Editorial

Obsessive-compulsive (Anankastic) Personality Disorder: A Poorly Researched Landscape with Significant Clinical Relevance

INTRODUCTION

The constellation of features similar to the obsessive-compulsive (anankastic) personality disorder (OCPD) was first described by Pierre Janet in 1903 as the "psychasthenic state." This was later endorsed by Freud in his 1908 work entitled, "Character and Anal Eroticism."[1] In 1952, the American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorders (DSM) made it a diagnosable psychiatric condition. However, unlike other personality disorders, it has been included in all the revisions of the DSM including the DSM-V. Prevalence studies have identified OCPD as a common disorder with a point prevalence rate of 8.7% in an outpatient sample and with a prevalence rate of 23.3% in a psychiatric inpatient sample, according to DSM-IV and DSM-IIIR criteria, respectively.[2]

CO-OCCURRING CONDITIONS

It is associated with multiple co-morbid conditions. According to an excellent recent review by Diedrich and Voderholzer[2] the most frequent ones are anxiety disorders with a prevalence of 23-24% and affective disorders with a prevalence of 24%. Among the anxiety disorders, Obsessive-compulsive disorder (OCD) is one of the best researched co-morbid disorders, which has co-occurrence rates of 23-45%. Though Pierre Janet initially posited "psychasthenic state," as a necessary condition for the development of obsessive-compulsive symptoms, later researchers like Berg *et al*.[3] contended that the direction of the relationship is obscure, and it might be that OCPD develops as a coping strategy after the onset of OCD. Whichever may be the direction of the relationship, many agree that majority of people suffering from OCD have at least one personality disorder[4,5] and that there are high rates of OCPD. Some have even suggested that OCD with OCPD has to be considered as a separate sub-type.[6] We can even consider that certain patients with "poor insight OCD" subtype, instead of being delusional, might fit into the category of OCD with OCPD traits (i.e., poor insight interpreted as ego-syntonicity) and might respond to selective serotonin reuptake inhibitors (SSRIs) and cognitive-behavioral therapy (CBT)-exposure and response prevention with/without antipsychotic augmentation, as is the case with resistant OCD.

Since 1920s many researchers found the presence of OCPD traits in significant number of people suffering from the depressive disorder.[7,8] In routine clinical practice, many practitioners observe an occurrence of premorbid OCPD traits such as perfectionism, high moral standards, in the people suffering from the depressive disorder. Co-occurrence of OCPD in depressive disorder has been associated with accelerated relapse of depression.[9]

The DSM-V diagnosis of disruptive mood dysregulation disorder (DMDD), which is subsumed under the depressive disorders, may also be theoretically related to OCPD due to the fact that many depressive patients have OCPD traits and that the OCPD traits of perfectionism and rigidity might predispose the individual to irritability and impulsive aggression, more so in the adolescents. In a study[10] which examined co-occurrence of impulsive aggression and several Axis I and II conditions (n = 118), 24% of clinic-referred patients with impulsive aggression had OCPD compared

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to 52% who had antisocial personality disorders; among self-referred patients with impulsive aggression, 52% had OCPD. Further investigation into the co-occurrence of behavioral disinhibition and OCPD is warranted.

OCPD trait of perfectionism has been shown to be associated with the core psychopathology of Eating disorders and somatoform disorders such as body dysmorphic disorder (BDD), hypochondriasis and chronic fatigue syndrome. OCPD and Perfectionism are proposed by some, as predisposing factors for eating disorders.[11]

Fineberg *et al*.[12,13] have laid out the arguments suggesting either a reclassification of OCPD under obsessive-compulsive and related disorders (OCRDs) or provision of a "dual parenting" option by classifying it both under OCRDs and personality disorders. Some of the reasons being that:

1. There is an elevated co-morbidity with other compulsive disorders such as OCD, BDD, eating disorders, etc.,
2. There are shared endophenotypes with OCD, BDD, schizo-obsessive disorder like extra-dimensional set shift and cognitive inflexibility which reflect a likely cortico-striatal involvement.
3. There are shared pharmacological and psychological treatment modalities.

