

THE EFFICACY OF COGNITIVE BEHAVIOR THERAPY FOR OBSESSIVE COMPULSIVE PERSONALITY DISORDER

Syeda Razia Bhukhari, Farhana Saba and Syeda Ishrat Fatima
National Institute of Psychology, Qauid-e-Azam University, Islamabad

ABSTRACT

Objectives: *To study the impact of Cognitive Behavior Therapy in the treatment of Obsessive Compulsive Personality Disorder (OCPD)*

Design: *Case Study*

Place and Duration of Study: *National Institute of Psychology, Qauid-e-Azam University, Islamabad from June 2016 to Dec 2016.*

Methods and Materials: *The study demonstrates the case of a 20 years old girl. She appeared with certain disturbing behaviors including perfectionism, following rules and regulations, rigidity and inflexibility of beliefs, orderliness, anxiety, and excessive attention to minute details, mood swings, irritability and isolation. She was assessed with mental status examination, Standard Progressive Matrices, Rotter Incomplete Sentence Blank, Human Figure Drawing Test and Thematic Apperception Test. These measures revealed poor interpersonal relationships, inadequate self-image, guilt, aggression, sexual conflicts, anxiety, need for affection, and feelings of deprivation, perfectionism, emotional instability and egocentricity. Obsessive-Compulsive Personality Disorder Scale and Depression Anxiety Stress Scale were used in pre and post testing. The treatment plan consisted of Cognitive Behavior Therapy and psycho education of family.*

Findings: *Patient showed improved functioning and her symptoms were markedly reduced. Result revealed that there is a significant difference in the pre and post scores. This indicated that that CBT is very effective treatment of OCPD*

Keyword's: *Obsessive Compulsive Personality Disorder; Depressive Symptoms; Case Study; Cognitive Behavior Therapy*

INTRODUCTION

Childhood neglect can have harmful and rigorous effects on child's development. It effects the development of child emotionally, socially, cognitively and in terms of behavior. Further, children who are neglected and abused physically come with more deficient, asocial and withdrawn personalities (Hildyard & Wolfe, 2002). Nordahl and Tore (1997) argued that faulty parenting has a major role in developing personality disorders. Emotional abuse in childhood clearly affects psychological development of the child. These children are unable to use effective coping strategies throughout their life and came across many psychological issues, which needs to be focused in counseling and psychotherapy (Wurdeman, 2015). Emotionally abusive parenting results in emotional deregulation and maladaptive social functioning on the part of child. It also contributes to insecurity in relationship with others that leads to both internalizing and externalizing issues (Riggs, 2010).

According to Gluck (2014) people who have been raised in an environment with lack of intimacy, rigidity, perfectionism and restricted to express their feelings are usually experience OCPD. CBT is an effective treatment of OCPD. Strauss, Hayes, Johnson et al. (2006) were investigated an open trial of traditional individual CBT. The trial, which contained 16 patients having OCPD have taken up to 52 weekly sessions of CBT. Results revealed that 53% of patients having OCPD revealed clinically significant decrease in depression symptoms, and 83% showed clinically significant decreases in OCPD symptoms. Since, it can be said that CBT-based approach was much useful for OCPD (Beck & Freeman, 1990). According to Samuels and Costa (2012) CBT is highly effective in treating OCPD. Cognitive Behavioral Therapy is much helpful in treating OCPD patient with the help of number of CBT techniques such as cognitive restructuring and thought sampling and thought stopping etc (Sperry & Sperry, 2016).

The rational of this case study is to investigate the effectiveness of CBT techniques with OCPD in Pakistani culture. Considering the existing literature following hypotheses were framed:

1. CBT intervention will be effective in the reduction of scores on Anxiety, Depression and Stress scale in patient with OCPD.
2. CBT intervention will be effective in the reduction of scores on OCPD scale in patient with OCPD.

METHOD

Case Description

The present study demonstrates the case of Miss A.A: A 20 year's old student belonging to a middle class socioeconomic status. She had three sisters. She has been raised in a strict home environment, with undue expectations from her to perform home chores in a perfect manner like the elder members. For her, parents were emotionally cold and coercive. She has always been expected to organize home and arrange things in an order the way her grandmother likes her to do. In her childhood, her grandmother always tried to overpower her. Her failure in meeting the expectations mostly result in harsh attitude of the parents and a grandmother.

When she was 15 years old she used to stay isolated and experienced mood swings. She started perfection in all matters, looking for excessive ordering, anxiety and giving attention to minute details. With the passage of time, she became more involved in these acts and used to stay depressed and had difficulty in concentration. She was having same symptoms since 3 years. Apart from these issues, she performed very well in studies and remained an above average student throughout her academic career. She has good terms with her class fellows. She has good relations with her siblings and mother. Her mother also listened to her issues and was on her side in all matters.

