OCD Symptoms and Adlerian Psychology

A Literature Review

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Abstract

This research notes the various OCD causes, subtypes, and the treatment options currently offered to OCD sufferers. The leading psychotherapeutic treatment modality was noted to be cognitive behavioral therapy (CBT). It was found that Adlerian treatment for OCD symptom reduction was absent from the current literature. This research suggests Adlerian psychotherapy may be ineffective because it uses an encouragement based model. This noted limitation was due to the fact that some OCD compulsions focus on reassurance seeking. To test this limitation, Adlerian therapy was compared to leading OCD treatment options noted in the research literature as effective treatment options. After review, Adlerian based treatment was suggested as a possible new option for OCD sufferers due to the similarities it had with CBT and the possible benefits it could offer. The writer argues that the leading treatment models are ineffective for some OCD sufferers and the Adlerian approach may be a new useful treatment option for these individuals when effectively administered.
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OCD Symptoms and Adlerian Psychology

Obsessive-compulsive disorder (OCD) is relatively common and currently affects roughly 1.6% of the US population according to Himle, Chatters, Taylor, and Nguyen (2011) and has an estimated lifetime prevalence ranging between 2-3.5% according to Marques, LeBlanc, Weingarden, Timpano, Jenike, and Wilhelm (2010). This research is aimed at understanding the effectiveness of using Adlerian based psychotherapy to reduce OCD symptoms. The impetus for this was to examine the presumed limitation of Adlerian psychotherapy with OCD clients.

Interestingly, this writer did not find any studies analyzing the effectiveness of Adlerian therapy with OCD symptom reduction. However, the literature did provide a possible limitation for the Adlerian psychotherapeutic model due to the general positive reinforcement and encouragement paradigm utilized with Adlerian techniques (Dinkmeyer, 1972; Sperry & Carlson, 1996). As positive techniques could potentially exacerbate OCD symptoms stemming from the client’s exaggerated needs for control and perfection, and these symptoms manifest in the need for frequent reassuring and pacifying. In this way, Adlerian psychotherapy could feed certain compulsive symptoms if the encouragement and general positive focus inadvertently feed the OCD client’s need for this type of reinforcement.

To explore this possible connection between the positive focus of Adlerian therapy and the potential, but inadvertent, reinforcement the OCD client might perceive; this paper will first explore the various presentations of the disorder as defined by the American Psychiatric Association (APA, 2004) and the presenting symptomologies noted within the literature reviewed. Next, this paper examines the known treatment options and highlights the most effective options presented in the literature. Then, this study will review the salient Adlerian treatment techniques generally utilized for a range of neurotic presentations and compare these
techniques to the known effective OCD treatment options discovered within the research literature. Throughout this discussion, the writer will identify areas that correspond with concepts from an Adlerian framework.

**OCD Etiology and Clinical Implications**

OCD is considered a serious and persistent mental illness (SPMI) and persons with this condition often face significant functional impairments (Fineberg, 2007). The disorder is characterized by uncontrolled obsessive thoughts and rumination. The invasive and obsessive thoughts are generally ego-dystonic (though this is not characteristic of persons with a hoarding compulsion) and are consciously known by the individual to be unrealistic, over exaggerated and unwanted responses to normal daily situational stimuli. Likewise, the accompanying compulsions are typically represented by repetitive mental acts or physical behaviors that attempt to compensate for the invasive thoughts that are consciously understood by the individual to be overindulgent and troubling (Fenger, Mortensen, Rasmussen, & Lau, 2007).

OCD has a long and noted history as a disorder; described first in 1621 when medical scholar and practitioner Robert Burton detailed the disorder’s symptomatology (Carmin, 2005). Sperry and Carlson (1996) noted that Adler paid special attention to OCD-like features (though he did not use the contemporary pathologic framework) and classified it as a prototype for all mental disorders. Sperry and Carlson also stated that Adler detailed eight distinct features of what he labeled the *Compulsive Neurosis*. However, Adler’s explanation of this specific disorder appears to be quite similar to his overarching theory of the neurotic condition typically displayed by individuals. Adler highlighted the use of *Compulsive Neurosis* as a way for the “neurotic” to avoid life tasks by using a “hesitating attitude” towards the tasks of social living (Sperry & Carlson). Adler felt that the main features of OCD were clearly manifestations of the mind that
caused individuals to be cautious and perhaps avoidant when life tasks became difficult and anxiety producing.

Sperry and Carlson (1996) also state that Adler believed that individuals with OCD, or in Adler’s original terminology *Compulsive Neurosis*, were likely choosing their symptoms due to the pampering they received as children. In some ways this makes sense using modern standards, as Sperry and Carlson note that most OCD suffers are typically average to gifted intellectually and are typically from more stable and reasonably affluent households, which tend to value achievement and perfection when performing tasks. Adding to this theoretical framework, these individuals were then rewarded for their consistent performances and compulsiveness and likely were “pampered” in the form of a reward for their repetitive achievement. Individuals from less privileged families are expected to contribute to the family without such rewards and thus less frequently develop OCD tendencies. In this way, one can understand how these more affluent familial psychodynamics may facilitate the fostering of child papering and OCD symptom formation and maintenance.

Several authors, including Marques et al. (2010), Pallanti, Bernardi, Antonini, Singh, and Hollander (2009), Maltby and Tolin (2005) and Carmin (2005), report that many individuals who suffer from OCD symptoms do not receive care due to problems with access to care, fear of treatment, skepticism of treatment success, and social stigma. Marques et al. report an average gap of 9.72 years between the time of initial OCD symptom onset and the start of treatment, for those individuals who do in fact seek treatment.

Another reason for the gap between symptom onset and the actual start of treatment appears to be the OCD sufferers need for control, along with perfectionistic characteristics generally found in this population; these characteristics are well accounted throughout the
literature by many leading researchers like Moulding, Kyrios, Doron, and Nedeljkovic, 2009; Phillips, Yorulmaz, Genco, and Woody, 2010; Pinto, Menard, Eisen, Mancebo, and Rasmussen, 2007; Schooler, Revell, Timpano, Wheaton, and Murphy, 2008; Taylor, Cole, Abramowitz, Olatunji, Timpano, and Tolin, 2010. This need for control and the need to be perfect, in particular, are at the foundation of Adler’s theory of symptom formation (Dinkmeyer, 1972; Disque & Bitter, 2004; Kaufman, 2007; Leak & Leak, 2006; Rasmussen & Dover, 2006; Watts & Pietrzak, 2000). According to these authors, Adlerian theory maintains “the need to be perfect” is the root cause for the use of symptoms as safeguarding mechanisms, or symptom formation, and the “courage to be imperfect” is the healthy approach needed to accomplish the necessary tasks of life, i.e. work, friendship, and love when faced with a challenge.

Further, this “need to be perfect” is essentially the need to avoid challenging one’s self-esteem, or self-worth by attempting a task that one has not yet mastered. Symptoms and excuses, then, allow the individual to avoid new challenges, and thus the anticipated failure is not perceived by the individual to be at their expense or self-esteem specifically. This overvaluation, to be seen as perfect to others and to assess life task as “victories” and “failures” as the basis for self-worth, within Adlerian terms, would then be the purpose of OCD symptomatology.

**Summary of Introduction to OCD and Adlerian Epistemological Theory**

Adler noted how OCD type presentations were a “prototype” neurosis to his psychological model (Sperry & Carlson, 1996). Others noted the long history of the disorder going back to the 17th century as an early psychological abnormality using a more medical model (Carmin, 2005) We have also seen how it is relatively common today with lifetime occurrences ranging around 3% (Himle et al., 2011). What we do know is that it is a serious mental disorder that deserves clinical attention. We also know that Adlerian techniques may not be the best
approach to take clinically due to the encouraging nature of the treatment due to the particular pathology of the disorder. For the remainder of this paper we will investigate the current research literature to test this writer’s hypothesis that some Adlerian treatment techniques may actually exacerbate certain types of OCD and discover if other treatment options may be more appropriate for this particular population.

