REVIEW ARTICLE

Psychiatric and Psychological Perspectives on the Treatment of Obsessive-Compulsive Personality Disorder: A Narrative Review

Tania Qamar

ABSTRACT

Background: Obsessive-Compulsive Personality Disorder (OCPD) is known as excessive control, a rigid commitment to norms, and an overarching commitment to perfectionism. Despite its prevalence, OCPD often goes undiagnosed or unnoticed, which leads to considerable impairments in quality of life and psychological functioning.

Objective: The objective of this narrative review is to examine the perspective of psychiatric and psychological treatment approaches for OCPD.

Method: This narrative review focused on literature published between 2000 and 2024, covering adult populations with OCPD across North America, Europe, and Asia. This narrative paper reviewed the different pharmacological and psychological treatment options that used to help individuals with OCPD.

Results/Review: Findings shown that psychiatric or pharmacological treatments are found beneficial, and SSRIs reduce the emotional rigidity or anxiety associated with OCPD. On the other hand, Cognitive-Behavioural Therapy (CBT), psychodynamic therapy, and other new psychological therapies were also found effective. Despite numerous treatment claims, a limited empirical literature has not proven the effectiveness of any treatment for OCPD.

Conclusions: Although CBT seems to have the most empirical support as a treatment, it is promising for improving the conditions of patients with OCPD. Future studies could focus on developing standardized treatment guidelines and intervention models to enhance the quality of care for patients with OCPD. It includes an examination of relevant predictors of treatment response that could provide beneficial clinical care for patients with OCPD.

Key Words: *Obsessive-Compulsive Personality Disorder, SSRIs, Psychiatric Treatments, Psychological Treatment.*

Introduction

Clinical Context: Key Features and Functional Limitations

Obsessive-Compulsive Personality Disorder (OCPD) is a persistent medical condition characterised by extreme perfectionism, and an obsession with order and small details, and a strong desire to control one's environment. The Diagnostic and Statistical Manual-Fifth Edition-Text Revision (DSM-5-TR) describes OCPD as a pattern of symptoms that results in clinically significant distress or impairment in functioning. The American Psychological Association (APA) lists the following things as possible causes of OCPD symptoms: an unhealthy fixation on work or productivity, an unhealthy fixation on details and order, moral and ethical stubbornness, refusal to delegate, disengagement from oneself and others, and indecision.[1] Individuals with Obsessive-Compulsive Personality Disorder (OCPD) show a range of symptoms characterized by indecisiveness, emotional disconnection, and a rigid need for control.[1,2]

These include difficulty expressing emotions, extreme reactions to disruptions in control, resistance to changes in routine, procrastination driven by perfectionism, and obsessive attention to detail that often leads to inefficiency and missed deadlines.[3,4] Their compulsive behaviour extends to re-reading or re-watching materials due to fear of overlooking details. OCPD significantly impairs psychological well-being and social functioning, with studies[5,6] indicating comparable declines in quality of life to those seen in Obsessive Compulsive Disorder (OCD). Moreover, OCPD, often comorbid with

Correspondence:
Tania Qamar
School of Applied Psychology and Social Work Policy (SAPSP)
Universiti Utara Malaysia (UUM)
E-mail: taniaqamar56@gmail.com

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borderline personality disorder, incurs significant economic costs due to healthcare needs and work disruptions. The disorder is marked by interpersonal difficulties, where individuals tend to be inflexible, demanding, and overly reliant on rigid standards, leading to frequent relational conflicts.[7]

In addition, individuals with OCPD have extremely high standards for the behaviour of others. A study found that people with OCPD are highly directing and cold in their relationships, and they also experience hostile-dominant interpersonal issues.[7] Some of the interpersonal issues that have been described are attributed to the fact that individuals with OCPD are less adept at empathic perspective-taking than healthy controls. Another study showed that emotionally sensitive people have the ability to understand the appropriate affective response to another person and to experience sympathy and concern for others.[8] However, they are limited in their ability to follow this intuition and indicate the adequate emotional responses in social situations or consider different points of view of others. Perfectionism is recognized as a fundamental characteristic of OCPD in both research and clinical reports, with perfectionism being a major cause of functional impairment.[8]

Obsessive-Compulsive Personality Disorder (OCPD) is strongly associated with maladaptive perfectionism and depressive symptoms, which significantly elevate the risk of suicidal ideation and behaviours.[9] Individuals with OCPD often believe that anything short of perfection is unacceptable and tend to derive self-worth from external validation, leading to emotional distress and poor relationship functioning. Compared to patients with depression alone, those with OCPD demonstrate a higher frequency of suicide attempts and experience fewer protective factors such as reduced anxiety or reasons to live.[10] The variety in OCPD, which comes from its subjective diagnostic criteria, shows up in different clinical styles, each with its own specific thinking, feelings, behaviours, and ways of interacting with others. Anxious types tend to procrastinate, fixate on details, and experience self-critical indecisiveness, while dominant types are more aggressive, skeptical, and inflexible.[11] These different emotional styles, persistent anxiety versus constant irritation, highlight the complexity and variety in OCPD cases, making it important to create specific treatment plans.

