

Experiential Avoidance in Obsessive-Compulsive Disorder Therapy. Case Study.

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Abstract

Introduction: *In the practical field of psychotherapy we frequently have to deal with a complex pathology. Sometimes it is difficult to detect the causes for a specific pathology or to identify the main pathology and the secondary ones. This derives from the complexity of the human psyche and sometimes it is conditioned by the period of time during which this pathology has evolved.*

Objectives: *In the case we are going to present, the pathology has a long history with adolescence onset and it seems that obsessive-compulsive symptoms were developed either as a particular manner of dealing with negative family experiences or as a manner of avoiding the necessity to deal with this kind of experiences.*

Method: *In this particular case, the obsessive-compulsive pathology found a way to express itself in a graphic-plastic manner that helped the patient experience a new way of understanding and curing himself. Additionally, we will present some personal aspects about the obsessive-compulsive disorder that helped us deal with patients in practical psychotherapy. We used an integrative approach as a therapy method in order to help the patient gain control of his symptoms.*

Results: *The psychotherapy result was an improvement of the patient's life quality and a significant gain of control over the negative life experience.*

Keywords: *client resources, emotion expression, death anxiety*

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I. Introduction

Obsessive-compulsive disorder has been described since the 17th century, back when Oxford Don and Robert Burton reported a case in their compendium, *The Anatomy of Melancholy* (1621).

Modern concepts of OCD started to develop in France and Germany in the 19th century. At the end of the 20th century, when the brain imaging techniques became possible, the neurochemical modifications could finally be understood.

Specialized literature suggests that, in cases with an early start, the general characteristic of the disease is rather the tendency towards exactitude, order, rituals, meanwhile the cases with a late start are dominated by the tendency towards aggression, the compulsions related to contamination/washing and it is also frequently associated with panic attacks.

Studies have shown that the inception age is usually before 25 and many times during childhood or adolescence. Among people who require treatment, the average inception age seems to be lower in men than in women.

According to a report from 1989, in a sample of 70 children and adolescents evaluated at the National Institute for Mental Health Care, the average inception age was 9.6 years old for boys and 11.0 for girls. In a sample of 263 patients, adults and children, Lensi and his collaborators (1996) reported that the average inception age was 21 for men and 24 for women (<http://ocd.stanford.edu/about/>).

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), launched in 2013, includes a new chapter dedicated to obsessive-compulsive disorders and the related disorders including the body dysmorphic disorder, hoarding disorder, foraging disorder, Trichotillomania (compulsive hair pulling with bald spots). Before that, the obsessive-compulsive disorders used to be grouped together with the impulse control disorders, which were not grouped elsewhere. The American Psychiatric Association defines these disorders through the presence of obsessions, compulsions or both.

Obsessions are defined by (1) and (2) as follows:

1. Recurring and persistent thoughts or images that are experienced as intrusive and unwanted, leading to anxiety and suffering;

2. The attempt of a person to suppress or ignore such thoughts, impulses or images or to neutralize them with another thought or action.

Compulsions are defined by (1) and (2) as follows:

1. Repetitive behavior (such as washing hands, command or control), or mental acts (counting, repeating words in a silent voice), as a response to an obsession or according to the rules that have to be rigidly applied;

2. Behaviors or mental acts that are supposed to prevent and diminish distress or prevent certain feared situations or events and which are not connected in a way that they could neutralize or prevent as they are meant to do in a realistic way or are clearly excessive.

Co-morbidity

Patients with OCD present a high risk of having co-morbid (co-existing) major depression and other anxiety disorders. In a sample of 100 OCD patients who were evaluated by means of a structured psychiatric interview, the most common concurrent disorders were: major depression (31%), social phobia (11%), eating disorder (8%), simple phobia (7%), panic disorder (6%) and Tourette's syndrome (5%). In Koran et al.'s 1998 Kaiser Health Plan study, 26% of the patients had no co-morbid psychiatric condition diagnosed during the one year study period - 37% had one and 38% had two or more co-morbid conditions. These proportions did not differ substantially between men and women. The most commonly diagnosed co-morbid conditions were major depression, which affected more than a half, other anxiety disorders, affecting one quarter, and personality disorders, diagnosed in a little more than 10%. Panic disorder and generalized anxiety disorder were the most common anxiety disorders. Bipolar mood (manic-depressive) disorder was uncommon and schizophrenia was rare. Except for eating disorders, which were diagnosed in 1/20 women, the rates of specific co-morbid conditions were not strikingly different between men and women. (<http://ocd.stanford.edu/about/>)