**OCD Subtypes, Symptoms, and Potential Causal Factors**

This section discusses the potential causes of the disorder and its various presentations. This section also explores whether the Adlerian framework seems applicable to contemporary findings. There is still much to learn about the nature of OCD symptom formation, maintenance, and the true effects this mental disorder has on the individuals who experience it. What is known is that OCD is clearly debilitating when it is severe and causes much distress and functional impairment even in milder cases.

**Biological Connections to OCD**

In examining genetic and familiar associations with OCD, Schooler et al. (2008) state that the majority of the studies they reviewed indicate a familial and genetic association when looking at OCD patterns between siblings. However, they note that many of these studies were found to have serious methodical issues. One of the main limitations noted was the limited weight given to psychosocial factors. That is, siblings likely share many characteristics that extend beyond their biological connectedness, like their socialization patterns and similar life events, and these similarities could lead to similar symptomologies.

Schooler et al. (2008) expand on the previous work they found in the research literature, related to OCD familial association, in their study by making methodological improvements. They found individuals with a genetic familial association had an increased likelihood of
developing OCD symptoms when compared to nonrelated individuals. They also reported that individuals with genetic familiar associations were more likely to have more disabling symptoms, earlier onset, and greater co-morbidity with other axis I psychiatric disorders, as compared with OCD suffers who did not have a genetic familial association. In fact, their test group had an average of 2.95 additional disorders vs. 2.54 when compared to the OCD control group without familial association.

It is difficult to say if this .41 increase in OCD co-morbidity is statistically relevant due the sample size and nature of the disorder, as it pertains to what previous authors like Sperry and Carlson (1996) and other Adlerian's identify in the root causes of the disorder from a psychodynamic perspective. That is, an increase in additional disorders may be associated with socialization dynamics, as much or more than purely biological connections.

Adding to this, another major limitation of this study was the exclusion of depressed persons who did not experience OCD while not depressed. Excluding this group may have skewed the relatively limited statistical difference cited by Schooler et al. (2008), again when considering familial associations and other clinically significant axis I co-morbid disorders. Complicating this limitation further, the author’s note that 65% of OCD patients also suffer from major depressive disorder and thus, illustrating a clear association between the two disorders. This flaw in their methodological approach seems troubling due to the clear association between depression and OCD and therefore the difference in their biologically associated group with greater rates of other co-morbid axis I disorders may be spurious in nature.

Schooler et al. (2008) conclude that the greater genetic loading, the greater the functional impairment and co-morbidity with other axis I disorders. What is unclear is to what end can one conclude these finding were biologically based vs. the formation of similar psychosocial factors,
despite their attempts to improve this methodological limitation observed in previous studies. In this way, without further data we are not able to completely discredit the Adlerian theory of neurotic symptom formation as a potential basis for OCD symptom formation.

As previously noted the evidence suggests that earlier onset OCD presents clients with increased functional impairment. In their review of the literature, Butwicka and Gmitrowicz (2010) note how the age of OCD onset can influence the severity and subtype of juvenile onset OCD. The connection here seems to lead to an association between the type and severity of OCD and the age of onset generally, as this phenomenon impacts both adolescents and adults depending on when symptoms presented in their developmental stages.

To look into this association, Butwicka and Gmitrowicz (2010) conducted a study with a large sample of 132 participants, with three comparison groups who were statistically sexually homogenous (44 adolescents, 43 adults with onset at 18 years of age or later, and 45 adults with onset prior to 18) with males being slightly over represented. The authors reviewed inpatient medical records that were compiled by certified child and adolescent psychiatrists. They concluded that the age of OCD onset was impactful on OCD subtype and severity.

An interesting aspect of these findings was that the earlier the onset and thus more severe functional impairment, the more chemotherapy resistant the individuals were to serotonin reuptake inhibitors (SSRI). That is, the more biologically connected the OCD appeared to be the less medications had any significant efficacy for most of these individuals. This contradicts the notion that early onset OCD is related to biological association, as logic suggests the more biologically associated a disease is, the greater the benefit chemotherapies would be, as they would work to alter an imbalance in the biologically based pathology of the subject. This study also presented co-morbidity rates of 45% for the three control groups collectively, regarding
additional axis I psychiatric disorders (Butwicka & Gmitrowicz, 2010). The limitations of this study appear to be the limited control the researchers had with regards to measurement validity, as they did not administer the interviews with their research subjects.

Miyata et al. (1998) note in their review of the literature, that the classical explanation of OCD etiology and symptom formation is rooted in the psychodynamic theoretical notion of defense mechanisms. Within Adlerian circles these formations would be more consistently described as attempts at safeguarding self-esteem (Dinkmeyer, 1972; Sperry & Carlson, 1996; Leak & Leak, 2006; Watts & Pietrak, 2000). Miyata et al. note that while these etiologic paradigms and the corresponding psychotherapies may be useful, new chemotherapies are an effective means to reduce OCD. They note how clomipramine and select serotonin reuptake inhibitors (SSRI) are effective options in addition to utilizing psychotherapeutic treatments. This then, presents possible evidence to a biological association with OCD symptoms and possibly OCD formation. They go on to argue that event-specific, or phenomenological-based disturbances are less likely to lead to OCD than biological associations generally.

To highlight this specific point further, Miyata et al. (1998) state that biological vulnerabilities related to mental processing deficiencies may lead to OCD symptom formation, but OCD symptom severity is less likely to lead to mental processing impairment. That is, cognitive impairment can be associated with OCD onset, but OCD is not necessarily associated with cognitive impairment, and thus showing a possible link to a co-morbid association with processing deficits and OCD symptom formation. This finding, if proven to be valid, would then contradict Sperry and Carlson’s (1996) notion that OCD symptom formation often manifests in relatively gifted intellectually and affluent persons and thus may point to limitations in the Adlerian framework.
Adding to the possibility of a biological vulnerability to OCD symptom formation, Kyung et al. (2008) note that there are some negative indicators of mental performance associated with persons who have OCD based checking compulsions. They utilized an OCD group with checking and cleaning compulsions with a control group of healthy individuals. Their research study sought to test the nonverbal memory capacities of the three groups and show possible associations to nonverbal memory dysfunction with OCD. They postulate that the lack of sufficient nonverbal memory is associated with the need for near constant checking behavior. The possible limitations of these findings are that the individuals who suffered from the checking compulsions may have increased anxiety, which then could limit their nonverbal memory due to enacting a stress response. That is, individuals more focused on contamination fears and subsequent cleaning type compulsions, along with the normal control group, may have experienced less anxiety and thus had less non-verbal memory impairment (Eberhart & Hammen, 2010).

**Neurotic OCD Symptom Formation**

Moulding et al. (2009) found that the misinterpretation of thought, coupled with the level of mistaken belief formation can lead to an increase in the prevalence of OCD in society generally. This notion appears to be in line with Adlerian neurosis formation and maladaptive lifestyle formation, as the Adlerian model generally notes how mistaken beliefs about life and the amount of rigidity one has about life, generally lead to maladaptive symptom formation, and in this case OCD symptom formation (Dinkmeyer, 1972; Leak & Leak, 2006; Sperry & Carlson, 1996; Watts & Pietrak, 2000).

Moulding et al. (2009) and Taylor et al. (2010) note several types of mistaken beliefs that could lead to OCD formation. Those are inflated responsibility, over importance of thoughts, the
importance of controlling one's thoughts, overestimation of threat, intolerance of uncertainty, and
the need to be perfect. Adding to this Rasmussen and Dover (2006) note that, “…for many with
obsessive-compulsive condition, the expectation is perfection, which can only be attained by
focusing on a very specific task or a very limited number of tasks” (p. 378).

