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OCD VS. OCPD

When one hears the words obsessive-compulsive, which pathology comes to mind? Arguably it would be obsessive-compulsive disorder (OCD), characterised by intrusive thoughts and repetitive rituals. However, there is a condition described as obsessive-compulsive, but which is characterised by rigidity, being overly organised with perfectionistic personality traits and behaviours that significantly interfere with life, namely obsessive-compulsive personality disorder (OCPD).

MEETING BUCKY CANTOR

People with mental health issues can be found in places not necessarily limited to doctors' or scientists' offices. A decade ago, a novel called "Nemesis" by Phillip Roth told a fictional story about the protagonist Bucky Cantor, 23-year-old gym teacher during the outbreak of polio in Newark, New Jersey back in 1944.

The protagonist was depicted as extremely rigid in his sense of duty and morals to the extent of being heartlessly harsh to himself. Growing up with a warm grandmother, yet no parents and an overly strict, dominant, and critical grandfather, one of the major messages to him from early life was that "man's every endeavor should be imbued with responsibility." The protagonist was also depicted as someone who prioritised work as a teacher over leisure, health and even family matters. Throughout the story, the high standards of being a good teacher, a role model to the kids and good partner was a repetitive theme, which caused a great level of distress and guilt to the protagonist. Eventually, the thought that he might have infected some of the playground boys with polio left him with an extreme sense of guilt and distress, which ruined most of his areas of life and dreams. Bucky Cantor was depicted as exceptionally perfectionistic, overly structured and dedicated to work with tremendous emotional inhibition and need for control over his environment.

Bucky Cantor is a symbolic representation of personality difficulties presented by individuals with obsessive-compulsive personality disorder (OCPD). Despite being portrayed as an authority figure, his life was filled with extreme

distress, personal inner conflicts, and suffering typical of individuals with OCPD.

WHAT IS OCPD?

Obsessive-compulsive personality traits are present in many of us and can be quite adaptive. Nevertheless, taken to the extreme, it can become debilitating and cause significant suffering for the person and significant others. OCPD in DSM-5 or anankastic personality disorder in ICD-10, has traditionally been characterised as an excessive preoccupation with orderliness, mental and interpersonal control, and perfectionism at the expense to efficiency, openness, and flexibility. The maladaptive patterns of OCPD usually have an onset in late adolescence or early adulthood. The traits of OCPD are usually stable over time, significantly impair functioning, and cause significant distress. Even though it's quite common, OCPD is still a relatively under-diagnosed disorder lacking empirical research.

Notably, with the introduction of ICD-11, there was a dramatic shift in conceptualisation of personality disorders. In the new dimensional approach of the ICD-11, the anankastia domain overlaps with DSM-5 OCPD traits as well as the low disinhibition (low levels of impulsivity) domain. Anankastia is described as a narrow focus to an individual's rigid standards of perfection, right or wrong categorisation, and a high need to control oneself, others, and/or the environment to meet those high standards. In a clinical sense, the individuals that will present with the highest anankastia and/or lowest disinhibition traits will most likely have the highest OCPD symptoms as well. Furthermore, egosyntonicity, or compatibility with the conscious self-concept, is one of the most important aspects in personality-related disorders. Individuals with OCPD may see their symptoms as valuable assets of their personality, which they would have difficulty changing, and which give them a sense of self-identity and structure in life.

OCPD EPIDEMIOLOGY AND COMORBIDITY WITH OTHER MENTAL DISORDERS

Most of us are more familiar with the other personality disorders, such as borderline, antisocial, or narcissistic personality disorder, due to the increased attention by the scientific community, clinicians, and even popular media, as they usually manifest as extremely maladaptive and socially undesirable. Nevertheless, the arguably somewhat lesser known OCPD is considered one of the most common personality disorders in the general population, with lifetime prevalence rates ranging from 2.1 % to 7.9 %. The prevalence of OCPD tends to rise in psychiatric populations, increasing up to 25 %.

Considering comorbidity with other mental health disorders, OCPD is often comorbid with OCD, mood and anxiety disorders, eating disorders, and substance-related disorders. OCPD is also often comorbid with other personality disorders, including avoidant, paranoid, schizotypal, borderline, and narcissistic personality disorder.

OCPD VS. OCD

According to DSM-5/DSM-5-TR, to meet the criteria for OCPD, the patient must have at least four out of eight symptoms associated with significant distress and impairment, including preoccupation with details, perfectionism, workaholism, over-conscientiousness, hoarding, need for control, miserliness, and rigidity. In contrast, to meet the diagnostic criteria for OCD, the person must have obsessions and/or compulsions that are time consuming (at least one hour/day) and/or cause significant distress in daily functioning, while the symptoms should not be better explained by other mental disorder, substance abuse or medical condition.

Some parallels and overlapping features between OCPD and OCD can be drawn that present a diagnostic challenge. First, in both OCPD and OCD, there may be a preoccupation with detail. Moreover, while someone with OCPD may tend to be overly rigid in terms of order and cleanliness, a person with OCD may manifest similar behaviors as part of their contamination obsessions and cleaning compulsions. Secondly, both OCPD and OCD may tend to overestimate threat and find it difficult to tolerate uncertainty. Thirdly, even though perfectionism is not a core feature of OCD, it may be a contributing factor to OCD symptomatology, resulting in repetitive ordering and arranging behaviours. Fourthly, in both OCPD and OCD, the importance of "right" vs. taboo thoughts may be emphasised to a great extent.

