problems where the central psychological concern is the fact that adjustment might be compromised at the cost of execution of the repetitive problems/actions/rituals for the client as well as the caregivers. It might form a discrete cluster of problems associated with anxiety and impulse control.

At least one in 200 young children suffer from OCD (Flament, 1988) which might lead to disruptions in their academic, social and vocational development and functioning (Swedo, Rapoport , Leonard, Lenane M, Cheslow, 1989; Adams,Waas, March, and Smith,1994). Between a third and half of the paediatric cases of OCD might continue to display significant symptomatology in adulthood which compromises social and vocational adjustment (Leonard ,2001).

OCD is a condition typically characterised by distressing obsessional thoughts or impulses on the one hand and compulsive rituals which help to reduce anxiety associated with the obsessions on the other. In other words, Obsessional thoughts can be thought of as exaggerations of important aspects of normal cognitive functioning (Salkovskis 1999).

Clinical features and Diagnostic Criteria---
ICD 10 criteria for Obsessive Compulsive Disorder:

The International Classification of Diseases (ICD-10) Classification of Obsessive-Compulsive Disorder (ICD-10 Code F42):--

The essential feature of this disorder is recurrent obsessional thoughts or compulsive acts. Obsessional thoughts are ideas, images or impulses that enter the individual's mind again and again in a stereotyped form, almost invariably distressing (because they are violent or obscene, or simply because they are perceived as senseless) and the sufferer often tries, unsuccessfully, to resist them. They are, recognized as the individual's own thoughts, involuntary and often repugnant.

Compulsive acts or rituals are stereotyped behaviours that are repeated again and again, not inherently enjoyable; individual often views them as preventing some objectively unlikely event, often involving harm to or caused by himself or herself. Usually, though not invariably, this behaviour is recognized by the individual as pointless or ineffectual and repeated attempts are made to resist it; in very long-standing cases, resistance may be minimal. Autonomic anxiety symptoms are often present, but distressing feelings of internal or psychic tension without obvious autonomic arousal are also common.

Obsessive-compulsive disorder is equally common in men and women, and there are often prominent anankastic features in the underlying personality. Onset is usually in childhood or early adult life. The course is variable and more likely to be chronic in the absence of significant depressive symptoms.

Diagnostic Guidelines For a definite diagnosis, obsessional symptoms or compulsive acts, or both, must be present on most days for at least 2 successive weeks and be a source of distress or interference with activities. The obsessional symptoms should have the following characteristics: (a) they must be recognized as the individual's own thoughts or impulses: (b) there must be at least one thought or act that is still resisted unsuccessfully, even though others may be present which the sufferer no longer resists; (c) the thought of carrying out the act must not in itself be pleasurable (simple relief of tension or anxiety is not regarded as pleasure in this sense); (d) the thoughts, images, or impulses must be unpleasantly repetitive.
Includes: anankastic neurosis; obsessional neurosis; obsessive-compulsive neurosis

Excludes: obsessive-compulsive personality (disorder) (F60.5)

Differential Diagnosis Differentiating between obsessive-compulsive disorder and a depressive disorder may be difficult because these two types of symptoms so frequently occur together. In an acute episode of disorder, precedence should be given to the symptoms that developed first; when both types are present but neither predominates, it is usually best to regard the

depression as primary. In chronic disorders the symptoms that most frequently persist in the absence of the other should be given priority.

Occasional panic attacks or mild phobic symptoms are no bar to the diagnosis. However, obsessional symptoms developing in the presence of schizophrenia, Tourette's syndrome, or organic mental disorder should be regarded as part of these conditions. Although obsessional thoughts and compulsive acts commonly coexist, it is useful to be able to specify one set of symptoms as predominant in some individuals, since they may respond to different treatments.

F42.0 Predominantly Obsessional Thoughts Or Ruminations These may take the form of ideas, mental images, or impulses to act. They are very variable in content but nearly always distressing to the individual. Sometimes the ideas are merely futile, involving an endless and quasi-philosophical consideration of imponderable alternatives. This indecisive consideration of alternatives is an important element in much other obsessional rumination and is often associated with an inability to make trivial but necessary decisions in day-to-day living.