As noted previously, Adlerians would contend that most, if not all, symptom formation is
the direct result of an individual’s need to be perfect (Dinkmeyer, 1972; Leak & Leak, 2006;
Sperry & Carlson, 1996; Watts & Pietrak, 2000). Therefore, the need to control thoughts,
situations, and have certainty, is all tied to the need to maintain perfection or the outward
perception of perfection. Moulding et al. (2009) contend they found evidence from their
research that supports the notion that, “…higher levels of desire for control and lower levels of
sense of control would be related to higher OCD symptoms” (p.86). To highlight this further,
these authors illustrate how intrusive thought formation occurs within nonclinical and clinical
populations. They report that the increased frequency and distress intrusive thoughts cause are
the main differences between OCD persons and non-OCD persons. These authors conclude that
“…lower overall sense of control led to higher OC {obsessive compulsive} symptoms, both
directly and indirectly via OC beliefs; in contrast higher desire for control was indirectly related
to higher OC symptoms via increased obsessional beliefs” (Moulding et al., 2009, p. 88).

**Psychological Vulnerabilities Based on Culture and Religiosity**

Recent research suggests that OCD and related psychological vulnerabilities may not be
tied with biological vulnerabilities. In their literature review, Yorulmaz and Woody (2010) note
the association between the development of OCD symptoms and cognitive traits that require the
need (or perceived need) for thought control. The authors believe that OCD symptom formation
is associated with religiosity, self-esteem, and personality characteristics.
These authors (Yorulmaz & Woody, 2010) investigated the impact of culture and contributing psychological vulnerabilities. They conducted a non-clinical study utilizing young adults with an average age of 21.26 years from Turkey who were 51% female, and persons who were 19.99 years old from Canada who were 75% female. Their results centered on the amount of rigid religiosity and level of collectivist cultural ideology present in each sample and how these factors impacted OCD symptom formation. To summarize their results, they found that both studies showed that the younger the individual, the higher the level of OCD neuroticism and symptom severity. Also, those individuals were found to over-value the need to take responsibility, to overestimate potential threat, to be intolerant of uncertainty, to possess high needs for perfection, and to hold the belief that thinking leads to actual real life occurrences.

Within the Turkish sample, increased religiosity and collectivism led to increased thought control formations which, in turn, led to OCD symptoms of excess worry and thought suppression. Whereas the Canadian sample, whose subjects had less rigid religiosity and tended to be less culturally collectivistic, presented symptoms that included self-punishment techniques (Yorulmaz & Woody, 2010). The Turkish study suggested that rigid religiosity may lead to OCD; this is probably due to the highly structuralized, ritualistic behavior patterns it encourages, as well as anxiety based in concern for spiritual salvation. Alternatively, within the less religious Canadian group, the ambivalence about certainty and less-definable group identity also led to OCD symptom formation, though it took the form of rigid personal rules or morals leading to self-punishment when the individuals failed to live up to their self-imposed standards. The major limitations of this data are around the cross-cultural population, the assumptions the authors make about culture, and the age and limited information related to the non-clinical population.
Himle et al. (2011) also notes evidence suggesting that increased religiosity can lead to increased OCD symptom severity within their non-clinical sample of undergraduate college students. They note that highly devout Catholic and Protestant students reported higher levels of OCD when compared to less devout cohorts, as well as other devout groups of individuals. They also found many studies from their review which provided a similar association to OCD severity and religiosity. However, they note that persons with OCD or other anxiety disorders were not necessarily more prone to high levels of religiosity and being highly devote was not necessarily a precursor to developing OCD. That is, OCD sufferers may have elevated symptoms if highly devote, however OCD formation and maintenance is not tied to being highly religious generally. This finding may point to an association with biology or other psychosocial factors. However, what is clear is that the higher the need for control and perfection, based on one’s personal beliefs, does seem to be positively correlated with an increased likelihood of OCD symptom formation.

Adding to this, religious-based OCD, according to Himle et al. (2011), is connected to the need to be perfect in relationship to one’s deity through devotion and externalized rule compliance and OCD symptom formation arises from the need to be pure at all times and the expression of spiritual piety. These authors note that many religious-based compulsions involve cleaning oneself or completing a prayer or ritual in way that the individual’s faith would consider perfect to the deity. Intrusive thoughts often arise from an idea or image that the individual’s religions teachings consider blasphemous. Behaviors including washing, checking, and ordering are often present, as well as frequent asking for forgiveness or acceptance from others. The authors note that chemotherapies are uniquely ineffective with this specific type OCD symptomatology, pointing to a more neurotic-based association with this subset of individuals.
OCD Association to Belief Structure and Adlerian Based Theory

Adding to this, Taylor et al. (2010) note that OCD related compulsions are typically used to deter some feared event or to lower stress. In their research study, they used a nonclinical sample to look at the effects that dysfunctional belief formation has on OCD presentation and maintenance. They found that dysfunctional beliefs derived from an inflated sense of “personal responsibility” and “overestimation of threat” and checking, neutralizing, obsessing, hoarding, and washing behaviors were associated with “perfection and intolerance of uncertainty” and “over importance of thoughts and the need to control these thoughts” (p.165). According to their findings, the greatest indicator of OCD symptom formation was individual feeling overly responsible to avoid a heightened perception of danger was shown to be the greatest indicator of OCD symptom formation according to their findings. The authors do note however, that only 23% of the variance for OCD symptom formation is accounted for due to mistaken belief formation generally, thus indicating the possibility that OCD formation is due to biological factors to some extent. If these results are to be considered valid, the Adlerian belief that mistaken beliefs lead to safeguarding symptoms would be called, at least partially, into question. To cloud this further, the authors postulate that the reason for this small variance may be due to the unaccounted for association of mistaken beliefs and life events that manifest as triggers for the OCD symptom formation. In this way Adler’s view may be partially supported, as he believed that OCD symptoms were the mind’s response to a myriad of factors on a psychosocial level (Sperry & Carlson, 1996). Taylor et al. (2010) goes on to show that a significant amount of the variance was associated with genetic (36%) and environmental factors (45%). To sum up, these authors indicate that there is evidence to support theoretic notions that mistaken beliefs
cause OCD symptom formation. However, it is likely that other important associations are also likely present with this disorder.

**Summary of the Biopsychosocial OCD Associations**

The literature reviewed thus far has provided evidence of a biological association with some forms of OCD, but the existing literature is not in agreement with how this association factors with OCD symptom formation, maintenance, and severity (Butwicka & Gmitrowicz, 2010; Kyung et al., 2008; Miyata et al., 1998; Schooler et al., 2008). The main inconsistency found in the research was related to the connection with early age of onset and familial association and more serious OCD subtypes, functional impairment, and co-morbidity with other axis I disorders. The association with genetics, age of onset, and impact would appear to be more biologically-based.

However, individuals with earlier onset OCD and more correlated impairment are more resistant to pharmological interventions (Butwicka & Gmitrowicz, 2010). This empirical evidence directly calls into question whether early onset OCD is as biologically based as some researchers have suggested. What is unclear is whether neurotic disorders, like OCD, cause the chemical disturbances or if chemical imbalances lead to symptom formation. What does seem to be clear is that there seems to be an inflated need for control for the individual experiencing the OCD symptoms (Himle et al., 201; Molding et al., 2009; Yorulmaz & Woody, 2010). It also appears that the need for perfection often accompanies this need for control. This latter distinction would support the Adlerian notion of neurotic symptom formation, maintenance, and (in part) severity.
OCD Treatment Options and Outcomes

There are many ways to attempt to treat OCD and, for the next section of this discussion, we will look at the various psychotherapeutic and pharmalogical models, noting potential treatment outcomes for the various models presented from the salient research. We will also investigate why treatment options are not utilized or underutilized by individuals experiencing OCD symptoms.