OCD seems to be associated with a mildly increased risk of alcohol abuse and addiction. Rates of OCD observed among alcoholic patients admitted to inpatient and outpatient treatment programs exceed the rate in the general population, but not to the extent suggested by Karno et al.'s study in 1988, which attributed alcohol abuse or addiction to 24% of OCD subjects. (<http://ocd.stanford.edu/about/>)

Reports of the lifetime rate of body dysmorphic disorder (fear of imagined ugliness) in OCD patients are also prevalent, as well as findings by Barsky in 1992 indicating that patients with hypochondria have an elevated lifetime prevalence rate of OCD compared to medical outpatients from the same clinic. Eating disorders may be more common in OCD patients than in the general population, but the data are sparse. According to Rothenberg in 1990,

OCD symptoms are common in patients with anorexia nervosa, only second to depressive disorders. Trichotillomania (compulsive hair pulling with bald spots) is another co-morbidity of OCD, as well as Tourette's syndrome (the combination of behavioral and vocal tics). (<http://ocd.stanford.edu/about/>)

Quality of Life

OCD impairs patients' quality of life. In 1996, in a study on 60 patients, Koran, Thienemann and Davenport reported that medication-free patients with moderate to severe OCD reported worse social functioning and performance in work and other activities than the general population and the patients with diabetes. The more severe the OCD, the more impaired the patients' social functioning, even after controlling the effects of concurrent depression. Moreover, Rasmussen and Eisen noted in 1992 that another indicator of reduced quality of life is lower likelihood of OCD patients getting married.

The high personal cost of OCD is mirrored in high social costs. In 1995, Dupont et al. reported that the estimated 1990 direct costs of OCD to the United States economy were \$2.1 billion, and the indirect cost (i.e., lost productivity) \$6.2 billion. If a greater proportion of individuals with OCD were in treatment, the direct costs would have been considerably higher. For example, according to Nestadt et al. in 1994, among a random sample of the Baltimore study participants, only 1 out of 15 individuals (7%) whom a psychiatrist judged to need treatment was receiving it. Rasmussen and Eisen reported in 1988 that the delay between symptom onset and first care seeking is often prolonged by a mean of seven years, while Marks in 1992 reported 10 years. Even with much of the treatment foregone, OCD accounted for almost 6% of the estimated 1990 cost of all mental illness. In 1995, Leon, Portera and Wissman reported that high social costs were also reflected in the high rates of unemployment in OCD patients and receipt of disability and welfare payments. Family members suffer as well. Many studies indicate that patients' symptoms may create disharmony, angry or anguished demands for participating in rituals, a draining dependency, restricted access to rooms or living space, difficulty in taking holidays and interference with work obligations. (<http://ocd.stanford.edu/about/>)

Personal conclusions about OCD

There are situations when you can perfectly diagnose one case in a very specific way. Then you just have to fill in the gaps and start the healing.

There are also cases when you can only partially diagnose one person with a specific diagnose, the other manifestations being rather various.

There are situations when the personality in front of you is exactly the one that the specialists describe as being inclined towards specific diagnostics and there are also cases in which this personality is extremely diversified and, all of a sudden, nothing makes sense anymore.

Nevertheless, in each case there are constant symptomatology elements, which become a challenge for you, as a psychotherapist, and for the one in front of you.

1. A difficult childhood from the emotional point of view. We frequently have to deal with an authoritative and demanding parent who projects his own personal frustrations onto his child.

2. Distorted family and marital relationships in which, many times, the child plays the role of a mediator between his parents.

3. In his family, the subject always plays the role of the strong one, the one on whom everyone can rely on, the one who never disappoints, the one who listens to everyone but whom is never really listened to.

4. The subjects have taken responsibility for their own lives since they were very young.

5. They are persons with a remarkable intelligence.

6. They frequently create a social mask and a role in which expressing their own emotions is inactive and even unacceptable because that would contradict their chosen role.