The relationship between obsessional ruminations and depression is particularly close: a diagnosis of obsessive-compulsive disorder should be preferred only if ruminations arise or persist in the absence of a depressive disorder.

References: Adapted from ICD-10: World Health Organisation. The ICD–10 Classification of Mental and Behavioural Disorders. Geneva: WHO, 1992

Nature of the Problem:

In the current case study Anil had checking obsessions, where he strived to be sure that he has not been responsible for harm coming to himself or others especially his mother. He also had blasphemous thoughts and religious doubts.His mental compulsions can be roughly classified as ‘restitution’ (putting right) and verification (like checking).(Salkovskis,1985). Sometimes his behaviour was accompanied by a subjective sense of resistance to performing the compulsive behaviour. These compulsive behaviours were usually carried out in a stereotyped way or according to idiosyncratically defined “rules “and were associated with temporary anxiety relief.

Prevalence studies:

Studies on OCD in children revealed that OCD is much more common during adolescence than has been previously thought; it is both underdiagnosed and undertreated (Flament,1988). Although the disorder affects individuals of all ages, the period of greatest risk is from childhood to middle adulthood(Nestadt, Romanoski, Folstein and Mc Hugh, 1994).

The prevalence rates among 4-16 year old children was 12 percent overall with 9.4 percent of children had scholastic problems (**Srinath et. al.,,2005**). Lifetime prevalence of OCD was 0.6% (Khanna, Gururaj,1993).

Co morbidity studies:

The common co-morbid disorders could be tic disorder, anxiety, depression, anorexia, bulimia, hyperkinetic disorders, developmental delays, elimination problems and schizophrenia. Between 1 and 2 percent of children have OCD. It can appear as early as 2 years of age, the most common period of onset is late childhood or early adolescence. The condition may be chronic and continuous or episodic, with one in three cases showing full recovery and one in ten having a continuous deteriorating course. OCD is distinct from the normal rituals of childhood which are prominent in the pre-school years and wane by the age of 8 or 9 years, when hobbies involving collecting and ordering selected objects, toys and trinkets take their place (Carr,1999).

Theoretical perspectives:

No single theory can explain OCD. A multidisciplinary approach to understand OCD is made in the following way.The Biologicalview explains OCD as a structural problem in the basal ganglia. Serotonin hypothesis puts forward the view that OCD symptoms occur due to too rapid a re-uptake of the serotonin or abnormally low level of serotonin. The neuro-ethological theory also states that the basal ganglia and serotonin abnormalities might lead to the inappropriate release of fixed patterns of grooming or self-protective behaviour.

Psychodynamic theory explains OCD as repressed sexual-aggressive impulses associated with early parent-child conflict over toilet-training which might be displaced and substituted by less unacceptable thoughts or impulses. When these intrude into consciousness, they are experienced as ego alien because they have been disowned or isolated and might lead to cause anxiety, which is further managed by carrying out a compulsive ritual to undo or cancel out the undesirable impulse.

Cognitive-Behaviour Theory puts forth that non-threatening stimuli through being paired with anxiety-provoking stimuli, by a process of classical conditioning, come to elicit intrusive anxiety-provoking thoughts which are neutralized by engaging in compulsive rituals. Such rituals bring relief and so reinforced. Genetic factors and socialization experiences may render some people vulnerable to developing intrusive, unacceptable, obsessive thoughts.

According to Family systems theory **f**amily lifecycle transitions precipitate the onset of OCD in individuals whose socialization has rendered them vulnerable to developing obsession and compulsions. The family become involved in patterns of interaction that maintain the child’s compulsive ritualistic behaviour because of their beliefs about OCD and child care, and because symptom-maintain in patterns of interaction may meet their needs (Carr,1999).

Psychotherapeutic Treatment Approach:

Abundant clinical and emerging empirical evidence suggest that cognitive-behavioural psychotherapy, alone or in combination with pharmacotherapy, is an effective treatment for OCD in children and adolescents (March,1995).