Cognitive Behavioral Therapy and Exposure Relapse Prevention

Cognitive Behavioral Therapy (CBT) was noted as being the primary psychotherapeutic treatment modality (Bevem & Salkovskis, 2010; Himle et al., 2011; Malby et al., 2005; Renshaw, Steketee, & Chambless, 2005; Sperry & Carlson, 1996). The basic premise is that maladaptive thoughts lead to symptom formation and if these maladaptive thoughts or mistaken beliefs can be changed, so too can the troubling behavior. Within this theoretical orientation (CBT) a subset exists called exposure and response prevention therapy (ERP) (Himle et al.). ERP is used to help individuals face their most intense fears related to their obsessions and compulsions. Participants are exposed to real life or imagined anxiety producing stimuli (Himle et al.). The exposures typically start off with the least anxiety producing exposure and gradually the exposure gains in intensity until the individual is “desensitized” or until they have been exposed enough to the anxiety producing event, so as they realize that no real harm will come to them from the specific exposure (Himle et al.). Within the CBT framework often the client will record the most troubling thoughts they have, first on paper and then on audio recorder to maximize the exposure. Then they will review these recordings between sessions to make the troubling thoughts more regular, whereby, to foster a sense of normalcy within the context of their daily life. This then allows for some control over the invasive thoughts, as the individual is
purposely inviting and encouraging the thoughts, vs. being victim to them (Himle et al.). Other techniques involve leaving visual representation of the troubling thought(s) around a place of safety or comfort. This allows for the mitigation of the stress causing stimuli, by bringing it into a place known by the individual to be relatively safe and anxiety neutral (Himle et al.). Other ERP models involve encouraging the client to purposely break a moral code that they hold too rigidly, to help realize that perfection is not needed and that little to harm resulted due to venturing outside the confines of their cognitive rigidity (Himle et al.). One other technique used with ERP is called blocking. With this the client is asked to block any invasive thought formation by simply not engaging in the continuance of previously compulsive behavior that accompanies the obsession (Himle et al.). The rationale here, is that if the individual has the courage to attempt to block their “normalized” response or thought formation they have created, they will see no harm resulted and thus the need for the thoughts and actions are unneeded and not useful.

**Intensive vs. Traditional OCD Treatment Outcomes**

Next this writer will review another subset of the CBT theoretical framework by noting the study by Bevan, Oldfield, and Salkovkis (2010). They conducted a study that sought to learn whether intensive outpatient behavioral therapy was more effective than traditional weekly therapy when treating OCD with CBT treatment models. Their results were mixed, as they showed that the individuals who completed the higher intensity treatment reported they felt this approach to be effective. Whereas, the control group that utilized more traditional weekly treatment options noted that they thought they would experience trouble with the more intensive therapy. This was due to the perception that it would be too overwhelming for them to move more quickly and in a more intensive way when facing their disorder (Bevan et al.). These
authors note that the more intensive treatment option would be good for individuals who needed results more immediately and for those who were more impacted functionally, with regards to major life areas like interpersonal relationships and employment. In these specific cases, one could see how the lengthier intervention could result in a loss of close personal support and the financial resources needed for treatment if the functional impairment was severe enough, so a time sensitive treatment would seem more effective due to these situational factors, but perhaps less effective if these factors were removed. Therefore, the more intensive treatment would seem to be a more appropriate and effective model for this population.

One consideration to note, with the intensive option, is the follow up needed and the potential for ongoing support needs, when the relatively short and intensive invention concluded, as this may impact long term results and overall efficacy (Bevan et al., 2010). This fact might lead one to assume that shorter intervention may not have allowed for enough autonomous work outside of the therapy, and that the control group may have benefited from this longer period with intermittent support. That is, the intensive group may have had increased support for immediate improvement but without ongoing support after, they may have not learned the needed skills the more traditional group did from their lengthier treatment.

The noted limitations by Bevan et al. (2011) study were how the intensive group had longer sessions with two therapists vs. the control group having only one therapist with shorter sessions over a longer stretch of time. They also note that only retrospective data was collected from participants that completed treatment, thus reducing the day by day interpretations by the individuals. Also, the study totally discounted and omitted the individuals who did not complete treatment and those who did not participate at all and thus did not fully encapsulate the possible ineffectiveness of this treatment model.
Group Based OCD Treatment Outcomes

The next treatment modality this writer will examine is again a subset of the CBT model. This model utilizes CBT concepts in a group-based therapeutic setting. The primary benefit to this model appears to be the time savings from resource sharing and peer support. We will look at the results presented by Fenger, Mortensen, Rasmussen, and Lau (2007) to examine this modality. These authors note an assumption that individual treatment would be more effective than group, due to the specific nature of the symptom formation within each individual, but discover no significant difference between effectiveness of individual or group CBT. The theorized reason for this relative neutrality was due to the increased motivation and natural positive peer pressure noted for out of session homework completion (Fenger et al.). The group therapeutic model utilized in their study focused on the identification of mistaken beliefs, psycho-education, exposure training, and blocking techniques to help elevate OCD invasive thoughts. Fenger et al., (2007) also note during the mid-phase of treatment utilized, “…connection between thoughts and feelings and the connections between childhood experiences and their unfitted rules for their adult lives …” (p. 336). This area of their treatment model appears to mirror the Adlerian framework. In that, Adlerians believe that faulty lifestyle convictions are formed during childhood and these convictions lead to unhelpful beliefs that lead to inappropriate emotional responses to life tasks, which then lead to maladaptive behavior, which then supports the individual’s unhealthy style of life (Dinkmeyer, 1972; Leak & Leak, 2006; Sperry & Carlson, 1996; Watts & Pietrak, 2000).

One important finding from Fenger et al. (2007) study was that the group process led individuals to feel less “crazy,” as they were able to witness and empathize with others who shared similar thought formations and troubling symptoms related to their specific OCD
presentations. A second important finding was that although the group process was theorized to increase the treatment compliance of out-of-session work, roughly half of the individuals who completed the CBT group failed to complete their out-of-session work, including their exposure-based assignments.

This then, led the therapist(s) who conducted the groups to feel as if they had insufficient time to practice working through the “cognitive distortions” inherent with OCD symptom formation, as the clients who failed to complete the out of session work primarily focused on their daily problems with anxiety and interpersonal issues (Fenger et al., 2007). Also of note, the population involved in this study had a co-morbid association of 25% with other psychological disorders and 75% of the individuals had had at least one previously unsuccessful treatment outcome. In addition, many individuals had variances in their OCD symptom presentation, when compared to the group spectrum, and this was thought to make treatment progress more difficult. The authors note these factors as possible reasons for their limited ability to show strong effectiveness of their CBT group work, when compared to other studies from their review that did provide strong evidence to support effectiveness (Fenger et al.). It appears that the limited ability to complete out-of-session work was a leading factor related to the limited effectiveness of this particular treatment option and study. Therefore, it is not surprising that their study revealed limited treatment effectiveness compared to other studies that may have had a greater out-of-session work compliance rate. It is important to note that they do show support for group CBT over individual psychotherapy overall and believe that the idiosyncratic nature of their sample population and potential methodical issues may have caused a weaker association for their studies group-based CBT.
Family Based Therapy Approach

The use of family based therapy was also described in the literature focusing on OCD treatment options. Renshaw, Steketee, and Chambless (2005) reported that the family structure and the extent that it is either overly accommodating or antagonistic was an important factor in the formation of OCD symptoms in children and adolescents. That is, the level to which the familial belief structure is too loose or too rigid may support the continuation or maintenance of OCD symptomology. The authors note that the “best practice” when working with children and adolescents with OCD symptoms is to utilize family-based therapy in conjunction with other leading treatment modalities. These authors (from their review of the literature) also believe this practice may be useful with adult populations, as well as other individuals and particularly support networks appear to have a significant effect on symptom formation, maintenance, and remission. The authors note that family therapy may be useful to help all parts of the family understand how OCD symptoms are formed and maintained and how the role of family structure, beliefs, and behaviors are significant in this formation and maintenance.

