THE OBSESSIVE – COMPULSIVE PERSONALITY DISORDER, APPROACHED BY COGNITIVE-BEHAVIOURAL THERAPY

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Abstract: *The obsessive – compulsive personality disorder includes a thinking pattern characterized by rigidity, meticulosity and perfectionism. The cognitive – behavioural psychotherapeutic intervention aims at altering the central beliefs and the dysfunctional cognitive schemas present in this disorder. Also, in case of a comorbidity of Axis II, the treatment of a disorder within Axis I, produces direct effects upon the dimensions of one's personality.*

Rezumat: *Tulburarea de personalitate obsesiv-compulsivă include un model de gândire caracterizat de rigiditate, meticulozitate şi perfecţionism. Intervenţia psihoterapeutică cognitiv-comportamentală urmăreşte modificarea credinţelor centrale şi a schemelor cognitive disfuncţionale prezente în cadrul acestei tulburări. De asemenea, tratarea unei tulburări de Axa-I, în cazul unei comorbidităţi de Axa II, produce efecte directe asupra dimensiunilor personalităţii, în cadrul unor tulburări de personalitate.*

Obsessive - Compulsive Personality Disorder (OCPD):

The Diagnostic and Statistical Manual of Mental Disorders (DSM – IV – TR) defines ten personality disorders, (PD) broadly classified in three groups (American Psychiatric Association, 2000). The diagnostic criteria describe specific cognitive processes, affective responses and behavioral tendencies which may be linked to maladaptive functioning schemas. To diagnose a patient with a PD, he or she must meet a minimum specified number of criteria.(1) The severity of a PD can be identified by assessing the degree of manifestation within traits, this being achieved by investigating the stylistic elements of the PD.(2) The three groups are categorized in three clusters: A, B, C. Cluster C contains the Avoidant and Dependent Personality Disorders, as well as the Obsessive – Compulsive Personality Disorder (OCPD).(3)

In terms of *the big five factors,* OCPD is defined by a high level of the conscientiousness dimension.(4) Within this PD, an exaggerated need for self-control occurs both personally and inter-personally, due to cognitive strategies based on extreme rigor, meticulosity and perfectionism.(5) However, a distinction needs to be made between the obsessive – compulsive disorder (OCD) and OCPD. Empirical studies have shown differences between obsessive personalities and OCD; most OCD patients do not manifest a pre-morbid obsessive – compulsive personality (Pollak 1979; Rachman and Hodgson, 1980).(6)

Cognitive – behavioural intervention in OCPD:

Cognitive – behavioural therapy (CBT) aims at putting into practice the experimental reasoning of the study of human behaviours.(7) The development in the last decades of the medicine based on scientific proof and the emergence of the *evidence based* concept have contributed to the quick assimilation of these models into the CBT.(8) The cognitive model starts from the premise that there is a connection between human emotions and behaviours, these being influenced by the ways in which humans perceive and judge or represent to themselves certain life events. In conclusion, it is not life events that generate a certain degree of discomfort, but the way in which they are interpreted by the individual.(9) The behavioural model, also known as the ABC behavioural model, is based on the functional behaviour analysis. The ABC behavioural model is an application into therapy of the behaviourist model (Skinner, 1974), to which information processing elements, such as expectations, have been added. The model claims that all behaviours are generated as a result of a process of information processing induced by stimuli and maintained by their consequences. Behavioural ABC is interpreted as: A – antecedents, B – behaviour, C – consequences.(10)

It should be added that the CBT theory of anxiety and depression contains the concept of vulnerability. Anxiety occurs against a background of personal vulnerability, thus, at an initial assessment of anxiety, a wrong perception occurs related to the possibility to produce damages and detrimental individual consequences, which are, of course, overestimated by the subject.(11) PDs are explained by way of cognitive schemas for coding and processing information about self and others (Beck et al 2003). The *maintenance schema* refers to the processes through which *maladaptive schemas* are rigidly accepted. The *avoiding schema,* acting upon the emotional, cognitive and behavioural dimensions, is activated in order to avoid the

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negative effects associated with the schema itself. The *compensation schema* is a way of overcompensating a maladaptive schema.(12)

The main psychotherapeutic objective in the case of PD treatment is altering the content of these schemas. If a comorbidity exists, the order supposes treating the Axis I disorder first, after which the Axis II disorder is approached.(13)

This is recommended also due to the fact that some studies have revealed that the treatment of an Axis I disorder can have beneficial effects on the Axis II comorbidity. Mavissakalian and Hamman (1987), in their study of agoraphobia, found that four out of seven subjects, who have also met the criteria for a specific PD, before treatment, no longer met the criteria for a PD after ending the therapy. This did not apply to patients with a mixed PD.(12)

Other studies based on the big five model of Costa and McCrae (1992) define personality in terms of behaviour sets. A behavioural therapeutic intervention automatically alters these sets; thus, a significant clinical effect is produced in the dimensional sphere of the personality. A study following the dimensional changes in personality after CBT intervention was performed in a therapy group manifesting a comorbidity between social anxiety and avoidant PD. The pre-treatment versus post-treatment differences for the group as a whole represented a decrease in neurosis, an increase in extroversion, as well as a slight modification of agreeability.(14)

Beck A.T. Beck (1976) groups emotional disorder symptoms under the form of automatic negative thoughts which in turn influence emotions, the latter having a direct effect on behaviours. Automatic thoughts can be defined as thoughts which occur spontaneously, effortlessly and without the patient's becoming aware of them. The patient becomes aware of them only when asked to focus on them. Automatic thoughts can also occur in the form of images (JS Beck, 1995; Hackmann,1998). Discussing and altering automatic negative thoughts determines a positive change, both emotionally and in the patient's behaviour.(15)

An effective cognitive treatment technique in the case of OCPD patients is the cost – benefit analysis. The technique consists of the therapist and the patient together drawing up a behaviour list, and then discussing the advantages and disadvantages resulting from certain behaviours. All arguments and counterarguments are written on two columns. The goal is to determine the patient to realize the absurdity of some actions and behaviours cantered around perfectionism and which cause the patient's discomfort. Another efficient technique, behavioural this time, consists of the behavioural experiment. For example, the therapist draws up a plan together with the patient, the latter estimating the consequences which that experiment may have. The behavioural experiment is performed based on automatic negative thoughts, the reality being distorted by the patient. After the behavioural experiment, the patient's pre-experiment expectations are compared with what actually happened. The main goal is to make the patient expose himself or herself to anxiogenic stimuli, thus achieving behavioural desensitization. Secondly, the patient will realise that the result of his or her actions is not as „catastrophic" as he or she had expected. Other useful techniques are filling in the form for monitoring automatic dysfunctional thoughts, relaxation techniques, gradual exposure to anxiogenic stimuli (in the form of activity diaries).(12) All these must be maintained with other techniques, such as cognitive restructuring, decatastrophisation, using gradual scales, reattribution techniques, guided imagery etc.

Conclusions:

CBT is an efficient treatment method in the case of OCPD and anxious or depressive comorbidities sometimes associated with it. Positive changes resulted from therapy can be perceived in the personality traits such as extroversion, agreeability and emotional stability. All of these are altered positively, resulting in a series of adaptive behaviours which provide the patient with better strategies for approaching life events.

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