II. CASE SUMMARY

Master “Anil” is 17 year old boy, currently pursuing a Diploma course, belonging to a middle-class Hindu nuclear family, is the only son of his parents. He was brought by his mother with the presenting complaints of difficulty in studying, repeated checking whether he would remember his lessons correctly, reassurance seeking, repeated thoughts of being punished by “God”, duration being for last 5-6 years, with

insidious onset, continuous course, with progress improving currently. Family history revealed father and paternal grandfather with alcohol abuse and paternal grandmother of unknown psychiatric illness. Anil was sent to boarding school in Grade VIII at the age of 14 Years. However, his academic performance started deteriorating considerably from Grade VIII. He had difficulty in concentrating in his studies due to repeated thoughts about being punished by "God". Educational history reveals his academic performance was initially above average. He did not have many friends and used to spend most of his time all by himself in school and at home. Home situation was uncongenial in nature with marital discord between parents. Past psychiatric history revealed that he was under medication since 8 years of age as he used to worry about everything, repeatedly seeking reassurance and repeated checking and difficulty to complete his work during examinations. He was under psychiatric medication. Temperamentally, he did not have many friends since childhood and was not very social, had to be told about everything, lethargic, lack of motivation. Mental status examination through most of the sessions revealed appearance well kempt and tidy, eye contact maintained adequately, rapport could be established easily as attitude towards the examiner was cooperative, attention could be aroused and sustained for an appreciable period of time, speech was relevant, coherent and goal directed, adequate cognitive functions, objective affect was anxious, irritable in the initial sessions, euthymic mostly at the later sessions, thought stream, form and possession was normal, thought content revealed obsessive thoughts, compulsive covert checking, helplessness with Grade VI level of insight (Emotional Insight).
On the basis of case history and mental status examination the Provisional diagnosis of Obsessive Compulsive Disorder-Predominantly Obsessional Thoughts or Ruminations was given.

Points in Favour for the above diagnosis are as follows:--

1. Repeated thoughts/ ideas, images or impulses that entered his mind again and again in a stereotyped form
2. Invariably distressing
3. Often tried, unsuccessfully, to resist them.
4. Recognized as the individual's own thoughts, even though they are involuntary and often repugnant.
5. Mental neutralizing and avoidance behavior mostly