One challenge to this, as noted by Renshaw et al. (2005), is that many children and adolescents are brought to treatment by a parent and so this parent may be worried they will be held responsible or accused of creating the disorder for their child. This seems to be a major issue and would likely lead to the need for special accommodations when working within the family unit and could cause overall resistance when working towards family-based change. Therefore, special clinical judgment appears to be needed when addressing the appropriateness of utilizing this family based approach.
Barriers to Treatment and the Adlerian Approach

Throughout this review, evidence has been presented to illustrate the potential reasons for treatment refusal and ineffectiveness. Maltby and Tolin (2005) note that one of these reasons is that clinicians and researchers alike are not in agreement with the best methods to use and many clinicians may or may not have the education and training to utilize the leading treatment options.

Maltby and Tolin (2005) and Twohig et al. (2010) note that 25% of OCD clients refuse to use ERP based therapy even after learning that it is (generally) believed to be an effective treatment modality, based on clinical effectiveness. Some reasons for this may include an inability to face their fears, to lose control, or concern for leaving their symptoms that are fostering avoidance in some aspect of their lives. Further, Twohig et al. note that other studies have shown that only 15-53% of individuals who meet criteria for an axis I disorder seek and receive treatment. The purpose of this research is not to discover the root causes for treatment reluctance or to discover why individuals are denied care, but it is important to note some of the potential barriers individuals do have regarding OCD treatment. Of note, the research conducted by Maltby et al. (2005) does suggest that anxiety may be partially responsible for treatment refusal and for ERP specifically. This researcher speculates that anxiety may also be associated with many other treatment hesitancies or refusals.

From an Adlerian framework, individuals create and maintain their symptoms because they are useful and serve a purpose to them. Generally these symptoms are used for avoiding a life task they lack courage in facing (Dinkmeyer, 1972; Leak & Leak, 2006; Sperry & Carlson, 1996; Watts & Pietrak, 2000). Maltby et al. (2005) notes from their study that increasing awareness and courage leads to more treatment engagement for ERP generally and this
researcher speculates that this practice would be useful for many other disorders as well. Adding to this, Adlerian based interventions may help individuals understand their mistaken beliefs and way of understanding life and thus, may lead to further willingness to explore options to reduce OCD symptoms.

**Potential New OCD Treatment Option**

One alternative to ERP suggested by Twohig et al. (2010) is acceptance and commitment therapy (ACT). This treatment option focuses on psychological flexibility through acceptance, self as context, being present, values, and committing to action without the need for exposure based treatment exercises like ERP. They show positive results for ACT but admit that this treatment modality was not yet ready to compete directly with leading OCD treatment options like ERP at the time of their study. They do contend, however, that because ACT eliminates the need for exposure-based techniques, it could be worthy of investigation.

**Chemotherapeutic Treatment Options**

Chemotherapeutic treatment options have been shown to be effective at reducing OCD symptoms (Carmin, 2005; Fenger et al., 2005; Fineberg, 2007; Miyata et al., 2007; Pallanti, Bernardi, Antonini, Singh, & Hollander, 2009). Fenger et al. (2005) notes that SSRI’s are about as effective as CBT based modalities, but are less likely to achieve long term reduction of OCD symptoms and are much less likely to result in full symptom remission. Adding to this, Pallanti et al. note that, “…about 40% of OCD patients do not respond to first-line select serotonin reuptake inhibitors treatment…” (p. 1047). In light of this, Fineberg et al. notes that drugs, in general, provide an improvement with OCD symptoms between 21.6% and 61.3% of the time. Rasmussen and Dover (2006) contend that, “…biochemically based, yet highly controversial ‘causal’ explanation of emotional disorders most typically reflect the necessary physiological
covariates necessary for these adaptive mechanisms to occur and are not the originating causal factor” (p. 372). That is, despite the evidence that shows chemical imbalance can be improved by utilizing pharmological based therapies; these imbalances are likely the cause of psychological issues, not the inverse.

Fenger et al. (2005) goes on to note that SSRI’s and some anti-psychotics can be combined to increase the rate of effectiveness with SSRI’s resistant persons. They go on to cite the potential side effects of classical OCD treatment specific SSRI’s and offer an alternative medication called Ondansetron. This medication is considered to be a serotonergic antagonist and seems to be in conflict with the prevailing understanding of why SSRI’s work at reducing OCD symptoms for some individuals. Their conclusion is that Ondansetron augmentation exhibited the potential for effectively treating OCD symptoms and seemed particularly effective at elevating symptoms with SSRI resistant persons.

Summary of Effective OCD Treatment Options

In sum, the research presented in this section shows that the leading psychotherapeutic model for treating OCD is CBT (Bevem & Salkovskis, 2010; Himle et al., 2011; Malby et al., 2005; Renshaw et al., 2005; Sperry & Carlson, 1996). More specifically the use of exposure and relapse prevention (ERP) techniques are commonly believed to be the industry standard when working to effectively treat OCD clients (Himle et al.). Other conjoining therapeutic techniques were also noted to be helpful when added to CBT, like group (Fenger et al., 2007), family (Renshaw et al.), and intensive-based treatment option (Bevan & Salkovkis).

However, the research has also shown that some individuals are reluctant and refuse to enter psychotherapy that utilizes this CBT and ERP approach. One alternative presented by Twohig et al. (2010) was the use of acceptance and commitment therapy (ACT). This technique
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does not require the client to face their feared stimuli, but teaches coping skills related to relaxation and acceptance of self.

For individuals who are reluctant or refuse psychotherapeutic options, pharmological based treatment might be more appropriate. However, Fenger et al. (2005) contends that the leading OCD chemotherapies are only about as effective as the leading psychotherapeutic modalities, but have poorer results to long term symptom reduction and remission. In addition, about 40% of clients do not respond to first line SSRI’s.

Further, despite the evidence that OCD affects the brain's chemical balance, Ramussen and Dover (2006) note that this imbalance is likely the response psychosocial issues and not the causal reasons for the symptom presentation (except in rare situations). Therefore, it is clear that a new approach is needed to address psychotherapy-reluctant persons.

Adlerian Based Theory and Treatment Modalities

Throughout this paper Adlerian concepts have been referred to as they have been relevant to the existing literature on OCD symptom formation and treatment. Next, this research will highlight some of the leading concepts and treatment modalities utilized within Adlerian psychology and psychotherapy treatment model. This section will also display how each technique works in conjunction with the other(s) to form a holistic approach that can be mendable to the incorporation of other useful psychotherapeutic paradigms and treatment modalities.

Therapeutic Encouragement

At the base of the Adlerian psychotherapeutic model is the concept of encouragement (Dinkmeyer, 1972; Leak & Leak, 2006; Sperry & Carlson, 1996; Watts & Pietrak, 2000). Within Adlerian psychology therapeutic encouragement is used in many ways. It is used to foster
courage to a discouraged client who may be creating or maintaining symptoms to avoid an area of life, or a task of life (Dinkmeyer). Dinkemeyer (1972) notes that, “…encouragement on the part of the counselor is comprised of both verbal and nonverbal procedures than enable a counselee to experience and become aware of his own worth” (p. 177). The author goes on to elaborate that through encouragement the client is able to see that their self-esteem and overall worth is not tied to production or winning and losing, but to the fact that they are a unique and worthwhile human being. The basic function of therapeutic encouragement, after the client’s self-worth is established, is to help correct the basic mistaken beliefs that are getting in the way of the client achieving their underlining goal to feel good within their social context through feeling that they belong, are significant, and safe and secure (Dinkmeyer; Sperry & Carlson; Watts & Pierzak).