7. Their generalized anxiety state related to the safety of their self. This fact comes as a sort of counter-balance of the fact that their role implies that they take care of everyone else while no one „takes care” of them, and when I say this I only refer to their emotional part. The beliefs related to their personal responsibility reveal the fact that an individual has the significant power of causing or preventing certain negative crucial results, but according to the subject's perception, these should be prevented. The distorted and exaggerated evaluations, which follow the criteria of responsibility, motivate the compulsive behaviors, through which the person is trying to prevent danger and reduce the burden of social responsibility.

8. Their mental state deteriorates in the moment they „are allowed” to do this, when things around them seem to reach a certain balance.

9. The psychic conflict, which represents the basis of these manifestations, seems to be partially conscious, partially unconscious. They feel the need for authentic emotional expression but this thing would ruin their whole image and their whole fragile balance which they have built with such great previous effort.

When this conflict escalates, they reach the climax of their obsessive-compulsive manifestations and the meaningless and uncontrolled repetition seems to be saying the same thing over and over again: „I cannot escape the prison which I, myself, have built with such great effort for so many years. I'm the only one who knows how powerful this prison is! I'm the only one who knows my most intimate thoughts and emotions which I've denied for many years in a row because I was afraid they would be unacceptable to the others. But I cannot take it anymore and my mind keeps repeating to me that something bad could happen to me: I could get sick because of all of these germs around me, so I have to wash myself a lot and very often and I never know if it's enough, I could always miss something so I have to wash myself again!!! I think I could get sick and I think I should control my body several times in order to see if there's any modification since last minute, when I last controlled myself.”

10. Rarely can you identify a trigger for these disorders. Most of the times, there are multiple cases spread along the way, but the disorder is created step by step, starting with apparently innocent manifestations until reaching serious symptoms, which take over you along with depressive disorder and generalized anxiety. The biological vulnerability is also not excluded. For instance, some therapists consider that in the nosological category of Axis II disorders, their development appears after the interaction between the genetic predispositions towards certain personality characteristics and early experiences (Beck, 2005 apud. Lăzărescu, M., 2009, p. 92). The obsessive-compulsive disorders are found in almost all people, with a reduced intensity, the pathological ones being isolated, intense and disturbing. Behind those disorders also lies a psychic ground predisposition of anxious-phobic type, which can alternatively become acute due to inner reasons or surrounding circumstances favoring sequential compulsive acts.

11. Most of the times, subjects have had other types of obsessive-compulsive manifestations in which the object of obsession was outside the patient's body and, therefore, it was easier to deal with, before the episode for which they come to therapy. For example, the obsession of arranging socks or one's own clothes or the obsession of avoiding certain people from the entourage, who could somehow have a negative influence on one's self. Later on, when one's own body or own safety makes the object of obsession, things slip out of control.

12. The aggravating situation is that in which one's own obsessions transfer to the people around the

subject: they are also not allowed to touch certain objects in order to avoid contamination, certain areas of the house could be completely isolated, or certain objects should not be found in the house anymore (knives, for example). The interpretability and suspicion regarding the people around them grows. The medical checkups are misinterpreted, what the people around them say is interpreted in the favor of their obsession, obviously supporting the false ideas about one's safety.

13. As a common evolution element, we have to deal with self-isolation. It is a conscious mechanism of avoiding as much as possible certain circumstances, which the subject considers difficult to control. The obsession that one's smell is overwhelming, followed by the compulsion of washing especially in the armpit area is very difficult to control when your job requires frequent contact with the others, as well as avoiding common transportation or other crowded areas in which one could get contaminated with germs much easier.

14. The conscious admission, of each of these patients, of the absurdity of their own thoughts, emotions and behaviors, which obviously sets this disorder under the category of neurosis and, moreover, the tiring fight of avoiding this kind of behaviors followed by giving up and the accentuation of the manifestations.

15. Shame, as a common element, comes to make these people's lives even harder. Many of them try to hide the symptomatology as much as they can; nevertheless, shame is rather social, given the fact that it is pretty hard for them to hide the obsessive-compulsive manifestations from close people, this feeling also leading to the increase of self-isolation. The symptomatology cannot be completely hidden from the people around them especially when it comes to ritualizing certain gestures. This aspect has a negative influence on the individual's performances and social life. Most patients have a tendency towards absurd meticulousness, towards a raving perfectionism.

