ADLERIAN REALITY IN OBSESSIVE-COMPULSIVE DISORDER

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Abstract:The attitude and interpretation of the individual towards the world and life, later determines his own lifestyle, which remains and forms the basis of his character.
Adler has proposed a typology of patterns that will dominate lifestyle, one of whom is the addicted type - it is he who takes it without giving it back. In difficult moments in life, the individual must learn to rely on others. Otherwise, when the social interest is low and feels overwhelmed, the individual can develop psychiatric disorders such as phobias, obsessions, compulsions and generalized anxiety.
In this article, by reference to the cases encountered in my clinical experience, I will try to capture the important role of the Adlerian psychotherapy approach in the obsessive-compulsive disorder.
The methods and techniques used are: case study, observation, conversation, lifestyle inventory, family analysis through family constellation, and early memories.

Keywords: lifestyle, obsessive-compulsive disorder, basic beliefs, depression and anxiety.

In conceiving this article I started from the idea that everyone builds its own reality around him, depending on how the world looks in his eyes.

In Adler's view, lifestyle is the same as character. Lifestyle is being acquired as a result of social interactions, forming between 4 and 5 years and is difficult to change later. Later, it will function as a basic skeleton for future behaviour.

In his various works, Adler has used various terms for lifestyle: personality, individuality, or self. Life style is not as determined as it seems at first glance, because Adler introduces the concept of the "creative force of the ego" (self).

In his later works, Adler postulates that the self is created by the individual himself, this, being not only the passive amount of childhood experiences. Early experiences are not important in themselves, but rather by the attitude of the subject towards them. Neither heredity, nor the environment determines the structure of the personality, but the way the subject interprets the respective experiences, lay at the basis of the creative construction of the subject's attitude towards the world and life. Once created, lifestyle remains constant and forms the basis of character, which defines the attitudes and behaviours of the subject.

According to Adler, man has four beliefs about his lifestyle: the concept of himself (who I am), the ideal self (who should I be to find my place in the world), the image of the world (beliefs about others) and ethical beliefs (personal good and bad code).

Rejecting the inclusion of people in exclusive categories, only for teaching purposes, Adler proposed a typology consisting of four patterns that can dominate lifestyle in general:

- **The dependent type** - the one who does not give back. To cope with the difficulties in life, he must rely on others. The amount of energy or social interest is very low, and when it feels overwhelmed it can develop mental disorders such as phobias, obsessions, compulsions, generalized anxiety.
- **The avoidant type** - one who avoids social contact for fear of failure or rejection. It has the lowest level of energy or social interest and is prone to psychosis.
- **The guiding type** - characterized from the early childhood by the tendency to be dominant and aggressive. The high level of energy makes him pursue

personal power at any price. It is prone to antisocial behaviour - sadistic, alcoholic, drug-dependent, and suicidal.

- **The useful social type** - the healthy, open and active. It has an optimal level of energy and social interest. It is a mature, positive, personalized, caring person. He does not want to be superior to others, but wants to solve his problems so that he is useful to others.

Man is seen as a social being dominated by conscious rather than unconscious. What we are and what we do depends entirely on us and not on the contents of the unconscious, so we can control our fate alone and we are not a victim of it. Everyone builds their reality around them, depending on how they look at the world.

Case presentation

A 32-year-old patient, T.A, dental nurse, attended the cabinet. This was sent by the GP for specialist help. T.A. encounters difficulties in living her life under normal conditions because of obsessive thoughts and compulsive behaviours that seemed impossible to master.

Obsessive-compulsive disorder is an anxiety disorder characterized by uncontrollable, undesirable and repetitive thoughts and ritual behaviours that the patient feels obliged to follow. People who suffer from this mental disorder are able to realize that their thoughts and actions are irrational, but they feel unable to get rid of them. These obsessions occur in particular when we think of something else or we are trying to do something.