Dinkmeyer (1972) goes on to note that therapeutic encouragement is also used to show the client their strengths, rather than their weakness, or their health vs. their pathology. Watts and Pierzak (2000) note that therapeutic encouragement skills involved engaging in active listening, providing an empathy-based relationship, showing genuine respect for and confidence in, and by helping clients realize their special resources, contributions, and other areas of life that then helps foster a new perspective of self which is strength based, not deficit focused.

One other important note regarding therapeutic encouragement is that each individual utilizes their own evaluation system when looking at their life and the existential, phenomenological aspects therein. Therefore, each individual will respond to life in a unique and differential way and will need encouragement in ways that make sense to them, and so each therapeutic intervention by the Adlerian psychotherapist requires that their encouragement reflect
the unique, idiosyncratic variances from individual to individual, otherwise the encouragement is not likely to spur the individual to attempt what they have been avoiding.

Watts (2000) notes a study by Manaster and Corsini from 1982 that states “Adlerians do not see people as psychotically sick, but discouraged. The process of psychotherapy is not seen by Adlerians as ‘curing’ anything, but as a process of encouragement” (Watts, 2000, p. 160).

**The Use of Early Recollections for Symptom Reduction**

The next major treatment modality utilized by the Adlerian psychotherapist is termed “early recollections” or ER’s. Disque and Bitter (2004) note that ER’s are useful because they can be used to flesh out a current issue by utilizing the stored emotion from a past event, in which the client has retained and reinforced the memory in their current behavior. That is, the events of the past, that an individual holds to, create the beliefs they use for their future behavior. Therefore, if a client believes the world is bad because of an event from the past, then they may choose, unknowing, to view the world as being bad overall and will look for situations that reinforce that belief. This technique allows the client to view a past event in a non-threatening way and helps them utilize objectivity skills that would not likely be possible by looking at a current problem. Disque and Bitter note that the use of ER’s, in this way, can foster near immediate relief from distress and the ability for the individual to meet the life task in a clearer way. In this way, ER’s may be useful in helping individuals address their invasive thoughts presented in their OCD symptoms. If an individual can recall the past event that may have cemented the need for invasive thoughts and subsequent compulsions, they may be able to recognize the uselessness of their current behavior through this new insight.

The clinical validity of ER’s has been shown within other disciplines as well. From Penfield’s (1952) work in neurology and psychiatry he notes that memory is stored holistically
and through his experiments he shows how individual memory cells contain visual, emotional, and visceral data that is stored in way that supports Adlerian ER therapeutic ideology (Disque & Bitter, 2004). Disque and Bitter goes on to note how memory is a reflection of the individuals particular way of interpretation and so memory is inherently and subjective association with the perception of particular events and these perceptions or interpretations are construed based on the individualistic interpretation, not on objective event recording. Therefore, ER’s are likely to be emotional data stored for a particular purpose, but which are “filled in” with current perceptions of the world that support the emotive response once felt during their development. This “filling in” is the area that is likely to be occupied with unhealthy belief structures that facilitate the maintenance of unwanted behaviors and distressful life experiences. Disque and Bitter note a quote from Clark (2002) that states, “From an Adlerian perspective, the memory an individual chooses to maintain actually predisposes her or him to find ‘triggers’ and similar events in current experiences” (Disque and Bitter, 2004, p. 119)

Social Interest and Mental Wellness

The next major Adlerian concept that is utilized during psychotherapy is called Social Interest (SI). SI is one of the main concepts that tie together the other main constructs of Adler’s theory of personality (Leak & Leak, 2006). In many ways, the notion of social interest is at the heart of Adlerian psychological involvement. According to Leak and Leak (2006), “Social interest involves a genuine and generous concern for the welfare of other and that positive mental health requires the presents of social interest. Social interest is manifested in such attributes as empathy, cooperation, and other prosocial orientations towards others” (p. 207). Therefore without a connection to others, individuals would likely attempt to live life in relative isolation and this isolation would render them mentally unwell or neurotic.
The basic idea of therapeutic SI is to help clients learn to be helpful and cooperative to others and themselves and to facilitate a connection and responsibility to others. As we have seen thus far in this review, when individuals become fixated too much on themselves and on the need for control and perfection, OCD type symptoms can manifest. In this way, from an Adlerian framework these individuals are using their symptoms to avoid useful, cooperative relationships with others, albeit at an “out of awareness” level. Through cooperation with the therapist, group members, and friends and family they are often able to reduce symptoms without the aid of pharmacological means. We have also seen that in extreme cases when the individual focuses too much on salvation and ridged rule compliance, the chemical reactions in the pharmacological therapies are largely ineffective. Leak and Leak (2006) found that positive SI was empirically associated with many areas of mental health, including self-determinism, purpose of life and absence of alienation, healthy values related to intrinsic needs, and healthy psychosocial interpersonal intimacy. Each of these positive associations of increased SI, noted above, express the polar opposite “style of life” attributes individuals experiencing OCD symptoms display and it also clear that once these OCD symptoms are reduced or eliminated these areas of life task functioning increase.

**Adlerian Lifestyle Assessment**

Tying these concepts together is the assessment tool known as the lifestyle assessment (LSA) White, 2005; Rasmussen, 2006). The LSA is comprised of data collection that focused on belied formation that occurred during the developmental stages of life and can be conceptualized as the “style of life” an individual develops to cope with life’s challenges during their developmental stages. The LSA assessment then looks to discover faulty beliefs developed about life, that were once useful, but now show the reasons for the individual’s discouragement in
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adulthood (because the childhood beliefs are now limiting as an adult) and subsequent disorder, as well as the safeguarding techniques used at addressing the discouragement (White, 2005; Rasmussen, 2006). The LSA when used well incorporates many aspects of the Adlerian frame work like therapeutic encouragement, use of symptoms, therapeutic alignment, early recollections, holism, client centeredness, and promotion of client strengths. The data collected is then used to help illustrate to the client how they have been using their beliefs about the world in unhelpful ways along a teleological goal directed way that is not fully understood by the individual (Rasmussen). Thus the purpose of the LSA to uncover the “fictive” goal of this purposeful direction the client seeks by using mistaken belief structures, which then manifest into maladaptive social behaviors. Further the LSA collects data about ones family of origin and constellation, and the interpretation of this dynamic (White).

Usefulness of a Blended Approach

Kaufman (2007) provides a newer treatment modality that incorporates classical Adlerian techniques with the use of Guided Visual Imagery (GVI). He notes the trend towards an increasing level of stress per individual in the modern world. He proposes the use of Adlerian based GVI as one possible solution for this increasing problem. He notes that the ability to cope with life’s stressors is inherently between the mind body connection and that we can train our mind body connection to accept therapeutic intervention that facilitates a state of calm through the use of GVI. This technique is based on the interplay between the mind and use of oxygen, in the way of therapeutic breath work, which allows for a relaxation effect.

The use of this specific type of breath work may be useful in the conjunction with other tested treatments for OCD. In particular for the techniques inherent in ERP when individuals are instructed to avoid performing their compulsions, they have typically been using, to elevate their
obsessions. Kaufman (2007) also notes that GVI utilizes a technique that enables an individual to focus on a particular place mentally that fosters the ability to focus away from externalized stimuli and allows the individual to focus within on internal events of the mind.

It appears that this too could be useful with OCD clients that are attempting to avoid compulsions, however it could also lead to more invasive thought formation potentially. More research is likely needed in this area to understand if this technique would be useful in this area. Kaufman (2007) goes on to state that the further the individual goes into a “trance” like state by using the breath work and internal focusing techniques, the more the power of suggestions can be utilized by the psychotherapist administering the treatment to help correct faulty style of life mistaken beliefs that are associated with the anxiety response symptoms.