16. Embracing mystical thinking or rather mystical beliefs, in contradiction to everything they have previously built. An event could be evaluated and interpreted, then based on this, a specific reaction appears. The interpretation expresses itself through automatic thinking triggered by beliefs that were formed especially during childhood. In the anxiety case, the beliefs regarding danger are present. Beck (1995, apud Lăzărescu, 2009) considers that there are two big categories of beliefs: the nuclear, global, rigid and overgeneralizing and the intermediate beliefs, which could be rules/expectations, presumptions and

attitudes, all of these elements mediating between events and the person's reactions.

Gustave Le Bon tried to demonstrate the character of the belief, which he states is neither voluntary, nor rational. Many times, in therapy with obsessive-compulsive persons, this was the key: identifying and becoming aware of the beliefs that constitute the basis of the disorder, beliefs which, most of the times, had their origins in childhood, as most of our beliefs. Therefore, a bridge over time is needed... a bridge that links the rational, mature being with the moments in which everything was possible, during childhood.

II. Case study

We consider this case to be relevant for the theme of the present paper, both for the inception modality, the manifestations and the solutions identified for solving the case.

The subject O.C., aged 34, has a profession that requires artistic skills, fits in the diagnosis of obsessive-compulsive disorder, in accordance with the DSM criteria listed above.

The subject was not diagnosed by a psychiatrist due to the fact that he is not a fan of medication and prefers a psychotherapeutic approach instead. Further on, during our meetings, after realizing the severity of his situation, he accepted the possibility of starting a medical treatment.

The manifestations, which he complained about, suggested rather an anxious symptomatology with panic attacks than an obsessive-compulsive disorder, the main symptoms being:

- A permanent anguish state with the idea that something bad could happen to him
- Psychomotor agitation
- Sleeping difficulties
- The feeling that he cannot control the occurrence of certain thoughts and anguish states.

The therapy went on for 8 months with a frequency of 2 meetings per week during the first 2 months and, later on, with a frequency of 1 meeting per week.

The subject talks during the first meeting about the moments he relates to the occurrence of this state. Approximately two years before, he had gone through a difficult period, when he had been under the suspicion of having a tumor in his left shoulder, diagnosis which was disproved later on. Then, step by step, he began to fancy the idea of the cancer occurrence possibility, though he was only preoccupied with the gland form. Once obsessive, this thought was accompanied by the compulsion of repeatedly self-

checking in the area of the armpit, the inguinal canal, the sub-mandible area etc. He also did a series of medical checkups in order to verify his health state.

During the following meetings, the history of the case is being outlined, which proves that the obsessive-compulsive symptoms first appeared approximately two years before manifesting themselves more or less acute in various forms.

The subject's family environment during his childhood was marked by affection insecurity and emotional tension, first of all due to the dysfunctional relationship between the parents. The fights they had used to be intense, with violent manifestations on behalf of the father, especially verbally, and even if they were not so frequent, there was a permanent negative tension, of heavy silence, which determined him, at a certain point when he was a child, to sleep with his shoes on, so to be always „ready to run". In his mother, he saw a permanent struggle, a resigned attitude, which also affected him in a negative way.

He went to a high school away from home. This period was described as one of relative inner peace. The adolescence period came with a series of major transformations in his life. It is the period in which he got to know his future wife. Moreover, an important turnover took place in his origin family. His mom chose to travel to a foreign country to work and the relationship with her became colder and colder. Instead, he got closer to his father, who was very significant for the subject in the following period. This soulful approach to his father took place after a dramatic accident in which he hit his father after his father had insulted him. From a psychological point of view, this direct confrontation reveals, on the one hand, the development of an aggressive part of the involved one and, on the other hand, an impossibility of adequate emotional expression. The reaction of his father to this event was that of accepting his son as an equal, all of a sudden opening the communication path between them, despite the fact that up to that moment they only used to address a few words to each other.

There is also an alcohol consumption history, but for an insignificant period and also a tobacco abuse, reaching a consumption of 3 packages a day, which lasted until a year ago, when he decided to give up smoking in order to avoid health problems and which coincides with an abrupt trigger of the present symptomatology.