People who suffer from anxiety tend to be more submissive, people-pleasers, and conflict-averse, whereas individuals who are more dominant tend to be more critical, aggressive, and confrontational.[11] The literature provided a broad perspective at Cognitive-Behavioral Therapy (CBT) for OCPD. However, the treatment would work better for each patient depending on how they present and how much they are expected to lose in their daily life.[11] Individuals with the controlling personality type would benefit from developing emotion regulation abilities, whereas both types find it easier to acclimatize and tolerate distress through behavioral trials. Many diverse factors draw people with OCPD to treatment.[12] People with OCPD feel distressed when they can't complete work or school projects. This distress is typically either due to their inability to manage their time effectively or the quality of work they expect to complete.

Obsessive-Compulsive Personality Disorder (OCPD) is a prevalent yet underrecognized personality disorder, affecting 2% to 8% of the population[12]. Individuals with OCPD often experience a sense of being "stuck" in their professional or educational lives due to chronic self-criticism and unmet expectations of others, leading to persistent negative moods. These challenges frequently extend to intimate relationships, causing distress that prompts many to seek help in primary care or mental health settings.[13] Despite the high prevalence and notable impact of OCPD, there is a lack of public awareness, limited scientific literature, and a lack of treatment with proven efficacy. Moreover, mental health professionals often face difficulties in diagnosis due to inconsistent guidelines and insufficient familiarity with the disorder's distinct characteristics.[14,15] This situation points out the need for increased clinical attention and public education regarding OCPD.The rationale for this review is to synthesize psychiatric and psychological treatment perspectives to reduce the gaps in empirical evidence and guide future research and clinical practices.

Methods

This narrative review focused on literature published between 2000 and 2024, covering adult populations

with OCPD across North America, Europe, and Asia. The search strategy used keyword combinations such as "OCPD treatment," "Cognitive Behavioral Therapy OCPD," "SSRIs OCPD," and "psychotherapy for personality disorders" in databases including PubMed, PsycINFO, Scopus, and Google Scholar. Although the approach was not systematic, inclusion was based on relevance to psychiatric and psychological treatments, focusing on clinical trials, meta-analyses, and narrative syntheses from PubMed, PsycINFO, and Scopus databases. Inclusion criteria were peer-reviewed articles with clinical relevance to adult OCPD treatment.

Results

Evaluation and Treatment Interventions

Medical Intervention

Selective Serotonin Reuptake Inhibitors (SSRIs), including sertraline and fluoxetine, have been found to help individuals with Obsessive-Compulsive Personality Disorder (OCPD) experience a reduction in anxiety and rigidity.[16] As SSRIs change serotonin levels, the neurotransmitter is important in emotional regulation and compulsive behaviors. In a study, fluoxetine was shown to improve cognitive flexibility among subjects with OCPD, thereby lowering resistance to change.[17] Risperidone and other pharmacological treatments help with acute rigidity and emotional dysregulation.[18] However, concerns about the weight gain and sedating effects have led to a ban on its widespread use. In a brief study, mood stabilizers, particularly lamotrigine, were shown to decrease emotional instability for patients with OCPD.[19]

A study was conducted to examine the two groups of 24 people with DSM-IV OCPD who were randomly assigned to receive either fluvoxamine (50–100 mg/day) or a placebo for up to 12 weeks.[20] Results found an improvement in OCPD features in those who received fluvoxamine compared to the placebo group.[20] Additionally, literature studied that how SRI medications affect OCPD traits. For example,[21] administered sertraline and citalopram to 308 depressed patients with co-occurring personality disorders and found that both medication types were associated with reduced dysfunctional personality disorder traits; however, the most effective medication at reducing OCPD traits was citalopram. While SSRIs are reported to reduce OCPD rigidity (Fluoxetine and Citalopram), contradictory results exist regarding their efficacy. Some studies showed minimal changes in personality traits. Similarly, while CBT has showed improvements in trait perfectionism, its comparative efficacy to psychodynamic therapy remains debated due to the lack of head-to-head RCTs. A study found comparable results between both therapies, but limited by lack of OCPD-specific outcome measures.[21]

Another study examines two groups of OCD patients, which indicated that patients with OCPD who were taking clomipramine had significantly lower scores on a measure of OCPD features than did those who were taking imipramine[22]. Case reports studies have investigated the adaptability of OCPD characteristics to mood stabilisers and antipsychotics.[22] SRIs are the most prevalent pharmacological treatment for individuals with OCPD, yet more research into the medication treatment of primary OCPD is needed to provide the field with more high-quality evidence. Although no empirically validated gold standard treatment is available for OCPD, the therapy treatment is considered the best choice for intervention.[23] The next section reviews the available research on psychological and psychotherapies treatments for OCPD.