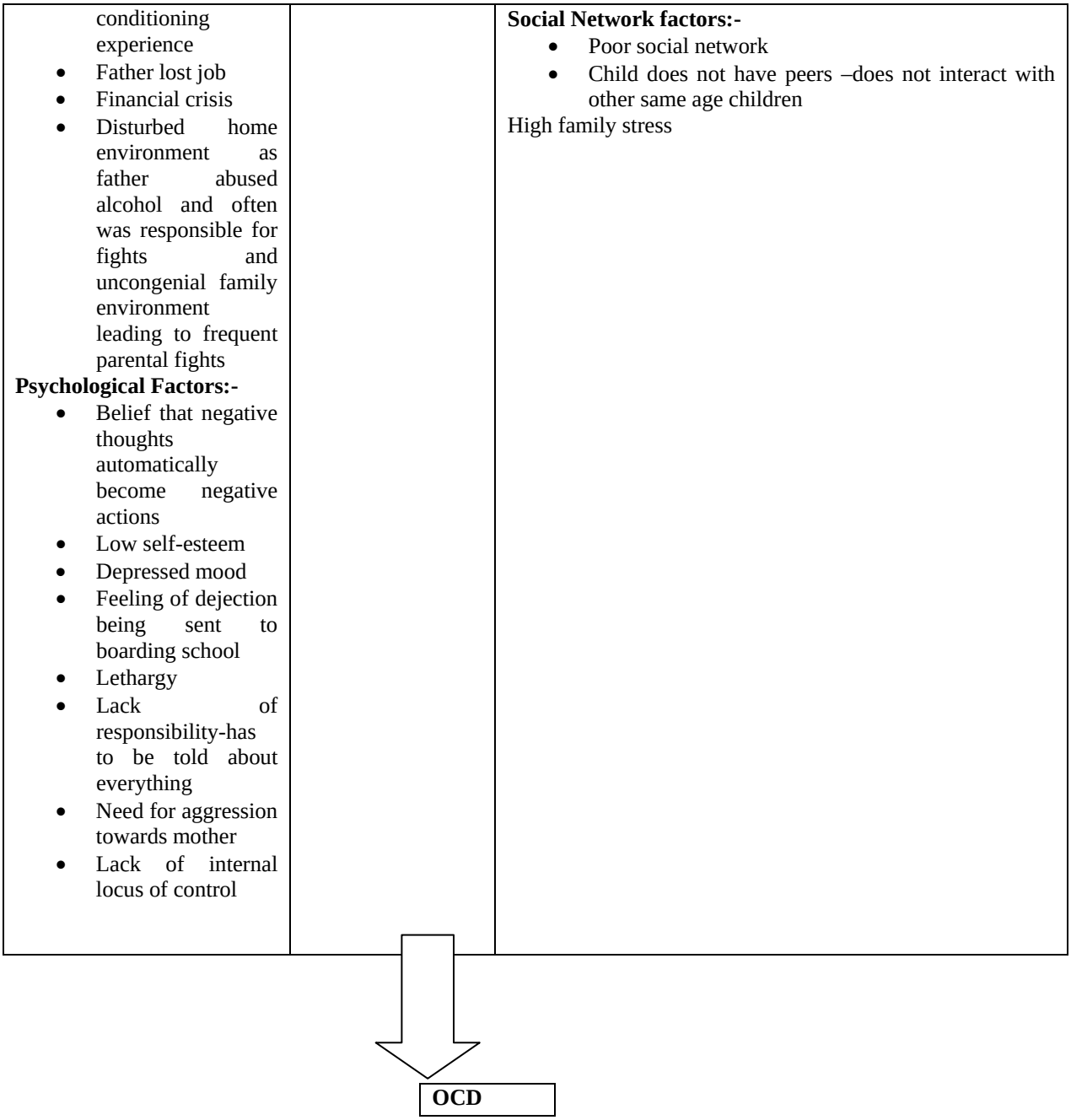
III. INVESTIGATIONS AND ASSESSMENTS

Anil first was taken to a Psychiatrist when he was 8 years old and was under medication since then. In 2015 Anil was again referred to a school counsellor in his boarding school by the school teachers since he had difficulty in concentrating in his studies, did not interact much with other children and worried about 'everything'. However, his condition did not improve and his mother was asked by the school principal to take him home. He was referred to a Clinical Psychologist for psychotherapy. Anil did not want to continue psychotherapy with the Psychologist after a few sessions. According to him the Psychologist did not 'understand his problem'. He was referred to another Clinical Psychologist where he continued to attend psychotherapy. His IQ assessment was done in 2015. The IQ score was found to be 122 indicating the intellectual functioning at 'Superior' category. There were no other psychological reports available with the parents. The Psychotherapy sessions were continued following Cognitive Behaviour Therapy. The regular progress on the therapy sessions were measured through rating scales like Child-Yale Brown Obsessive Compulsive Disorder Scale (C-YBOCS) and Yale Brown Obsessive Compulsive Disorder Scale (Y-BOCS).The psychotherapy sessions were conducted once a week initially, with gradually once in 15 days for the follow up sessions.

IV. PSYCHOTHERAPEUTIC PROGRAM:

PSYCHOPATHOLOGY FORMULATION:

PREDISPOSING FACTORS	**PRECIPITATING FACTORS**	**MAINTAING FACTORS**
Personal:-- • Temperamental factors like apathy, lack of responsibility, • Family history of alcohol abuse father and paternal grandfather **Contextual factors:-** • Parent-child relationship unhealthy especially with father • Stress in early childhood-	Highly stressful events at home and at school	• Compulsive behaviour is maintained by anxiety-reducing efforts • Anxiety being maintained by obsessional thoughts about danger associated with the stimuli • Father ambivalent about resolving the problem • Family never coped with similar problems before **Family System Factors:-** • Inadvertent reinforcement of problem behavior • Disturbed communication pattern among the parents and between father and child • Father not involved in child's treatment/management • Father emotionally unstable • Marital discord • Insecure working models for relationships • Dysfunctional coping strategies