When the individual is in this “trance” like state, the Adlerian psychotherapist then focuses the “suggestions” on individualized areas where the client may need courage (Kaufman, 2007). That is, the suggestions are focused on areas the client is avoiding and thus causing the anxiety response. However, Kaufman notes that it is common for the individual to be resistant to the therapeutic suggestion, if the suggestions are in too much opposition with the deeply rooted mistaken beliefs, which severely contradict the lifestyle convictions held by the individual. Therefore, it seems that GVI may be a useful tool at elevating some anxiety based neurosis, but more conscious collaborative work may be needed to address strong mistaken lifestyle convictions.

**Summary of Adlerian Approaches**

In sum, this section presented leading Adlerian psychotherapeutic perspectives and treatment modalities used with individuals to reduce or eliminate troubling symptoms, or in Adlerian terminology to increase courage. The first concept presented was the use of therapeutic
encouragement. Dinkmeyer (1972) notes this being a central tenant of Adlerian psychology and one of the main ways to help client’s foster courage to overcome the areas of life they have been avoiding and change their mistaken beliefs. In addition to this therapeutic encouragement is used to build client relationships, focus on strengths, and build self-esteem.

Adding to this Watts (2000) notes that the Adlerian approach sees people as discouraged and not pathological and thus providing courage is the way to help people become healthy. Early Recollections (ER’s) are also widely used by Adlerians to help bring out the foundations of mistaken belief formation from past foundational memories. The technique helps show patterns of life to the client in a non-threatening way that often leads to near instant relief and an increased ability to handle life tasks in an improved way (Disque & Bitter, 2004).

The next therapeutic construct used by Adlerians is the concept of Social Interest (SI). SI is a working, collaborative, and purposeful connection to the welfare of others that leads to a sense of group belonging, significance, and security, in addition to a healthy respect for the needs of self (Leak & Leak, 2006). Further, Adlerians believe it is this connection to self and others that leads to mental health. This has been highlighted throughout this review with illustrations of individuals with OCD symptoms who are too inwardly directed by needs for control and perfection, vs., the needs of self and the group.

The final fundamental Adlerian psychotherapeutic technique is the life style analysis (LSA) White (2005) and Rasmussen (2003) note how the LSA combines the use of therapeutic encouragement, ER’s, and SI, in a way that paints a picture for the client that illustrates their mistaken beliefs and overarching goal for life. It is through this insight that individuals can then choose to change their behaviors that are reinforcing their current issues. This assessment is
noted by these authors as the primary tool Adlerians use to provide structure for their therapeutic activities and this helps provide growth for clients in a holistic and flexible way.

Finally, an Adlerian technique is highlighted due to its potential for effective treatment of OCD, Kaufman (2007) notes the use of GVI as a potentially effective means to reduce anxiety in individuals through breath work and active mindfulness. It was postulated that this might be especially useful when used to help individuals avoid compulsions.

**Final Summary of OCD Literature**

Throughout this paper, evidence has been presented to support a biological association with some forms of OCD. The main inconsistency in this evidence is related to the connection with early age OCD onset and familial association to the more serious OCD subtypes, functional impairment, and co-morbidity with other axis I disorders (Butwicka & Gmitrowicz, 2010; Kyung et al., 2008; Miyata et al., 1998; Schooler et al., 2008). However, earlier onset OCD is more resistant to pharmacological interventions (Butwicka & Gmitrowicz, 2010).

This empirical evidence seems to refute the connection of early onset OCD with biological/chemical imbalances to some degree. Highlighting this more generally, Fenger et al. (2005) noted the leading OCD chemotherapies are as effective as the leading psychotherapeutic modalities, but have poorer results to long term symptom reduction and remission and about 40% of clients do not respond to leading medications. Also, most OCD suffers have an inflated need for control and perfection (Himle et al., 2011; Molding et al., 2009; Yorulmaz & Woody, 2010). This evidence together would support the notion that OCD is more likely tied to neurotic symptom formation, maintenance, and (in part) severity and particularly with individuals who have the most disabling OCD symptoms.
The leading psychotherapeutic model for treating OCD currently is cognitive behavioral therapy (CBT) (Bevem & Salkovskis, 2010; Himle et al., 2011; Malby et al., 2005; Renshaw, Steketee, & Chambless, 2005; Sperry & Carlson, 1996) and more specifically the use of exposure and relapse prevention (ERP) (Himle et al., 2011). Other conjoining therapeutic techniques were also noted to be helpful when added to CBT, like group (Fenger et al., 2007), family (Renshaw et al., 2005), and intensive-based treatment option (Bevan et al., 2010). However, the research has also shown that some individuals are reluctant and refuse to enter psychotherapy that utilizes this CBT and ERP approach (Maltby & Tolin, 2005; Twohig et al., 2010). One alternative presented was the use of acceptance and commitment therapy (ACT) (Twohig et al.). This technique does not require the client to face their feared stimuli, but teaches coping skills related to relaxation and acceptance of self. This points to the need for alternative treatment options and therefore Adlerian based treatment may be useful.

Dinkmeyer (1972) notes therapeutic encouragement as being a central concept for Adlerian psychology and one of the main ways to help client’s change. In addition to this therapeutic encouragement is used to build client relationships, focus on strengths, and build self-esteem. Watts (2000) also notes that the Adlerian approach sees people as discouraged and not pathological and thus providing courage is the way to help people become healthy.

Early Recollections (ER’s) are also widely used by Adlerians to help individuals see their patterns. The technique helps show patterns of life to the client in a non-threatening way that often leads to near instant relief and an increased ability to handle life’s task in an improved way (Disque & Bitter, 2004).

Another key concept for Adlerians psychotherapy intervention is Social Interest (SI) is a working, collaborative, and purposeful connection to the welfare of others that leads to a sense of
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group belonging, significance, and security, in addition to a healthy respect for the needs of self (Leak & Leak, 2006). Adlerians believe SI leads to mental health. This has been highlighted throughout this review with illustrations of individuals with OCD symptoms who are too inwardly directed by needs for control and perfection, vs., the needs of self and the group and in this way if Adlerian based psychotherapy could increase SI perhaps then too could it reduce OCD symptoms.

The Adlerian life style analysis (LSA) combines the use of therapeutic encouragement, ER’s, and SI, in a way that highlights mistaken beliefs and maladaptive behavior (White, 2005; Rasumussen, 2003). According to these authors this assessment is the key instrument that ties together the overall treatment model and offers the therapeutic structure needed provide a holistic treatment.

Finally, Kaufman (2007) notes the use of Adlerian based visual guided imagery (VGI) as a potentially effective means to reduce anxiety in individuals through breath work and active mindfulness. It was postulated that this might be especially useful when used to help individuals avoid compulsions and could serve as a good early model for treating OCD sufferers using a blended approach.