Miss A.A was brought to counseling centre as she was having complaints of perfectionism, following rules and regulations, rigidity and inflexibility of beliefs, orderliness, anxiety and excessive attention to minute details, mood swings, irritability and isolation. She was diagnosed with Obsessive Compulsive Personality Disorder (OCPD). She had not taken any prior treatment for these issues.

Diagnostic Assessment

Presenting complaints of the client were recorded and various tests were administered for diagnostic purpose. These tests include Standard Progressive Matrices (Raven, Raven & Court, 2003), Rotter Incomplete Sentence Blank (Rotter & Rafferty, 1950), Human Figure Drawing Test (Koppitz, 1967) and Thematic Apperception Test (Murray, 1943). Scores on SPM showed that she is above average in intellectual functioning. Score on RISB showed maladjustment as her score was 154 which is greater than the cutoff score that is 135. Stories on

TAT revealed poor interpersonal relationships, inadequate self-image, guilt, extreme aggression, sexual conflicts, and anxiety of being maltreated. HFD suggested maternal dependency, affection and love need, feelings of deprivation, sensitivity to criticism, perfectionism, emotional instability and egocentricity.

During case study Obsessive Compulsive Personality Disorder Scale (OCPD) (Leonard, 1976) and Depression Anxiety and Stress Scale (DASS) (Lovibond & Lovibond, 1995) have been used as pre and post measures.

Instruments

Depression Anxiety Stress Scale (DASS-21)

DASS was developed by Lovibond and Lovibond (1995). Total no of items is 21. it is a set of three self-report scales designed to identify the occurrence of negative emotional symptoms and severity of the negative emotional states of depression, anxiety and stress, containing of seven items in each scale. It is a screening scale, and useable for adolescents and adult population showed high reliability and validity. Depression (range=.91 to .97); Anxiety (range=.81 to .92); and Stress (range=.88 to .95).

Obsessive Compulsive Personality Disorder Scale (Leonard, 1976)

It is a 25 items scale which assesses the level of OCPD. This scale is highly reliable and valid and used to assess the traits of OCPD. In term of scoring 25-45 scores indicated not compulsive or uptight. 46-55 Scores revealed Mildly OCPD. Your compulsiveness is working for you, and you are successfully adaptive. 56-70 Scores suggested Moderately O-C. You are adaptive but uptightness has crept into your personality function, and you experience uncomfortable days of high tension. and 71-100. Scores showed Severely O-C. You are adaptive but quite uptight, insecure and driving hard. The closer you are to the rating of 100, the nearer you come to playing brinkmanship at the ragged edge that borders on exhaustion of your adaptive reserve and a slump into depression (Leonard, 1976).For cognitive assessment identification of negative automatic thoughts and negative schemas and cognitive restructuring has been done with the help of thought record sheets given by Beck (2011).

Ethical Consideration

Client's consent was taken both verbally and in a written form the client and she was assured that all identifying information related to her will be kept confidential. She was also told that she has the right to withdraw from the study at any time.

DSM-5 Case Formulation

Presenting complaints of Ms. AA were perfectionism, following rules and regulation, rigidity and inflexibility of beliefs, orderliness, anxiety and excessive attention to minute details. On the basis of DSM-5, she is diagnosed with obsessive compulsive personality disorder. Predisposing factors of Miss AA involve history of psychiatric illness in her family. Her aunt is diagnosed with schizophrenia and she is taking psychiatric medicines. She had a strict parenting; her authoritative father and grandmother were emotionally cold toward her since childhood, which compelled her to develop a perfectionist personality and anxiety. Due to her home environment, she used to stay isolated and did not make friends and as the time passed she became least social. It has been concluded from researches that mental disorders run in families and a person with lack of intimacy, rigid perfectionism, and expression of feelings is restricted are likely to develop OCPD (Samuels & Costa 2012).

Mental illness is more likely to pass OCPD to his or her children (Khan & Arnold, 2012). Research has shown that people who are raised in an environment where there is a lack of intimacy, rigid perfectionism, and expression of feelings is restricted, there these children are likely to develop OCPD later life (Samuels & Costa 2012). Precipitating factor of Miss A.A her symptoms got stirred due to a dispute with her father who scolded her for not obeying her grandmother. As she had coping deficits so she collapsed due to lack of social support. Perpetuating event of Miss A.A showed that her symptoms were maintained by constant environmental stressors at home, as she still lived with her grandmother who was a constant source of torture for her. Her father also snubbed her on daily matters hence, her symptoms were not cured.