Initial Phase:

The initial sessions were focussed on noting the detailed clinical interview, case history, mental status examination, psychoeducating the parents as well as the child. Initial baseline assessments were conducted in order to reframe and map the obsessive thoughts and the covertcompulsive behaviours. However, since Anil and his mother had previously attended psychotherapy sessions they reported that they knew about the disorder. Anil also reported that he knew about the management techniques and has learned about Exposure and Response Prevention (ERP) technique (Reddy, Sundar, Narayanaswamy and Math, 2017).before. He also reported that the technique did not help him much and he has already gone to many psychologists before so he does not have faith in psychotherapy. He also claimed that nobody would be able to 'understand' his distress. So the initial sessions were mostly focussed on building the rapport and rebuilding the trust in psychotherapy. Since Anil knew about ERP he was not also eager to relearn it and perform it. The initial sessions were also focussed on helping the child to make Activity Schedule followed by Mastery Pleasure daily. He was also convinced to keep a self-monitoring homework in order to help him construct a hierarchy of cues that elicit the distressing symptoms. He was also introduced to Deep Breathing relaxationtechnique (Carr,1999) along with Visual Analogue Scale (VAS) (Carr,1999))to quantify his subjective level of distress. However, Anil was not compliant to all the techniques which were given as Homework initially.

Middle Phase:

The habituation training as an extension of the exposure and response prevention along with thought stopping was introduced to the obsessional thoughts since Anil reported that he was unable to control his obsessional thoughts and felt helpless and these resulted in aggressive outbursts. The intrusive thoughts which are perceived by Anil as endangering his view of self, triggered an escalation in dysfunctional behaviours, or caused a more intense use of thought-control strategies (thought-suppression) (Rachman, 1997, 1998b, Rachman and Hodgson,1980). Anil was asked for deliberate thought evocation, writing the thoughts down repeatedly and listening to a "loop tape" of the thought in his own voice. However, Anil reported that the Thought Stopping Technique and writing the thoughts helped him much more than the loop tape technique and agreed to follow the thought stopping and writing the thoughts. The avoidance and compulsive activity were almost totally covert and were therefore difficult to gain access and to control initially. Hence initially anxiety was targeted to be reduced by repeated exposure to the feared thoughts. However, it was also difficult to make the thoughts predictable since Anil reported that the thoughts were 'automatic' and 'always' 'disturbed' him. And also it was difficult for him to identify initially the vividness, time of onset, speed of onset, intensity, duration, rate of occurrence and the actual detailed content of the thoughts (Carr, 1999).

The Obsessive Compulsive Cognition Working Group (OCCWG, 1997, 2003) had found the exaggerated evaluation of probability and cost of aversive events (i.e. overestimation of threat) is one of the core beliefs associated with OCD. Such world perceptions stem from early attachment experiences (Guidano and Liotti, 1983).Others theories related the individual's sense of security in the world to early attachment experiences (Ainsworth et al., 1978, Bowlby, 1973).

However, with time, Anil had gained the control on his thoughts especially with the Thought Stopping technique. He also reported that Thought Stopping Technique had helped him to keep his thoughts in his 'control' and reduced his discomfort. He reported that he can control his obsessive thoughts most of the time, also started learning Yoga and was preparing for his Grade X final examinations.