Discussion and Future Work

As noted in the beginning of this discussion, Adlerian based psychotherapy may be ineffective when treating certain types of OCD clients because of the encouraging nature it employs (Dinkmeyer, 1972). Himle et al. (2011) noted that asking for forgiveness and acceptance is a common compulsion found with individuals with OCD and is especially prevalent with individuals who fuse their religiosity with their OCD symptoms. One could also speculate that other OCD suffers who over emphasis the need for perfection and control could
also be expressing these compulsions indirectly through these types of reassurance seeking behaviors, although it is unknown how these types of behaviors play out completely within their compulsions. That is, even with compulsions that focus on washing, checking, symmetry, etc., there may still be a need to feel validated by others and Adlerian-based psychotherapy may in fact provide this validation that continues the compulsions. This literature review has also noted the strong evidence for CBT treatment models. What is interesting is how similar the major points of this model are to Adlerian ones, as illustrated on table 1 on page 42.
Table 1. Summary of Adlerian vs. Cognitive Behavioral Therapeutic Approaches

<table>
<thead>
<tr>
<th>Adlerian Based Therapy</th>
<th>Cognitive Behavioral Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses a Non Judgmental, Encouraging, and Collaborative Approach</td>
<td>Uses a Non Judgmental Collaborative Approach</td>
</tr>
<tr>
<td>Develops a Comprehensive Assessment that Identifies Mistaken Beliefs Based on Past Interpretations of Life</td>
<td>Develops and Assessment to Identify Thinking Errors that are Self-Defeating</td>
</tr>
<tr>
<td>Works to Change Mistaken Beliefs to Prosocial, Helpful Beliefs</td>
<td>Works to Replace Thinking Errors with More Realistic Health Beliefs</td>
</tr>
<tr>
<td>Is a Founding Theory and Shares Many Qualities with CBT</td>
<td>Is Considered a Best Practice for Treating OCD</td>
</tr>
<tr>
<td>Is Currently Not Used Frequently with OCD Clients</td>
<td>Is Currently Used Widely with OCD Client</td>
</tr>
<tr>
<td>Could Be Effective at Reducing OCD Symptoms</td>
<td>Has Been Shown to Be Effective at Reducing OCD Symptoms</td>
</tr>
</tbody>
</table>

Recommendations and Implications for Practice

It seems clear from the similarities present above between CBT and Adlerian therapy that Adlerian based psychotherapy could be used to reduce OCD symptoms generally and perhaps could even be more effective than the ERP models noted that focuses on exposure to the feared stimuli, due to the less troubling approach Adlerian therapy could potentially offer. What is clear however is that the traditional Adlerian approach would need to be modified to focus on encouraging the OCD client to overcome the need for symptoms and not reinforce their need to feel validated. Clearly, more research is needed to address whether Adlerian based interventions can be effective with OCD clients.

Improper use of Therapeutic Encouragement

As noted previously there is some evidence that Adlerian therapeutic encouragement may have some negative clinical implications if administered improperly for clients experiencing certain forms of OCD. Based on the evidence presented this writer believes clients who seek validation or reinforcement for their personal worth, from a therapist and others, will be served poorly by Adlerian clinicians if the encouragement model they use is not carefully administered. For instance, if a client who seeks approval, as part of the compulsion due to invasive thoughts or obsessions, seeks out therapy to contend with these thoughts, asks for support to cope with their perceived negative symptoms, they may be in fact seeking out what their compulsion has been all along; that being, reassurance that they are not “crazy” or “bad”, etc. An untrained Adlerian therapist (or other type) may then reinforce the client’s neurosis by expressing to the client that they “are good enough” or that they are a “worthwhile person”, or simply provide reassurance that despite their perception of their condition they are a good person. The clinically correct response to these attempts for validation would be to help the client find courage in
overcoming this need to seek reassurance, by encouraging them to discuss the invasive thoughts, their fear of being crazy, or by helping them purposely face the stimuli that is causing the OCD type symptomology through their avoidance. This task needs to be accomplished while also not engaging the client when they are “approval” seeking. That is, if a client tells the clinician they are “the best therapist they have ever had” or that “no one else has ever been able to help me before”, this writer suggests simply ignoring the comments and refocusing the therapy on the client by encouraging them to overcome that which they are avoiding. This will render the obsessions and compulsions unnecessary, as they symptoms will lose their purpose in allowing the client to avoid their feared stimuli.

**The Clinical Need for ERP with Adlerian Based Therapy**

The research literature has shown that Adlerian treatment modalities may not be enough on their own to fully help an individual experiencing some OCD type disorders. It is this writer’s recommendation that Adlerian psychotherapies be blended as much as possible with the evidence based practices for treating OCD. As noted previously there is much research that shows the efficacy of utilizing ERP and using these techniques along with Adlerian modalities will help the client move away from their need to have the OCD type symptoms. The good news is Adlerian modalities often focus on helping the client do what they are afraid to do or that which they are avoiding (Dinkmeyer, 1972; Leak & Leak, 2006; Sperry & Carlson, 1996; Watts & Pietrak, 2000). The clinical issue when working with some OCD clients is that the work of discovering what the client may be avoiding could be more difficult to discover than many other issues, as the client with invasive thinking may attempt “at all costs” to hold in their private thoughts due to worry that the therapist will assess them as “crazy or “bad” etc. Therefore, it is this writer’s recommendation that careful attention is paid during initial assessment to determine the possible
root cause of the disorder and then work towards helping the client use the techniques consistent with ERP along with Adlerian and other effective treatment modalities. To accomplish this this writer recommends the use of a LSA to obtain a picture of how and when the OCD symptomology began and why it may have first started for the client and then tie this information back to what is known about the specific OCD sub-type. This may mean that instead of encouraging a client to overcome an avoidant behavior, the clinician may instead help them overcome an avoidant thought, or series of thoughts, through the use of exposing the thought, then helping the client prevent the relapse. This process is then, in some ways antithetical to Adler’s notion that life is purposeful movement and that healthy individuals focus on useful and meaningful activities by not avoiding activities they are afraid to fail at (Dinkmeyer, 1972; Leak & Leak, 2006; Sperry & Carlson, 1996; Watts & Pietrak, 2000) If taken in the literal sense, as the clinician is asking the client to stop avoiding the useless thoughts which are causing the psychic disturbance and the subsequent useless acts that manifest in the form of compulsive assurance seeking type behaviors. However with careful assessment and specific training, the use of Adlerian therapy with ERP is likely to provide good treatment outcomes, however research will be needed to confirm this writer’s assumptions.

**Potential Clinical Issues with Biological Expressed OCD**

Throughout the review of the literature we have seen how OCD is often expressed through a neurotic presentation stemming from external and internal stimuli and the value the client attaches to these dynamics (Moulding et al. (2009). However in the rare event that the disorder is clearly causal to biological dynamics specifically, it would appear Adlerian modalities, even when using a multimodal approach, would be too simplistic too address the seeming more biological symptomology. In these clinical situations, a referral to a qualified
psychiatrist is recommended, closely followed by an additional therapeutic consultation to
determine if there are other issues that need attention therapeutically to rule a non-biological
disturbance. In the event the cause of the OCD is remedied purely by pharmological intervention
no further therapeutic intervention is recommended, but some continued follow up may be
necessary to account for possible placebo effect from the administering of the medication. Other
therapeutic services may also be required to ensure medication maintenance and compliance for
some clients.

The Importance of Using a Blended Approach

As previously noted, the use of blended therapeutic approach is important when utilizing
an Adlerian treatment model. This writer would recommend that clinicians, Adlerian or not,
utilize the available evidence based practice along with their practice based knowledge when
working with individuals experiencing OCD type symptomologies. As noted previously, in this
review, the use of Adlerian, CBT, ERP, Family, Group, and GVI along with some
pharmacological interventions may be useful when working with certain types of OCD clients.
The use and implementation will need clinical judgment based on the individual, the therapist
and evidence both from this research and from the professional practice of the clinician.

Final Recommendations for Practice

The final recommendation offered by this writer is to use a general principal or
philosophy when working with a client experiencing OCD type symptoms, in the form of
Adlerian Social Interest (SI) no matter the particular treatment modality of theoretical orientation
utilized by the clinician (Dinkmeyer, 1972; Leak & Leak, 2006; Sperry & Carlson, 1996; Watts
& Pietrak, 2000). This overarching concept will direct the therapy and will help the client be
more balanced between self and others and will help guild them towards a more useful way of
being. In this way helping the client achieve a more useful style of life, or Life Style (LS), through the use of the SI paradigm and this focus will directly counter the elements related to the presentation of the OCD type symptomologies (Leak & Leak, 2006). This focus on the individual LS, as it pertains to SI will allow the client and clinician to move more towards a holistic understanding of wellness and meaning for the client.
References


