## Case report

# Management difficulties in a patient with obsessive-compulsive personality disorder: attention on therapeutic relationship

**Md Arifuzzman,[1] Mekhala Sarkar,[2] Mohammad Muntasir Maruf[3]**

[1]MD Resident of Psychiatry, National Institute of Mental Health (NIMH), Dhaka, Bangladesh; [2]Associate Professor of Psychiatry, NIMH, Dhaka, Bangladesh; [3]Assistant Professor of Psychiatry, NIMH, Dhaka, Bangladesh.

**Article info**
Received : 05 Dec 2021
Accepted : 20 Dec 2021
Number of tabs : 00
Number of figs : 00
Number of refs : 09

**Correspondence**
Md Arifuzzaman
Mobile: +8801723003683
E-mail: arif.psychiatry@gmail.com

**Summary**

Despite high estimated prevalence, clinical recognition of obsessive-compulsive personality disorder is comparably lower. Multiple treatment options are available but very few data are present supporting their reliability. A case of obsessive-compulsive personality disorder was illustrated here. Diagnosis was made as he was perfectionist, over-conscientious and inflexible about morality, ethics and values, unable to delegate tasks with others, rigid and significantly functionally impaired. Along with pharmacological treatments, psychological interventions including cognitive behavioral therapy, problem solving counselling and family counselling were exercised where an effective therapeutic relationship with the patient was emphasized. Noticeable improvement was achieved thereafter. Further research is necessary regarding the management of the disorder.

**Bang J Psychiatry 2021;35(2): 36-38**

### Introduction

Obsessive-compulsive personality disorder (OCPD) is one of the most prevalent personality disorders.[1,2] In general population, estimated prevalence of this disorder ranges from 2.1% to 7.9%. It is featured by pervasive preoccupation with orderliness, perfectionism and control expensing flexibility, openness and efficiency and associated with significant functional impairment.[3,4,5] Large number of patients may not come to clinical attention.[6] Along with pharmacological treatments, psychological measures include cognitive behavioral therapy (CBT), group therapy, family counselling, enhancing coping strategies and avoiding situations creating difficulties. A therapeutic relationship of trust, respect and genuineness between a healthcare professional and a client or patient is very crucial for its management.[5,7,8] Here exemplified a case of OCPD who improved with pharmacological and psychological interventions highlighting strong therapeutic relationship.

### Case summary

A 35-year-old unmarried Muslim male telecommunication engineer, unemployed for 3 years was admitted to a non-government psychiatric hospital of Bangladesh on 11 November 2021 with the complaints of sudden clash with family members and social disengagement. Along with this, there was long disharmony among them owing to his excessive inflexibility about rules, morals and values. He was very conscientious and rigid about rules and standards from his late childhood. Despite this, he was often unable to accept other people's thoughts and works and avoided conversing with those who had different viewpoints. His food habit was also very restricted. In spite of having excellent academic qualifications and fine job skills, he could not continue his high salary job due to conflicts over regulations and ethics. A number of marriage proposals were turned down as they did not match his ideology.

During COVID-19, while being with family members, he had frequent arguments with them regarding his dietary habit, marital issues, lifestyle and other family matters. As a consequence, he began to avoid them and eventually maintained minimal interactions. Regardless of long unemployment and a high level of family discord, he expressed himself as content in those times. Following a verbal collision with family members and relatives, he had been slapped by his elder brother on his face and subsequently admitted to a drug addiction rehabilitation center where his hair was cut against his will. The entire situation was extremely humiliating to him and he was considering legal actions. No family history of psychiatric illness was reported. He was introvert, sensitive, and self-dependent. Regarding mental status examination, he denied any obsession, delusion or hallucination. Furthermore, he refused the necessity of any treatment for his condition.

Diagnosis was confirmed as obsessive-compulsive personality disorder according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). He was kept apart from his family during hospitalization. After performing routine examination, fluvoxamine was prescribed as 50 mg/day orally

and gradually increased to 150 mg/day. Six psychotherapy sessions comprising cognitive behavioral therapy and problem solving counselling were given in three weeks period. His strengths and weaknesses were identified. As he was sensitive and rigid, careful steps were taken to establish rapport and to gain trust. Adequate time was given to ventilate emotions. Cognitive therapy was given briefly as the patient wished to be discharged early. Detecting cognitive errors, cognitive restructuring was attempted by thought challenge. After forming a working therapeutic relationship, he was more open to discuss. As he realized misunderstandings with family members, concern regarding the insulting events was reduced and attitude towards them became positive. Also, he decided to launch his own business soon and marry afterward. Meals became less strict with more variations. His outlook towards social norms and communication became optimistic. In addition, he supported logical confrontation as better coping strategy rather than avoidance. Psychoeducation to family members as well as family counselling were given to resolve undue issues and improve communication. Family members realized the necessity of managing him carefully with respect. Besides, they affirmed not to criticize or argue with him unnecessarily and impose decision on him. After 3 weeks of admission, he was discharged from the hospital. He agreed to attend further psychotherapy sessions following discharge.