Psychodynamic Psychotherapy

Psychoanalytic explanations of Obsessive-Compulsive Personality Disorder (OCPD) attribute the cause of OCPD in children to either overly strict or overprotective parenting.[24] According to these theoretical models, OCPD traits develop due to the attachment insecurity experienced in early development[24]. Empirical research on the relationship between attachment and OCPD traits is limited. Though the timing is past-oriented, it is recently shown that the symptoms of OCPD were related to an ambivalent-avoidant attachment style in Iranian students.[25] A study indicated that individuals with OCPD showed more secure attachment styles compared to those with borderline personality disorder.[26] Prior to the emergence of OCPD, Freud posited a developmental link between the two disorders, indicating that OCPD features were already present.[27]

According to a study of adults, childhood OCPD traits are associated with an adult diagnosis of Obsessive-

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Compulsive Disorder (OCD).[28] At the same time[29] found that OCPD characteristics in adolescents were associated with simultaneous OCD symptoms in a cohort of children diagnosed with OCD. These findings provide support to the idea that OCPD features in childhood are associated with OCD (both current and future); however, further longitudinal research is required. The goal of insight-oriented psychodynamic treatment for OCPD is to identify the ways in which the symptoms of OCPD serve as a defense mechanism against the patient's own emotions of inadequacy and fear. After coming to this realization, patients strive to change their unyielding patterns and discard their unrealistic expectations of perfection in favour of a more realistic perspective.[29]

Patients suffering from personality disorders, such as OCPD, find relief through supportive-expressive psychodynamic therapy.[30] After 52 sessions, 14 patients with OCPD showed significant improvements in this study. However, there was no control group in this research[30]. In two more studies, Mixed personality disorder patients, especially some with OCPD, who received immediate psychodynamic therapies surpassed control group patients who had to wait.[31] However, findings did not directly evaluate changes in OCPD symptoms, and neither study specifically looked at improvement among people who had OCPD. Therefore, future researchers need to conduct further studies to evaluate the effectiveness of psychodynamic therapies.

Cognitive-Behavioural Therapy

Cognitive Behavioural Therapy (CBT) generally includes a mixture of perceptive and behavioural strategies. In order to address Obsessive-Compulsive Personality Disorder (OCPD), The general cognitive therapy dimension at involves finding and restructuring faulty ideas that lead to maladaptive behaviours.[32] Therapists instruct patients to consider the range of acceptable possibilities in order to challenge "all-or-nothing" thinking. Similarly, therapists also help patients to identify that when they exaggerate the repercussions of mistakes (catastrophizing) by asking them to consider the real impact of small mistakes. Behavioural components are also a part of CBT, and one of these is the use of behavioural trials to introduce the patient to stimuli and settings that trigger their fears.[32,16] Certain individuals diagnosed with OCPD experience challenges in forming connections, largely attributable to their inflexible cognitive frameworks and struggles with expressing emotions.

Young's schema-focused therapy[33] is designed to identify and restructure patients' maladaptive schemas as they are articulated during the therapy process, in light of this struggle. Despite the extensive description of numerous cognitive and behavioural approaches to OCPD[34], there is a lack of empirical research evaluating these treatments. A study was carried out involving individuals with severe depression who also fulfilled the DSM-IV criteria for OCPD. These participants received cognitive therapy specifically targeting OCPD. On average, after 22 sessions, all 10 patients reported decreased depression and anxiety, and 9 of those individuals no longer fulfilled the diagnostic criteria for OCPD. The limitations of this study were that it did not include a control group and had a small sample size.[35]

Another study that involved outpatients with OCPD (N=516) and avoidant personality disorder (N=524) who received cognitive treatment sessions up to 52 per week. 83% of OCPD patients experienced clinically significant improvements in symptom severity, whereas 53% improved depression severity.[36] However, definitive conclusions cannot be drawn about the effectiveness of CBT in treating OCPD because this open trial lacks a waitlist control group or alternative treatment. The most extensive cognitive-behavioral therapy research on OCPD was led.[37] Researchers in this study put together an open-label 10-week trial of group therapy for OCPD that included cognitive restructuring, psychoeducation, behavioral experiments, and planning for how to avoid relapse. The study was conducted with 116 outpatients who met DSM-IV criteria for OCPD. Results showed that treatment significantly reduced the severity of OCPD.[37]