Her insight towards her issues, her intellectual potentials, and high motivation towards the treatment were her protective factors. It was also indicated by the assessment that she has good chances of recovery.

Therapeutic Interventions

The client was brought to National Institute of Psychology, Qauid-e-Azam University by her mother for the purpose of treatment. Various techniques of Cognitive Behavior Therapy (psycho education, thought stop techniques, cognitive restructuring, pattern analysis strategies, and pattern change strategies, problem solving technique, social skills training, relaxation techniques, and relapse prevention strategies) were used in her treatment. Psycho education was given to client about obsessive compulsive personality disorder. In Initial sessions (1-5), her schemas, triggers, temperament and style were analyzed. These prototypes were assessed by using pattern analysis strategies. Middle phase (6-12). Thought stop techniques were used for challenging and eliminating negative thinking related to rigidity and extreme orderliness. Thought stop technique minimized negative thoughts of the client. Cognitive restructuring was applied in order to handle cognitive distortions and restructure her thoughts. Pattern change strategies were used after the maladaptive pattern of client was identified and analyzed in terms of schemas and skill deficits. Maladaptive patterns of client were renounced and replaced with more adaptive patterns by modifying schemas, modulating style dysregulations, and reversing skill deficits. Therapist and client worked in collaboration for effective treatment of client. Problem solving technique was used to solve her minor issues and concerns. A social skill training was given to client so that she can improve her communication skills and make better relationship with others. Relaxation techniques including Progressive Muscles Relaxation and deep breathing exercises were used to overcome her anxiety. Final phase (13-16) Relapse prevention strategies were taught to her so she would be able to function at her own. By applying these strategies client symptoms were reduced to a great extent that are showed in result section.

RESULTS

Table 1
Pre and post -test and follow up scores on OCPDS and DASS

Variables	Pre-test	Post-test	Pre-Post	Follow up
	<i>scores</i>	<i>scores</i>	<i>Difference</i>	<i>scores</i>
OCPD	69	25	44	20

DASS					
1. Depression	23	5	18	3	
Anxiety	21	8	13	4	
3. Stress	34	14	20	10	

The table shows raw score or composite scores for pretest, posttest and follow up. Pre-test scores on OCPD scale were very severe, post-test scores were moderate and follow up scores were normal. Scores on DASS show that pretest scores on depression were severe whereas on anxiety and stress were very severe. Post-test scores reveal that she had moderate depression, mild anxiety and normal stress. Follow-up scores on DASS indicate normal scores on depression, anxiety and stress.

Table 2
Pre and posttest difference showing the affectivity of CBT in treating OCPD

Variables	<i>Client treatment</i>	N	M	SD	df	t	Sig
OCPD & DASS scores	Pre-test	4	36.75	22.24	3	3.43	.004
	Post-test	4	13.00	48.83			

*P<.05**

DISCUSSION

The present case study is aimed to investigate the effectiveness of CBT in the reduction symptoms of obsessive compulsive personality disorder and symptoms of anxiety depression and stress. Treatment plan was based on CBT and comprised of 20 individual sessions, 50 min each. The outcome of CBT showed significant decrease in obsessive compulsive personality of the client. OCPD scale was used to measure before and after score of OCPD. Her score shows that now she is not having Obsessive Compulsive Personality Disorder. DASS was also administered and pre and post scores were observed. Before treatment, she had severe symptoms of depression, anxiety and stress but at the end of treatment she has no such symptoms anymore. Significant pre and posttest

difference ($t = 3.438 < p=0.05$) (see table 2) that showed CBT is highly effective in the treatment of OCPD.

Further, present case study finding showed that CBT is a very effective treatment of Obsessive Compulsive Personality Disorder. Previous researches are in line of present case study finding. Gluck (2014) found Cognitive Behavioral Therapy is useful treatment of Obsessive Compulsive Personality Disorder. Beck and Freeman, (1990) and Strauss, Hayes, Johnson et al. (2006) (2006) also confirmed that CBT is highly effective in the treatment of OCPD.