In the present case, the patient while sterilizing at the dental practice where she was working inadvertently stung with a medical instrument that according to the medical history of the patient could be infected with a form of hepatitis. From that moment on, the patient went into shock, was not able to work in the "alert rhythm" she was working in before, because she checked her work 3-4 times: "I was afraid of everything that was sharpened and with blood, for fear of infecting me with any disease", said the patient. She very carefully check medical gloves repeatedly. Extremely frequent thoughts, accompanied by anxiety, make memory and concentration more diminished. Because of this, the job duties were made with difficulty, which is why after several "months of torment and inefficiency" she resigned. This is where the "nightmare" began. Including on the street she was careful not to step on needles, and exits in nature were accompanied by the same anxious thoughts. Even banal domestic activities posed problems to the patient: she was afraid to get a hand with a person not to be infected with microbes or to touch an object previously touched by other people - including doors or money. She was obsessed with the thought that she did not lock the door well, that she did not close the bathroom faucet or that it did not stop the gas, that she did not remove the iron from the socket and returned from the road several times to check. She cannot bear to see that one thing is not in his place or placed in a certain position, so she checked the position of the towels that had to be placed in the same way all in a place specially arranged for them.

She had difficulty in the relationship she had, so she had a lack of adaptation to new situations. The person was rigid in her views and inflexible in how to approach the problems. Changes made her anxious and preferring a safe, risk-free routine that she knew. She preferred to stay at home with homework that gave her some peace. It is manifested by excessive, moralizing, humourless attitude, even by the stinging of the joy of others. The person in question was often petty to bad, and not at all happy to give or receive a gift. The indecision was another prominent feature. For the patient, it was difficult to weigh the advantages and disadvantages of new situations. She hung up on decisions and often asked more and more advice to confirm that the decisions made were the right ones. She was afraid of making mistakes and, after making a decision, was worried that her election had been incorrect.

In this situation, the support of the close ones is very important; reproaches, dissatisfaction with possible mistakes made by the patient, expressed either directly or indirectly, the comparison with the person who she was before the illness only maintains the symptoms of the disease and, implicitly, the poor functioning of the patient.

On a social level, the patient is sensitive to criticism, being overly preoccupied with the opinions of others, and expects to be judged as harsh as she is judging herself. Because of this, exits in society were increasingly rare, and almost non-existent friends. It raises issues at a relational level - in the family, because of the unreasonable insistence that others will follow exactly her way of acting, not letting others manifest themselves as they would.

Technique of meetings

Once we have established a relationship with the client, we began exploring the wrong beliefs of the client. One of the goals of counselling was to identify "basic" mistakes and bring them to the customer's attention. "Basic" errors are *basic* because they are the original ideas that a child develops to meet the needs of belonging and meaning something. They are considered to be wrong because they are erroneous conclusions from the child's perspective since he is engaged in the effort to establish a place in the world. It is the responsibility of the psychotherapist to discover these early, wrongly developed beliefs, and to help the client see how these false ideas are and how they can interfere with effective social and personal functioning.

Together, the following erroneous creeds have been identified: "Everything must be done irreproachably." "Improvisation and spontaneity cannot do anything good," "I have to control everything.", "You have to respect the rules in everything you do."

Sometimes only discussing the wrong beliefs with the client and bringing them to her attention is enough to make changes in client self-perception. However, at times, wrong beliefs and private logic are so embedded in the client's way of looking at life and self that talking about them does not bring any change. In this situation, we helped the client to introduce creative ways to re-examine their basic beliefs so that they can then make changes.

In this regard, I used the Life Style Inventory (LSI) work method and the Early Memo (EM) technique. By interpreting an EM or a series of EMs to a client, the psychotherapist can hold a "mirror reflecting the client's attitudes and intentions" (Ackerknecht, 1976, p. 54). EM can be an excellent tool to help the client reconsider their erroneous beliefs. It is then possible for the client to substitute negative and positive beliefs.