The suggestion to provide a "dual parenting" is thought to be viable, as they claim that international classification of diseases-10 (ICD-10) does something similar with the schizotypal disorder by classifying it under psychosis (F20-29) category even when DSM treats it as a personality disorder.

OCPD is also prevalent among people suffering from Parkinson's disease. In a recent study, 40% of patients with Parkinson's disease had a comorbid OCPD, which was 4 times more when compared with the control group.[14] OCPD criteria overlap with the "Parkinsonian personality" which was reported in earlier research.[15]

PERFECTIONISM AS A TRANS-DIAGNOSTIC PROCESS: ALTERNATIVE CONCEPTUALIZATION

A transdiagnostic process is a psychopathological aspect which occurs across several disorders and contributes to the maintenance of a psychiatric disorder. Common maintaining factors are considered to be the reason for the occurrence of co-morbidities.[11] Perfectionism is one such trans-diagnostic process which occurs in various anxiety disorders, mood disorders, eating disorders, somatoform disorders, and personality disorders. Hamachek[16,17] distinguished between normal-perfectionism which has more positive striving and neurotic perfectionism which has more maladaptive evaluative concerns. Though this distinction does not generally apply to all cases, it has clinical utility. Treatments geared to handle transdiagnostic processes are thought to better address co-morbidities and have practical efficacy and cost-effectiveness.[11] When interventions like CBT for perfectionism are compared with CBT for eating disorders, they show larger effect sizes and prove their efficacy in reducing global psychopathology in the long-term.[18] According to this view, it is apt to consider OCPD or its "perfectionism" trait, which is one of its core aspects, as something which has transdiagnostic significance.

ETIOLOGYAND MANAGEMENT

There have been multiple etiological theories of OCPD. Freudian theorists have posited fixation or strict parenting during anal-psychosexual stage. Where Erikson pointed to a failure in the psychosocial stage with the conflict in autonomy versus shame, social learning theorists claimed that it is due to maladaptive vicarious learning. Various problems have been pointed out with such "psychogenic" etiological theories.[19] Biological theories also have defined certain causal factors. Heritability studies like the one by Torgersen *et al*.[20] identified a very high heritability rate of 0.78, but others[21] found that only 27% of the variance can be accounted by genetic effects.

Despite issues of nonreplicability and inconsistent empirical evidence, there is interesting association between OCPD and the dopamine D3 receptor Gly/Gly genotype, the serotonin transporter 5-HTTLPR polymorphism and a blunted prolactin response to fenfluramine indicating a possible serotonin dysfunction.[2] The association of OCPD with Parkinson's disease brings in an interesting possibility of a common neurobiological pathway or correlate like the dysfunction of the frontal lobe-basal ganglia circuitry.

Several interventions were tried in OCPD patients. Psychological interventions such as cognitive therapy (CT), interpersonal therapy (IPT-found to be superior to CT), and schema therapy were found to be efficacious. Combination therapies were also found to be efficacious. Group CBT in combination with escitalopram was helpful in reducing OCPD traits and CBT along with fluoxetine was useful in depressive patients with perfectionism trait.[2] Therapeutic alliance, anxiety and variability in self-esteem are thought to be predictors of the efficacy of psychological treatments in OCPD. The potential usefulness of SSRIs in OCPD was discussed by Peter Kramer in his

popular book, Listening to Prozac.[22] Later studies with citalopram,[23] fluvoxamine,[24] and our focused clinical experience with escitalopram at Asha Clinic for Mood and Anxiety Disorders (also called Asha Bipolar Clinic), showed clinically meaningful reduction in OCPD traits, substantiating the possible serotonergic dysfunction. In the literature, sertraline[23] and other drugs[25] were also used with modest benefits.

Over the years, among the presentations of marital disharmony at our clinic, it is not uncommon to find OCPD as a culprit in one or (sometimes) both the partners. With use of SSRIs, we frequently observed reductions in neurotic-perfectionism with subsequent improvement in frustration tolerance and a calming effect on the anger outbursts, which later facilitated positive interpersonal relationships.