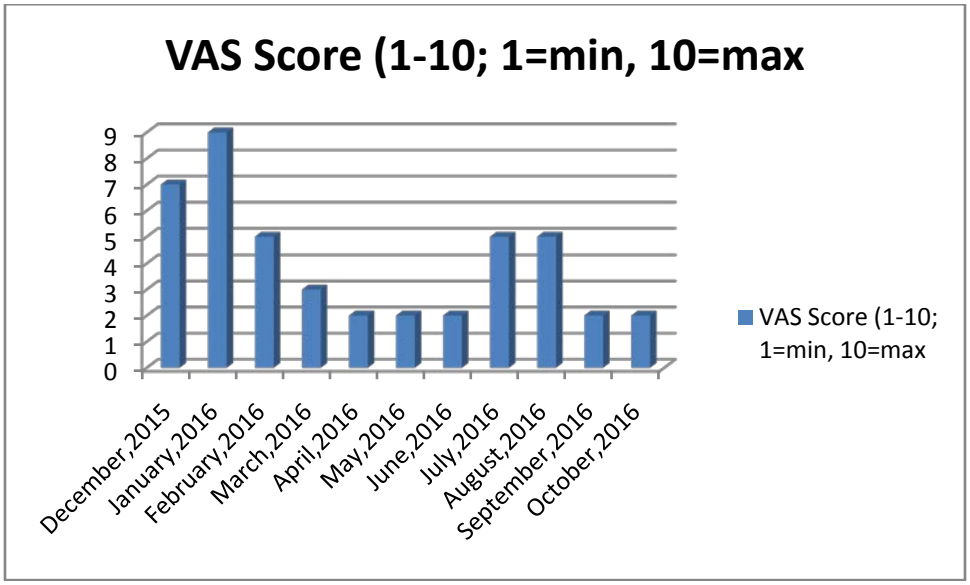
Apart from Mathematics, Anil passed in all the other subjects and currently pursuing a Diploma course. Several changes also took place at home. Anil's mother separated from the father and Anil and his mother started living in a separate house. Anil was quite positive in this decision and often used to console his mother when she was upset about the separation. He also reported that he is now confident that he would be 'successful in life' and was not upset when he heard about failing in Mathematics.

Terminal Phase:

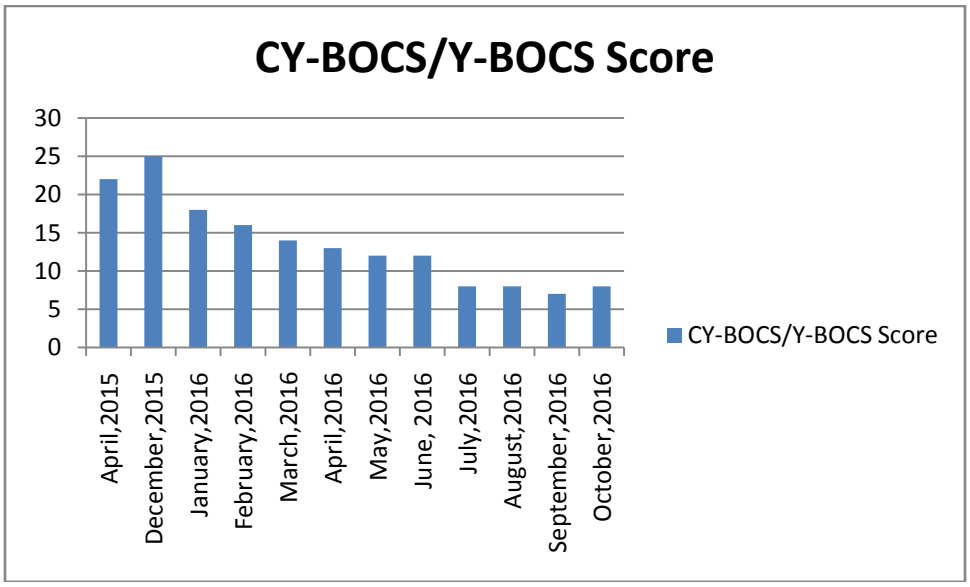
However, Anil is currently regularly attending the classes for the Diploma course and decided to complete his Grade Xth course from NIOS board. Anil also reported that he started his own blog where he writes poems and other write ups. He also reported that he wants to use the 'obsessive thoughts' which still come and distress him in the form of 'creative writing'. Anil however, does not like to go out and make new friends and stays at home. He is being reminded about the maintaining factors like relaxation techniques and cognitive distraction techniques which he reported that he would start working on them again.