It should be specified that EM does not determine behaviour, they reflect the self-image of the present, worldviews and the style of interaction with others of the client. These ideas, which govern the behaviour, may or may not be client-conscious. When asked to describe specific incidents that occurred in the early years of life, the client selects, modifies and imagines events that express the central themes and interests of his life.

Therapeutic approach

We began the visualization process with elementary relaxation techniques. Then I asked the client to view the specific incident, chosen to be that "basic" mistake. The process can be facilitated by suggesting to the client to think about EM from the observer position. Then the client described the scene. Eyes still closed, the client was asked to describe feelings / sensations experienced during the interaction.

To begin changing the "base" mistake, the client was asked to visualize herself as an adult who actually enters the scene. The client is asked to visualize the adult self by lining, reassuring the child's self, telling the child how valuable, important and loved it is. Then it is suggested that the visualized adult begin to reconsider any wrong beliefs about the realization of importance and belonging.

So I invited the client to close her eyes, sit comfortably in the chair, breathe deeply a few times, then remember an EM, and she told this remembrance:

"I remember walking with my mother to the church every Sunday. Whenever we leave home, Mom and I check the gate if it's closed, sometimes we check it out for 4 times. At the mother church I still wonder if I closed the door well. I remember sweating in my palms and I could not enjoy what is happening around me, being afraid I may not remember exactly what I did. Once I remember that I forgot the tap turned on until we came back home, and the parquet broke. Then my mother spoke ugly, she told me that I was not capable of anything and that everybody had to stand behind me to check that I'm not doing anything stupid."

When I asked the client how she felt, she said: "I feel unaccepted as I am, I got tired to do everything perfect to be in control all the time to feel safe and to feel that I mean something."

I guided the client through the EM view process described above. I invited the client to visualize herself entering the scene as an adult, then I encouraged her to embrace and reassure the child self. Then through this technique I led her through a process in which her adult self told to her child self that she did not need to always check everything, that she should not always be in control and that things were not necessary to be perfect all the time.

I have encouraged the adult self to tell the child self and to ensure that he is loved and important, even when things are not done perfectly. I asked the client if she wanted to change something in the view, she said, "I want her to know (the child's self) that she is truly loved and accepted as she is." After the adult self told the child self how much she loves her, I took the client out of visualization.

Together with the client I processed the EM view and discussed the changes she wanted to make in her basic beliefs. The client said she wanted to change her erroneous beliefs in the following way: "I do not want to live in tension anymore (checking, counting, etc.), anyway I cannot control everything, "I want to let me be wrong, for that I learn from mistakes and I do not want to be perfect all the time".

After this session, the client reported a release feeling. The client continued to examine her "basic" mistakes and see how these ideas interfere with her present functioning.

Conclusions

EM technology helps clients to understand their misconceptions more clearly and facilitates changes in the ways they gain importance. EM visualization is an action-oriented method useful for clients who have difficulty linking their early decisions and their present behaviour.

Visualization may also help clients who understand their problem, but they seem to have difficulty changing their feelings / emotions and behaviours.

EM visualization is one of the many therapeutic tools to use along with other strategies. It should never be used without a solid counsellor-therapist relationship and an understanding of the client's lifestyle. After visualization, it is necessary to process the client's experiences with him in order to ensure his understanding and well-being.

The causes of obsessive compulsive disorder are not exactly known. Researchers at the Mayo Clinic in Minnesota suggest there may be several causes. According to them, obsessive compulsive disorder can be caused by changes in the chemical activity of the body or in the brain's functioning.

Another explanation would be that the syndrome derives from certain behavioural habits learned with the passage of time. Insufficient serotonin levels may contribute to the appearance of OCD. After examining brain images of people suffering from this syndrome with images of a healthy person, there were observed differences in brain activity.

Other studies, the results of which give rise to controversy, link the infection to a type of pharyngeal streptococcus in childhood and the development of obsessive compulsive

disorder in adulthood. Everyday stress and family medical history may be risk factors that may predispose to such anxiety disorders.

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