## Discussion

Like other personality disorders, the treatment of OCPD is very challenging. It is time consuming and complex. Moreover, as this disorder is ego-syntonic, individuals usually do not have any distress regarding the symptoms as well as they rarely seek treatment for them.[6] Our patient was also brought to the hospital against his will and he opposed the need of treatment.

Although their efficacy was not much justified, several antidepressants, antiepileptics and benzodiazepines were found to be effective in treating OCPD in some studies. As fluvoxamine and carbamazepine were more studied among them,[7] the case was initiated with fluvoxamine aiming to reduce the distress caused by the derogatory incidents.

A dysfunctional therapeutic relationship was detected as a major barrier of treatment outcome of OCPD. Gaining trust and allowing the patient to talk freely are central in managing the disorder.[5,7] Furthermore, maintaining regular psychotherapy sessions is difficult.[9] As the patient was sensitive and rigid, engaging him in treatment as well as forming a trustworthy and respectful doctor-patient relationship were considerably challenging. Thus, greater time and attention were invested there and a stable therapeutic alliance was finally established. It created the opportunity to move forward with the management. The patient became free to discuss and gradually began to accept changes.

Despite the fact that psychological methods, in managing OCPD were observed as inconsistent, CBT was deemed one of the most effective options. Group CBT was found to be convincing in reducing the severity of some particular symptoms as well. In addition, problem solving counselling and strategies to cope better with situation were identified as crucial. It was also seen that treatment directed to avoiding situations that increase difficulties was also necessary in this regard.[5,7] In our case, CBT was given briefly and planned to be given after discharge as he didn't agree to stay in the hospital any longer. Though his cognitive errors were not corrected significantly, they might be improved on the following sessions. Group therapy was not possible as it was very difficult to arrange in that setting. However, problem solving counselling was given to combat adverse situations. As he accepted confrontation as better coping strategy, his usual avoidance might be reduced and he could better cope with difficult situations. Moreover, family counselling was given to minimize unfavorable circumstances. Since the family members were motivated, subsequent interactions with him were expected to be healthier. Along with this, the patient became positive towards family members as well as more flexible regarding food intake and marriage, was more optimistic towards social norms and communication, and was planning to be professionally active. All those changes signified improvement of his condition.

Prognosis of OCPD is variable and difficult to predict.[4] Ensuring drug compliance, regular psychotherapy sessions, proper family support and regular follow up, better prognosis of the patient would have been expected. As it was very difficult to engage him in treatment without a strong therapeutic relationship, it might be eventually the most critical point for better overall outcome.

## Conclusion

An effective therapeutic relationship seems to be pivotal in the management of obsessive-compulsive personality disorder. The case put some value on this point. Future epidemiological studies directed to management of this disorder should be conducted to obtain more reliable information.

## References

1. Wheaton MG, Pinto A. The role of experiential avoidance in obsessive-compulsive personality disorder traits. Personal Disord 2017;8(4):383-8.
2. Cheli S, MacBeth A, Popolo R, Dimaggio G. The intertwined path of perfectionism and self-criticism in a client with obsessive-compulsive personality disorder. J Clin Psychol 2020;76(11):2055-66.
3. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA: American Psychiatric Association Publishing; 2013. p. 678-81.

4. Sadock BJ, Sadock VA, Ruiz P. Kaplan and Sadock's synopsis of psychiatry. 11th ed. Philadelphia (USA): Wolters Kluwer; 2015. p. 756-7.

5. Harrison P, Cowen P, Burns T, Fazel M. Shorter oxford textbook of psychiatry. 7th ed. London, England: Oxford University Press; 2018. p. 407-12.

6. Koutoufa I, Furnham A. Mental health literacy and obsessive—compulsive personality disorder. Psychiatry Res 2014;30;215(1):223-8.

7. Diedrich A, Voderholzer U. Obsessive-compulsive personality disorder: a current review. Curr Psychiatry Rep 2015;17(2):2.

8. https://medical-dictionary.thefreedictionary.com/therapeutic+relationship

9. Yang R, Vigod SN, Hensel JM. Optional web-based videoconferencing added to office-based care for women receiving psychotherapy during the postpartum period: pilot randomized controlled trial. J Med Internet Res 2019;20;21(6).