Furthermore, after the intervention, individuals who showed reduced levels of trait anxiety and depression were more inclined to experience a reduction in their symptoms of OCPD. There was also predictive power in the level of distress prior to intervention.[37] However, a major limitation of this study was the lack of a control group. A study performed a randomized controlled trial of group

Cognitive Behavioral Therapy (CBT) that focused on clinical perfectionism instead of OCPD. Forty- Two participants with anxiety, eating, and mood disorders, as well as elevated perfectionism, were randomly assigned to a CBT group and a waitlist control group. The clinical perfectionism, dietary constraint, depressive symptoms, social anxiety, eating disorders, anxiety sensitivity, and ruminating behaviours of participants in the group CBT were considerably reduced.[38]

In addition, results showed a significant difference in the improvement of self-esteem and quality of life before and after treatment in the treatment group and between the two groups. The six-month follow-up confirmed the long-term maintenance of the CBT treatment. In addition to improving quality of life and self-esteem, the findings support the idea that CBT in a group setting is an effective strategy for addressing therapeutic perfectionism.[38] Due to the limited research that has directly compared psychodynamic and CBT, the available evidence does not prove the effectiveness of either approach in treating OCPD. For instance, in a prior study, 40 sessions of cognitive treatment (N=525) or short-term psychodynamic therapy (N=525; randomised) were administered to patients diagnosed with cluster C personality disorder[39].

Although OCPD was more commonly diagnosed in this sample, it was present in 17 people who met DSM-III criteria: the cognitive therapy group consisted of eight individuals (32%), while the psychodynamic group contained nine individuals (36%). Treatment and testing addressed symptom distress, interpersonal issues, and fundamental personality pathology. After two years, results showed that the symptoms among both patient groups were significantly improved. Furthermore, across all age groups, CBT and psychodynamic therapy both produced comparable levels of improvement. The cognitive-behavioural treatment used in this study was college-based and failed to emphasise a behaviour-focused approach[39]. This study did not compare treatment outcomes in OCPD patients specifically; therefore, more research is required to establish the effectiveness of both cognitive and psychodynamic treatment approaches for OCPD.

Other Psychological Treatments

A number of alternative treatments for Obsessive-Compulsive Personality Disorder (OCPD) have been evaluated using case-by-case analytic designs. For instance, two case studies were directed to adapt metacognitive therapy for individuals with OCPD.[40,41] Metacognitive therapy is meant to increase patients' awareness of their emotions and ability to understand and empathize with mental states while improving interpersonal functioning. The interpersonal difficulties typically experienced by patients with OCPD appear well-matched to this psychotherapy (although further study is necessary). Another study described Radically Open-DBT (RO-DBT) is a variation of Dialectical Behavioural Therapy (DBT) that targets emotional and cognitive restriction.[42]

They also documented a successful application of this adjustment with one person who presented with OCPD. In addition, previous research has issued a treatment manual for RO-DBT that addresses the treatment of overcontrol disorders, such as OCPD, as well as anorexia nervosa.[43] Acceptance and Commitment Therapy (ACT), considered a "third-wave" therapy, has also proven effective for personality disorders.[44] ACT is designed to facilitate a process of experiential acceptance by using metaphors, behavioral therapist approaches, and mindfulness training to help patients learn to act willingly and carry on with troubling internal experiences. In the context of OCPD, ACT assists with learning about the paradoxical effects of experiential avoidance.

The reason being, struggling coping mechanisms and unpleasant internal experiences (such emotions) frequently worsen when attempts to control or escape them are themselves challenging. In contrast, ACT treatment for OCPD encourages acceptance and tolerance of negative experiences rather than compulsive/controlling reactions. Patients learned to practice conscious toleration of distressing feelings related to their experience of imperfection or sudden disruptions in their structured routines, rather than reacting defensively by attempting to control their environment or the circumstantial challenge they encountered. There haven't been any ACT trials for OCPD, but a recent randomized controlled trial (RCT) study was conducted to

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explored that how well ACT works for clinical perfectionism.[45] Prior research showed that, a total of 53 participants were identified as having clinical perfectionism, and all consented to receive ACT (nobody was excluded) on an individual basis for a total of 10 weeks.