Outcome:

Graph 1: Graphical representation of the Mean Scores of ratings of subjective experience of anxiety given by Anil on a Visual Analogue Scale:



Graph III: Graphical representation of progress through sessions as assessed by CY-BOCS and Y-BOCS:



V. CLINICAL PSYCHOLOGIST'S REFLECTION

There were ambivalent attachments or insecure parent-child transactions in Anil's family, where Anil might be uncertain of the degree to which his parents loved him or wanted. This might have led to concurrent experience of both validation and rejection and resulted in difficulties integrating opposing self-perceptions as wanted/lovable and/or unwanted or unlovable. This insecure and ambivalent self-worth further led to chronic self-monitoring and ruminations about one's relation to others. Perfectionism and compulsive behaviours might have emerged as a means of securing approval and unifying one's self-perceptions as a worthy and lovable person. Hence this sensitivity to the development of OC symptoms may be associated with specific parenting variables, not generally evaluated by existing parenting measures, which lead to particular perceptions of self and the environment.

Early experiences of parenting can lead to the development of a dysfunctional self-structure and world-view relevant to OCD. Therefore there is a definite role of underlying vulnerability structures in the development and maintenance of OCD-related dysfunctional beliefs and symptoms.

6 main belief domains that might have played an important role in the development of obsessions from intrusive thoughts for Anil were inflated personal responsibility, over-importance of thought, beliefs about the importance of controlling his own thoughts, overestimation of threat and intolerance for uncertainty and perfectionism. (Taylor,Kyrios, Thordarson, Steketee and Frost, 2002). Hence, perceived parent-child interactions can be linked with anxiety difficulties(Arrindell,Emmelkamp andMonsma, ,1983). Studies by Ehiobuche,1988 found individuals with obsessions had reported their parents as rejecting, more overprotective, and less emotionally warm compared to individuals with low obsessional scores. Anil experienced confusing and ambivalent patterns of attachments with his parents which increased the risk for the development of obsessional problems in him(Guidano and Liotti,1983).

The self-perceptions were influenced by his early experiences and attachment with the parents, where impaired early child-parent interactions led to the development of impaired representations of the self and the world that hampered the later assimilation of new experiences into self-knowledge. These dysfunctional representations resulted in stereotyped and repetitious interactions with reality. Parental variables lead to Anil's over-reliance of certain aspects of self (ie self-concept comprising relatively few domains that were sensitive) coincided with the belief that the worlds are controllable but threatening. might be unique to OCD. (Giodano and Liotti,1983).

The therapy sessions were mostly targeted with the aim of invalidating the expectations and/or beliefs about the negative thoughts becoming negative actions. Previous results indicate that children with early-onset OCD benefit from a treatment approach tailored to their developmental needs and family context (Garcia, Freeman, Himle et al., 2009).Keeping in mind the developmental differences, in case of Anil, the traditional adult CBT approaches were modified, including age-appropriate techniques to address the family involvement and the impact of the psychosocial functioning (Piacentini and Langley,2004).

Anil from a very early age might have learned to become a "super-child" trying to be responsible for helping his mother to take care of the house, taking care of his father, often might be feeling guilty over his inability to "save" his father, despite repeated efforts. This inability might have led to a sense of poor self-image and difficulty in maintaining interpersonal relationships especially with people other than mother. Father's alcoholism, disturbed the interpersonal relationship between his parents, which might also have led to some "psychological scars" that manifested in the form of obsessive-compulsive disorder and an unrealistic need to be "perfect", in him. Therefore the constant searching for approval from others as well as self can also be related from the above mentioned facts (Gold,2016).Along with

the role of mothers, the role of fathers are also important for the development, prevention, and treatment of anxiety and anxiety disorders in children and adolescents Bogels and Phares2008).As stated in earlier studies, at least 57% of children and adolescents who were diagnosed with OCD, had some first-degree relative with a psychiatric diagnosis along with family conflicts, social withdrawal and poor school performance (Toro, Cervera,Osejo andSalamero, 1991).

Anil's father was 'belligerent type' of alcoholic who used to verbally abuse and argued with Anil's mother and Anil. Hence Anil was the recipient of the verbal and emotional abuse from his father. Corroborating with the past literature it can also be pointed out that since father's effect on child's externalizing and internalizing problems are immense (Phares and Compas,1992).Anil's psychopathology can also be associated with his father's characteristics as mentioned by his mother. Anil might have also learned the way his father used to manifest his anger by hitting self or others or throwing things.

