Case report

Obsessive-compulsive personality disorder: a challenging case treated with a psychopharmacological approach

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Summary

Obsessive-compulsive personality disorder is a subcategory of personality disorder, though prevalent is a less researched condition. Psychotherapy is the mainstay of treatment but provided data on its effectiveness are scarce. The case presented involves an unhappy 26-year-old lady preoccupied with perfectionism, inflexibility, reluctance to collaborate with others with significant interpersonal distress, and functional impairment. In addition to pharmacological treatment, psychological interventions including cognitive behaviour therapy, problem-solving counselling, and coping strategies were exercised on the ground of a trusting therapeutic alliance. Considerable improvement was noticed.

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Introduction

Obsessive-compulsive personality disorder (OCPD) is one of the most common personality disorders in the general population.[1] According to the American Psychiatric Association lifetime prevalence ranges from 2.1% to 7.9%.The hallmark features are pervasive preoccupation with orderliness, perfectionism, and mental and interpersonal control without room for flexibility and openness that interferes with the completion of a task efficiently.[2-4] The best-validated treatment for OCPD is cognitive behaviour therapy (CBT). There is also evidence of certain advantages with schema therapy, meta cognitive interpersonal therapy, and dynamic therapy.[5-7] Treatment is focused on avoiding situations causing difficulties and developing adaptive ways of coping with stressful situations. Pharmacological agents like selective serotonin reuptake inhibitor (SSRI) may be beneficial, especially when obsessive and compulsive symptoms breakthrough.

Case summary

A 26 years old unmarried Muslim female computer engineer, from an urban background middle-class family, unemployed for the last 1 year, came along with her father and was seen as an outdoor patient in a government psychiatric hospital of Bangladesh in February 2022 with the complaints of repeated failure of sending emails to respected authorities for higher study in abroad, preoccupied with perfectionism, inflexibility, reluctance to delegate task with others with significant interpersonal distress and functional impairment. She was excessively careful and repeatedly checking for possible mistakes during doing any task or important project. For higher study abroad, she had to send the completed project to respected authorities, but during doing that, she had developed a strong belief that her project was not perfect enough and so she must be rejected. She also thought that her project information will remain on online and she was seen by others as a failure person. The perfectionism and self-imposed high standards of performance cause significant dysfunction and distress in her. Besides that, the patient had to leave her job one year back due to missed deadlines and inability to make timely decisions. She was also reluctant to delegate tasks to others and unreasonably insist that everything be done her way. She was often unable to accept other people's thoughts as well as works and avoided conversing with those who had different opinions. Though she tends to be over-devoted to the work to the exclusion of involvement in leisure activities and friendships, she had to quit her job several times for her misery time management to maintain perfectionism. She admits that she often missed deadlines but claims that, they are unreasonable deadlines for the quality of work she provided. From her early adulthood, she had few friends and felt discomforted nearly every time during gathering of friends. She thought that those were a waste of time and rather she should study to obtain maximum benefit from the valuable time. She got involved in a romantic relationship twice but resulted in a break-upon both issues due to her rigidity, inflexibility and stubbornness. Her everyday relationships had a formal and serious quality and she carefully held herself back

until she was sure that whatever she said will be perfect. Friends and colleagues became frustrated by her constant rigidity. Among family members, she was much closer to her father and her mother seemed to be an over-protective parent. Her younger sister had social anxiety disorder and under treatment for that. No other family history of psychiatric illness was reported. Regarding mental status examination, the patient did not reveal any abnormalities in mood, thought processes, or thought content. Her appearance was very serious and manner was notable for its rigidity and stubbornness. The diagnosis was confirmed as Obsessive-Compulsive Personality Disorder according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). After taking elaborative history and mental state examination, to reduce her anxiety, Sertraline was prescribed as 50 mg/day orally and gradually increased to 150 mg/day. Ten psychotherapy sessions comprising cognitive behavioural therapy, problem-solving counselling, and dialectical behaviour therapy (DBT) techniques were applied over 12 weeks period. Her strengths and weakness were identified and careful steps were taken to establish rapport and gain trust. Adequate time was given to ventilate emotions. Thought diary was maintained by patients after a proper demonstration during therapy sessions. Dysfunctional thought records (DTR) were detected and the DTR allowed patients to list what the situation was, how they were feeling, and what their thoughts were when the problem occurred. She also taught a mindful approach of noticing, labelling, and redirecting her thoughts. Detecting cognitive errors, cognitive restructuring was attempted by thought challenge. DBT techniques for distress tolerance, emotion regulation, and improving interpersonal relationship were applied. Distress tolerance skills such as STOP skill, TIPP skill, pros and cons, distraction and self-soothing and to improve interpersonal relationships, identifying interpersonal priorities and DEAR MAN skills were demonstrated. Mindfulness, relaxation therapy, and skills for emotion regulation were applied accordingly throughout the sessions. Psychoeducation to family members as well as family counselling was to improve communication. As her symptoms improve satisfactorily, she is now advised to continue the medication and attend psychotherapy sessions once monthly for the next 3 months.

Discussion

People with OCPD seek treatment for difficulties secondary to their OCPD trait rather than for the disease itself.[8] This was reflected in our case too as the patient came for her difficulties in the academic and professional fields. The evidence for pharmacotherapy was limited. Study showed some benefits from fluvoxamine and carbamazepine and a comparative study between citalopram and sertraline showed a reduction of OCPD traits by both drugs.[3]

Our patient was brought to the hospital by her father and the case was initiated with Sertraline, which was titrated upward to the optimal dose. Adequate time was given to ventilate the patient and allow her to talk freely. By forming a trustworthy and respectful doctor-patient relationship, regular psychotherapy sessions were ensured. CBT was applied as a first-line psychotherapeutic intervention in our case. The cognitive therapy addressed some general goals, such as educating the patient about the role of perfectionism in producing and maintaining her presenting symptoms as well as helping the patient to evaluate her automatic thoughts and core beliefs that maintain perfectionism and rigidity.

Thought diary was maintained by the patient after the proper demonstration and was monitored each week between sessions. This help patient to list what the situation was, how they were feeling and what their thoughts were when the problem occurred. Thus, by maintaining a thought diary, we collaboratively identified the primary cognitive distortions and maladaptive patterns of thought that our patient used and maintained, such as perfectionism, overgeneralization, magnification etc. As our patient learned to recognize and understand distortions in her thought process, she started to respond rationally to her automatic thoughts.

Dialectical Behaviour Therapy (DBT) skills were applied to improve the interpersonal relationship and manage her distress and emotion more adaptively. Mindfulness was demonstrated briefly and relaxation techniques such as breathing exercise were practised to deal with anxiety. Besides problem-solving counselling and strategies were manifested to cope better with crucial situations.

After 12 sessions over a 3-month period, she was generally able to recognize the source of her stress and her dysfunctional automatic thoughts and can modify them. As a result, eventually, she was able to send an email and got a response from the authority. Moreover, family counselling was given to her family members to maintain her improvement. The prognosis of OCPD is diverse and difficult to predict.[3] But as the patient is educated well to recognize and deal with her dysfunctional core thought, by ensuring drug compliance, follow-up psychotherapy sessions and adequate family support, better prognosis of the patient would have been expected.

Conclusion

An effective therapeutic relationship with concern transference and countertransference and avoidance of giving direct advice seems to be vital in the management of OCPD. Moreover, it seems information regarding the management of OCPD needs better research data.

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