He got married early with his partner from his adolescence and they now have three children with ages between 1 and 8 years old.

The obsessive-compulsive symptomatology started to manifest when he was about 32 years old

through the obsession that he developed regarding his friend. He had constant obsessive thoughts about how to avoid him and how to speak to him. He became afraid of running into him. He was constantly avoiding the contact with him etc. He experienced feelings of repulsion and even latent aggression regarding him. Long time after the contact with his friend, he remembered the meeting which gave him an unpleasant persistent feeling, followed by feelings of anger and aggressive scenarios regarding him. At a certain level, he perceives him as a potential danger, which could somehow harm him or his family and which he is trying to avoid. This whole story extends over a year, proving, in the meantime, the impossibility of an authentic emotional communication with both his friend and his wife. He shares very little of his kneading with his wife. On the one hand he tries to protect her and on the other hand he realizes the absurdity of the situation.

This episode ends with the help of a few therapy sessions with another therapist, who reveals the fact that, in an unconscious way, he was projecting onto that person the negative feelings he had for his father. As soon as he becomes aware of this mechanism, these preoccupations disappear but they are replaced, shortly after that, with the present symptomatology.

We have to mention three other important events as contributive facts, lived intensely and subjectively:

- His father's death
- The chronic health problems of his second child which are very emotionally solicitant
- The birth of the third child
- The false diagnosis of tumor in his left shoulder
- Giving up smoking
- Difficulties of emotional expression, which determine the accumulation of negative tension and violent verbal or physical explosions

In order to understand the manner in which these events weaken the personality, we have to insist upon each of them.

The father's loss was experienced as a moment of losing the meaning of life. His father represented his anchor in day to day reality, the one who provided the feeling of stability and protection. The wake was also traumatizing due to the fact that he had to deal on his own with a series of morbid details, which were very hard to bear and which are very deeply carved into his memory, thus forcing him to face the idea of death. He goes through all those moments alone without sharing with his partner what he experienced. Due to the fact that she was a mommy, he agreed with her that she should not even participate

to the funeral. As a set time, his father's death had occurred two years before the first obsessive-compulsive episode started.

The second child was born with serious health problems, namely severe alimentary disorders. In this period, both partners experienced a tragedy through the natural pain given by the impossibility of treating their own child but also through the fear of losing him. The almost three and a half years since his father's death until he first showed up to therapy were extremely challenging with the health problems of the child, who did not feed on anything else but milk and had frequent episodes of throwing up at any attempt of normal feeding.

Because of the trauma he is going through with his second child, he does not agree with his wife, who expresses her wish to have a third child, which finally happens, causing O.C. a great anxiety. The third child was born in the period during which the subject started to experience obsessive thoughts related to a possible cancer sickness.

The false cancer diagnosis makes him face the idea of his own death – an extremely weakening factor in all the dynamic of his personal life. One of his dilemmas was related to the unconscious choice of the type of cancer that preoccupied him, type which had no connection whatsoever with his false diagnosis. The only direct link was a location in the shoulder area (the lymphatic cancer is also acting in the armpit area). He found no direct link and the only explanation is given by the difficulty of early diagnosis, of the big prevalence of deceases and by the treatment difficulties of this type of disease.

He gives up a significant addiction – smoking, the input being represented by about 3 packages a day and which, from a psychological point of view, had a role of discharge. Psychologically, after the father's death and after he got out of the crisis determined by the health state of the child, the patient's psyche symbolically triggered and revealed the two stages that he had been going through in the relationship with his father, as an expression of the suffering generated by his loss.

1. The tense relationship of terror and anguish which he experienced in the first part of his life in the relationship with his father and which he resolved on an emotional level with a lot less suffering.
2. The relation between losing someone dear to him, the fear of death, and, especially, the fear of making the loved ones suffer because of his own disappearance. This idea was translated in the fight with a potential disease in the attempt to prevent it, thus trying to avoid the emotional disaster that he could not manage in the

relationship with his father's loss. At the same time, an unconscious accusation starts outlining against his parent, who could have taken better care of himself so that he could have been next to him for a longer time.