However, Anil's father was also highly passive alcoholic at times (Ackerman, 1991). This inconsistency in parenting led to a crisis situation for Anil and his mother. It was a daily struggle for them to survive a situation while denying the existence of the father. Anil being torn between the parents at times he seemed loyal to his mother and at the same time feeling the anger for father as being deprived of the emotional and physical support from the father. This also might have been one reason to avoid peer activities outside home out of fear or shame and also learning some maladaptive ways of dealing with the negative emotional state. The sense of self-worth also was affected. However, Anil's father was also aware of the emotional hazards he was causing for Anil as he expressed his concern about not being able to meet the emotional needs of Anil.

Another thought can be put forward—Anil also experienced 'emotional separation' from the parents being sent to boarding school, often might be feeling rejected by parents. The lack of 'emotional security' might have prohibited Anil from intimate friendship/relationship. There was also inconsistency in the parenting.

Anil's mother always tried and attempted to fulfil the needs of her child, was also under constant pressure to protect her child from becoming like his father. She also tried to fulfil two roles both financially and emotionally. Hence there were times, where there were too much of concern and at the same time too little. Mother also became too protective about Anil. This protection was at times misunderstood by Anil leading to anger outbursts from him towards his mother. Anil was also forced into increased responsibilities and unfamiliar roles. The therapy sessions might have given him the path for acquiring and regaining a sense of trust in his parent especially mother as well as himself leading to acquisition of self-awareness and positive self-esteem. Some sense of security has also developed in him, and currently he has the goal to grow while accepting the circumstances and feeling good about himself.

VI. PSYCHIATRIST'S REFLECTION

Anil is a 17 year old boy from a middle socio economic status family residing in a major metropolitan city in India.His temperament is described as being difficult with elements of moodiness, stubborn-ness and lack of motivation.At the time of first evaluation he was living with both parents. Mother fulfilled criteria for depression while father fulfilled criteria for alcohol and nicotine dependence syndrome with significant narcissistic traits. Marital discord, inconsistent parenting and financial difficulties were present. It appeared that mother was primary caretaker with father rarely participating in the patient's upbringing. Mental status examination revealed obsessions, compulsions and magical thinking with partial insight.

Anil had been assessed by a number of Psychiatrists and been on medication and therapy since the age of 8 years. He was on venlafaxine 75mg twice daily, Fluvoxamine 100mg twice daily, risperidone 2 mg twice daily, trihexyphenidyl 2mg daily and clonazepam 0.25mg twice daily. These medicines were reported to be giving a good response with minimal side effects (primarily dry mouth). Hence the same medication was continued and it was planned to focus on individual therapy and family counselling while he remained stable on medication. Anil's follow up was regular and punctual. His compliance was adequate. He made satisfactory progress and continued regular therapy. He had been correctly diagnosed and had been on medication since several years. Addition of therapy helped to overcome the treatment resistant symptoms and provide good outcome.

VII. CONCLUSION

Based on Attachment theory the way Anil developed a sense of security based on the perception of having a secure-base to return to in case of need. This sense of security reflected his experience of being nurtured (ie perceived degree of feeling loved by the main caregiver and perceived degree of availability and responsiveness of the main caregiver that is his mother.This might have influenced Anil's perceptions of the world and of human nature (Bretherton and Munholland,1999).

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AUTHORS

First Author – Angana Mukherjee, Clinical Psychologist, M.A.(Speciaization-Clinical Psychology), M.Phil in Clinical Psychology, (Department of Psychology, University of Calcutta,) RCI Reg No.A28069,Mumbai, India; Email--anganamukherjee6@gmail.com

Second Author – Dr Vani Kulhalli, Psychiatrist, MD (Psychiatry), Department of Paediatrics, Dr BalabhaiNanavati Hospital, Mumbai, India; Email—vanibk@rediffmail.com

Correspondence Author – Email—anganamukherjee6@gmail.com, Ph- +91-9739087734.