NOSOLOGICAL ISSUES

One of the persistent problems with the diagnosis of OCPD is its heterogeneity.[26] There are problems of specificity due to the presence of polythetic criteria (i.e., without a hallmark feature) and problems of sensitivity due to overly concrete criteria such as miserliness and hoarding.[2]

Newly proposed research criteria in DSM-V[27] for OCPD offer an alternative model for conceptualization. For a diagnosis according to this alternative set, rigid perfectionism must be present, i.e., "perfectionism" gets more weight age than other criteria. The concrete criteria miserliness and hoarding have been removed in the alternative model. Alternative criteria are stricter and have both categorical and dimensional aspects. Giving a special status to perfectionism in DSM-V is to be considered as a change in the right direction. This arrangement of assigning two very dissimilar operational criteria (i.e., clinical and research criteria) for the same category, would make the research findings inapplicable in clinical practice.

The polythetic classification in DSM has been criticized by many theorists. Sutcliffe[28,29] commented that any classification that lacks a sense of common property or criterion, (as is the case in polythetic classification) makes it incapable of categorical distinctions between things. In such classifications, terms such as "classes," "cluster," and "category" become meaningless and thereby, according to him, the theory of polythetic classification becomes logically incoherent. Carroll[30] made a similar comment when he noted the importance of "weighted criteria or cardinal symptoms" and criticized DSM-V for continuing the polythetic categories that result in heterogeneity.

IMPLICATIONS FOR INTERNATIONAL CLASSIFICATION OF DISEASES-11

ICD-11, which is due by the year 2018,[31] would sure learn from the advances and mistakes of DSM-V. We would like to highlight few implications. They are to:

1. Propose and implement "weighted criteria" for OCPD as done in the DSM-V research criteria. This would reduce the confusing heterogeneity and help in application of research findings in the routine clinical practice.
2. Review the need for placing OCPD in OCRD. As it may help in the re-conceptualization of the disorder, and open a new window into the pharmacological research for the management of OCPD.
3. Inspire an agenda to investigate the relationship between OCPD and impulsive, uncontrolled, repetitive aggression (or behavioral disinhibition). Otherwise, the individuals with the clinical configuration of OCPD and aggression might be mistakenly diagnosed as an Atypical Bipolar Disorder or psychosis, which is being noticed by us on closer observation in the recent past.
4. Create a platform for recognizing trans-diagnostic psychopathological processes such as perfectionism for further research.
5. Consider the inclusion of DMDD for the clinical conceptualization of adolescents and young adults with behavioral disinhibition.

IMPLICATIONS FOR PSYCHIATRIC RESEARCH

The above discussion of various aspects of OCPD raises two very pertinent questions that have to be answered through research.

The first question: Is OCPD a common and clinically relevant predisposing factor in DMDD and other related conditions with behavioral disinhibition? As we have argued, due to the reason that DMDD has a conceptual relationship with Major Depressive Disorder, there arises a possibility of an association between OCPD or its traits and DMDD. Research has to elucidate whether OCPD functions as a predisposing factor in such conditions.

The more interesting, second question: Does pharmacotherapy help in the management of personality disorder like OCPD? The question basically asks whether we can manipulate or change someone's personality to a clinically relevant extent, with medication. In line with this neurobiological model of personality, we can expect that OCPD, which can be a common personality factor (culprit) in problems like

marital disharmony and adolescent adjustment issues, would be a major pharmacotherapeutic target. If SSRI were an effective therapeutic tool for the management of OCPD, it would raise many questions about the "medicalization of personality" and related ethics. Moreover, we would have to wonder about what the clinical assumption of pharmacotherapy for personality disorders might mean.

CONCLUSION

OCPD is a neglected area of research. Historical development and recent research reveal a need for better understanding of this condition and its management. DSM-V research criteria for OCPD encourage a more logical way of conceptualizing this disorder, and we suggest that they are incorporated in the forthcoming ICD-11. SSRIs, IPT, and CT are useful therapeutic strategies in the treatment of OCPD.

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