In present case study childhood experience and surrounding environment have major role in the development of Obsessive Compulsive Personality Disorder. Patient's thoughts (cognitions) lead to their emotions and consequent behavior. Of specific significance for individual having personality disorders is the way in which external events in the environment (such as interpersonal communication among others) are distinctively interpreted and give a meaning based upon core beliefs. Early childhood experiences, coupled with an innate, biologically-determined disposition, create patient's initial beliefs about the world. These initial beliefs evolve into fairly stable, core beliefs that shape people's perceptions and interpretations of subsequent experiences. When these preconceived beliefs are defective, falsify, or biased, patient may end up drawing distorted, irrational conclusions about the meaning of external events (particularly interpersonal communications). Patients may consequently behave in ways that cause unnecessary distress and suffering. CBT is predominantly useful for this because its stress on recognizing and altering distorted thought patterns. In specific, core beliefs underlying those patterns are exposed and challenged. Thus, cognitive-behavioral therapy functions to recognize and encounter negative automatic and defective clarifications of the environment that are driven by core beliefs. Applying CBT negative automatic thoughts can change and positively structured. Then the patient have OCPD will experience supreme level of well-being (Sperry & Sperry, 2016).

Conclusion

Present case study recommends that strict home environment and emotional abuse of children serve a significant role in concluding pre morbid personality of an individual and constant stressors cause personality disorders. These findings put forward that mental health care providers may include developmental aspect in diagnosing and treating children and adults. Moreover,

every individual seeks empathy on the part of his or her family, therefore it is stated that psycho education of family is very crucial. Client showed improvement in certain aspects which implies that Cognitive Behavior Therapy is very effective in dealing with behavioral and cognitive deficiencies of persons with personality disorders.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington, DC: Author.

Beck, J. S. (2011). *Cognitive therapy: Basics and beyond*. New York: Guilford Press.

Beck, A., & Freeman A. (1990). *Cognitive Therapy of Personality Disorders*. Guilford Press; New York, NY US.

Gluck, S. (2014). Personality disorders community, *Health Place America's Mental Health Channel*. Retrieved from: <http://www.healthyplace.com/personality-disorders/obsessive-compulsive-personality-disorder/what-is-obsessive-compulsive-personality-disorder/>

Hilyard, K. L., & Wolfe, D. A. (2002). Child neglect: developmental issues and outcomes. *Child Abuse and Neglect*, 26(7-7),679-695. doi: 10.1016/s0145-2134(02)00341-1.

Khan, R., & Arnold, P. (2012). Understanding OCPD- A look at the causes of Obsessive Compulsive Personality Disorder. *Health guide info*. Retrieved from: <http://www.healthguideinfo.com/ocd-causes/p81230/>

Koppitz, E.M. (1967). *Psychological Evaluation of Children's Human Figure Drawings*: New York.

Lovibond, S.H., & Lovibond, P.F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd. Ed.) Sydney: Psychological Foundation.

Leonard, C. (1976). Freedom from Compulsion: *How to liberate yourself from uptight, obsessive patterns of living that rob you of peace of mind*, New York, Simon & Schuster.

Murray, H.A. (1943). *Thematic Apperception Test manual*.MA: Harvard University Press, Cambridge.

Nordahl, H. M., & Tore, C. S. (1997). Perceptions of parental bonding in patients with various Personality disorders, lifetime depressive disorders, and healthy controls. *Journal of Personality Disorders*, 11,457-462.

Raven. J., Raven, J.C., & Court, J. H. (2003). *Manual of Raven's Progressive Matrices and Vocabulary Scales*. San Antonio, TX: Harcourt Assessment.

Riggs, S.A. (2010). Childhood Emotional Abuse and the Attachment System Across the Life Cycle: What Theory and Research Tell Us, *Journal of Aggression, Maltreatment & Trauma*, 19, 5-51.

Rotter, J.P., & Rafferty, J.E. (1950). *Rotter Incomplete Sentences Blank manual*: New York: The Psychological Corporation.

Samuels, J., & Costa, P.T. (2012). Obsessive-Compulsive Personality Disorder". In Widiger T (ed.). *The Oxford Handbook of Personality Disorders*. Oxford University Press. p. 568. ISBN 978-0-19-973501-3.

Sperry, L., & Sperry, J. (2016). Cognitive Behavior Therapy of DSM-5 Personality Disorders: Assessment, Case Conceptualization and Treatment. *Routledge*, 3, 197-207.

Strauss, J.L., Hayes, A. M., Johnson, S. L., Newman, C. F., Brown, G. K., Barber, J.P., Laurenceau, J., Beck, A.T. (2006). Early alliance, alliance ruptures, and symptom change in a nonrandomized trial of cognitive therapy for avoidant and obsessive-compulsive personality disorders. *Journal of Consulting and Clinical Psychology*, 74(2), 337–345.

Wurdeman, M. (2015). Impact of abuse on developing children: impact of abuse throughout a child's psychological development, *Counselor Education*, 1, 5-18.