David Shapiro (2009) compares the obsessive-compulsive experience with that of a pilot who flies through the night or through fog as if he could see everything very clearly because he considers he has precise and correct instruments, but nothing from his experience is adapted to reality and instead he only relies on certain indicators that he uses. In the same manner we could describe the experience of the subject who had the sensation of a clear perspective on his situation (he was about to get sick and die) and who was using the indicators which he interpreted according to his own rules. For example, if the entire family catches a cold and gets a fever and he does not get a fever, this could be an indicator of a gland problem.

During the meetings, the objectives of the therapy were outlined as follows:

1. To normalize the anxiety states.
2. To diminishing them by applying cognitive-behavioral techniques.
3. To outline the subject's life history and his manner of functioning from the point of view of the adaptive mechanisms.
4. To become aware of the inner motivation of acting in a certain manner – meaning – adopting an obsessive-compulsive symptomatology.
5. To identify the false beliefs which underlie the symptomatology.
6. To diminish the obsessive-compulsive symptomatology by accepting reality
7. Preventing relapses by learning some ways of emotional expression and by adopting some adaptive beliefs.

The used strategies and techniques are from the area of integrative psychotherapy. Besides cognitive-behavioral psychotherapy, we used imagery and relaxation techniques from the Ericksonian psychotherapy area, as well as techniques from experiential psychotherapy such as emotional expression through drawing with the purpose of becoming aware.

The experience of the drawing, which reflects one's own emotional feelings, was a benefic one and helped the subject clarify his feelings during therapy. As Iolanda Mitrofan (2000) states, the expressive-creative techniques are capable of underlining, not only the feeling and the expression of the present emotion by becoming aware of it, but also the perceptions and thoughts that follow it.

At first, the effort of translating everything into a plastic language was significant because it made him voluntarily deal with his feelings, with his fear of death. The representative drawing for the initial phase was a cross inside of which a coffin was outlined. Around this cross there were pairs of crying eyes which were looking at the cross. The image reflected the most powerful belief that underlay his obsessive-compulsive symptoms – the obsession of getting gland cancer followed by the compulsions of frequent and constant self-check. This belief was the fear of his imminent death and losing his loved ones.

The second drawing was represented by some rows of dark flowers, all on a dark ground, except a white one in the left corner of the page which was drawn on a piece of clear sky. All flowers were standing up, except the white one, which was upside down. The drawing represents an improvement on his state, of the good days he has, which are still few and seem unusual (the upside down flower) in comparison to the others. More than that, the only flower with five petals was the white one, the rest of them having six petals and representing death and his fears related to death.

The third drawing, which symbolized the idea of getting over his difficulties, was represented by peaceful water with a peaceful beach on which there were a few children playing. The sky was clear, with only a few white clouds from which two big eyes were looking at the children. The symbol reflects inner peace, the acceptance of the idea that he cannot control destiny and the belief that he would continue to watch over his children who could be fine in his absence.

The analysis of the subject's false beliefs had a very important role in the dynamic of the therapy and it also overcame the anxiety state, which would trigger when he would give up on them. We can state that this was the central point of the therapy – demolishing and developing the subject's capacity of giving up his maladaptive beliefs and replacing them with new adaptive ones. The obsessive-compulsive symptomatology of the subject was based on the following false beliefs:

- He will not reach the age of 35. The belief was based on a calculus made at his father's grave and represented the time between the death of his grandfather and that of his father. The thought was irrational but it became a belief which was feeding the symptomatology.

- By checking himself obsessively and using his hyper-attention regarding body signs, he could prevent and control the occurrence of the disease, and, if it appeared, he would be capable of applying a scenario

in which he disappears from his family, he isolates himself in order to fight cancer and protect his loved ones.

III. Results and conclusions

As Andre Manus states (1998), the essence of the obsessive personality is the difficulty of expressing feelings of warmth and tenderness. We would add that, besides this problem, in this case the individual is also incapable of receiving these feelings from the others, a characteristic which has been outlined in all dynamics of his life. The role he chose only implied protecting, loving and taking care of the close ones, without considering that he could also receive the same kind of feelings in exchange.

Psychotherapy ended with a conclusion stated by the subject – all he has done was out of too much

love. However, interpreted and applied in the wrong way, this love could have led to losing everything that he has ever tried to protect.

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