Two key aspects may help to differentiate OCPD from OCD. First, even though both OCPD and OCD may vary in terms of the degree of insight, individuals with OCPD may be fixated on the belief that their behaviour is appropriate and a core part of their personality (egosyntonic), whereas most OCD patients have egodystonic symptoms, meaning that they see their symptoms as upsetting and unwanted. Secondly, as DSM-5 suggest, the clinical manifestations between OCPD and OCD are rather different in that OCPD is not primarily characterised by intrusive thoughts (obsessions) or repetitive behaviours (compulsions) as in the case of OCD. Instead, its core feature is a pervasive maladaptive pattern of pathological perfectionism and rigid control. Of note is that these two disorders can co-exist, with DSM-5 suggesting that in such a case, both diagnoses should be assigned.

THE KEY CHARACTERISTICS OF OCPD:

- Preoccupation with details
- Perfectionism
- Workaholism
- Over-conscientiousness
- Hoarding
- Need for control
- Miserliness
- Rigidity

Table 1. Thompson score and biochemical markers for end organ dysfunction

OCPD criteria (DSM-5)	OCD criteria (DSM-5)
A persistent pattern of following criteria (at least four) that starts in early adulthood and are manifested in a various context: 1.Preoccupation with details including rules, list, order, organizational matters at the cost of major point of the activity; 2.Perfectionism that directly interferes with task completion due to overly strict standards; 3.Workaholism including excessive devotion to work, effectiveness and productivity at the expense of friendships and leisure time even when financially or economically not necessary; 4.Over-conscientiousness that is directly manifested by high scrupulosity and inflexibility in the matters of morality, ethic, and values (except for cultural/religious identification); 5.Hoarding including inability to discard worn-out and worthless objects with no sentimental meaning; 6.Need for control that is usually manifested by inability to delegate tasks and work with other unless they submit to his/her style of doing things; 7.Miserliness that includes stingy spending style towards self and others, while the money are seen as something to be hoarded for future catastrophes; 8.Rigidity and stubbornnes.	A.A presence of obsessions (i.e. repetitive and persistent thoughts), compulsions (i.e. repetitive [ritualistic] behaviors), or both; B.Obsessions/compulsions are time consuming (at least 1 hour/day) or cause a significant distress or impairment in daily functioning; C.Obsessive-compulsive symptoms are not caused by substance use or other medical condition; D.The disturbances are not better explained by other mental disorder.

SCREENING/ASSESSMENT FOR OCPD

Structured or semi-structured interviews are often used in screening for OCPD. The psychometrically sound instruments used to evaluate personality disorders, including OCPD, are the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II), the International Personality Disorder Examination (IPDE), the Structured Interview for DSM-IV Personality (SIDP), and the Diagnostic Interview for Personality Disorders (DIPD). The Compulsive Personality Assessment Scale (CPAS) was developed as an observer-rated semi-structured interview to measure the presence and severity of OCPD specifically, mapping directly on each of the DSM-5 criteria for OCPD. Each of the 8 criteria is rated from 0 to 4, and the maximum total score of the CPAS is 32. To meet a diagnosis of DSM-5 OCPD, a score of three (severe) or four (very severe) on at least four of the CPAS items should be presented. In addition, valid self-report measures such as Pathological Obsessive Compulsive Personality Scale (POPS) may also be used to assess the severity of OCPD traits in clinical practice.

CAN OCPD BE TREATED?

The scientific evidence for pharmacological treatment in case of OCPD is still limited. Until now, only two randomised controlled trials are available that evaluate the efficacy of pharmacological treatment for OCPD. Unfortunately, they provide very preliminary evidence on the efficacy of selective serotonin reuptake inhibitors (SSRIs; i.e., citalopram and fluvoxamine), with low levels of certainty.

In terms of non-pharmacological treatment, there are currently four randomised clinical trials available in the literature. In one of the most promising high quality multicenter randomised controlled trials by Bamelis and colleagues (2014), Schema therapy was found to be highly effective for treating personality disorder including OCPD. Schema therapy is one of the third generation CBT therapies, based on integrative approach that combines the elements of CBT, psychodynamic, psychodrama, and other therapeutic approaches. In addition, in three of the earlier studies, short-term psychodynamic therapy and cognitive therapy were found to be effective in treating DSM cluster C personality disorders, including OCPD. However, the number of patients was relatively small, and the evidence rather limited.

When drawing comparisons between treatment strategies for OCPD and OCD, accurate diagnosis is probably most important. Some data suggests that if OCPD is present as a comorbid diagnosis in OCD, the established treatment for OCD (i.e., SSRIs with CBT) will be less effective. Therefore, in the case of comorbid OCPD and OCD, greater emphasis should be placed on long-term evidence-based psychotherapy, like schema therapy, in order to target the egosyntonic nature of OCPD, as the presence of this personality disorder may interfere with the well-established short-term psychotherapy manuals and pharmacotherapy for OCD, as mentioned earlier.

CONCLUDING REMARKS

OCPD is a mental disorder that causes distress and significantly impairs functioning in several life domains. Despite a similar sounding name and some overlapping features, it differs significantly from OCD. These differences need to be taken into account during diagnosis as it has treatment implications. As yet however, there is still a relative paucity of studies on the possible pharmacological and psychological treatment for OCPD.

References available upon request