The ACT condition showed more improvement in all domains of clinical perfectionism, happiness, impaired functioning, stress, and change process than the comparison (waiting) group did. These data indicate that ACT for clinical perfectionism is feasible and useful.[45] Recently, a study adapted an effective General Psychiatric Management (GPM) for OCPD, which serve as a framework for mental health professionals in a more general approach to care[46]. GPM is based on current research in mental health treatment and can be adjusted for use with other personality disorders. GPM has some core ideas, which include informing the patient about their diagnosis, helping them feel positive about creating a life they are excited for, and dealing with any co-occurring disorders or concerns about safety.[46]

Proposed Model of Cognitive Behavioural Therapy for OCPD

This section suggests a new intervention that is based on and inspired by existing manualized Cognitive Behavioral Therapy (CBT) techniques. It includes skills training in how to control your emotions and relationships with others, Acceptance and Commitment Therapy (ACT) for perfectionism, and CBT for perfectionism. In CBT for Obsessive-Compulsive Personality Disorder (OCPD), it is essential for the therapist to emphasize that the goal is not to change the patient's fundamental character traits, lower their performance expectations, or make them content with average results. Rather, the objective is to help people replace their inflexible, internalised rules such as settling for "good enough" instead of perfection with more flexible and efficient principles.[47] Additionally, self-compassion replaces the constant cycle of harsh self-criticism.

Clinicians providing CBT for OCPD should encourage patients to reflect on their values and the ways that their OCPD characteristics affect their progress toward achieving those goals. For therapy to be successful, the therapist has to show the patient how changing their behaviour will align with their values.[47] It is common practice to advice patients to prioritize activities and tasks in a way that aligns with their beliefs while helping them with time management and activity planning. Mental health professionals can use the "dimmer switch of effort" as a helpful metaphor to recover time lost on strict, perfectionistic activities. The patient is advised to view the effort they exert on a task as a dimmer switch, one that can be adjusted in accordance with the perceived importance of the task, rather than as an on-off light switch that requires either the utmost effort or no effort.

In other words, one would put their best effort into things they deem important or that are in line with their values, while they deliberately put their least effort into things they deem mundane or unimportant, such as cleaning the dishes or vacuuming[47]. Therapists can encourage the patient to weigh the importance of each choice before investing time and resources in decision-making. For insignificant choices, they can flip a coin or make a "snap" decision; for decisions with higher importance compared to others. The patient can prioritize a specific value and engage in decision-making aligned with that value, even in the face of discomfort or tension arising from deviating from the conventional rule-based approach. Here, the current review used the analogy of a wallet or tank for mental resources to illustrate the initial phases of CBT for OCPD. Living under the constant pressure of strict regulations and perfectionistic practices, as well as the stresses of daily life, reduces one's mental capabilities.

Without enough resources, individuals suffering with OCPD are at a higher risk of experiencing burnout, which can take the form of sadness or worry, and they are also less inclined to resist the urge to exert control over their environment and other people. Self-care practices include obtaining sufficient sleep, adhering to a balanced diet, and participating in regular physical activity, engaging in leisure or pleasurable activities, and engaging in social interactions, are essential for the restoration of mental resources.[48] Problems with time management or putting things off until later, an unhealthy fixation on work or productivity, and unfavourable self-evaluation (such as feeling guilty or critical for failing to meet productivity targets) all have a negative effect on an individual's willingness

to engage in self-care.[49] Through the development of strategies to enhance within each of these areas of self-care, the patient could gradually reduce their susceptibility to low mood and distress, as well as enhance the psychological resources available for applying behavioural variations in CBT.

In addition, as indicated earlier, being open and willing to endure physical pain and unpleasant feelings is necessary to make these behavioural changes that prioritize self-care and balance. Individuals with OCPD, especially those who show a controlling presentation style, benefit considerably from acquiring the ability to control their negative emotions and be more adaptable in their relationships as a means of improving their ability to receive support from those around them, including their therapist.[50] In other words, the potential for changes in OCPD symptoms exists. Patients experience fewer connection breakdowns with their therapist and other supports; they are better able to manage their OCPD symptoms, which could be achieved through training in these skills. According to[51], behavioural experiments are a beneficial approach to evaluate perfectionism standards because they provide a chance to participants to gather their own data on the standard's validity and the probability of the undesirable event in a real-life setting. As a means of facilitating experiential learning, behavioral experiments involve working together; the patient and clinician determine which beliefs, rules, or standards are to be evaluated, and then the clinician devises an experiment to examine what happens when the patient deviates from the established norm. As an example of a behavioral experiment, one could sit down to dinner without completing the kitchen cleanup, wear new boots across grass, go to bed before roommates and let them sleep in, send a message or email without checking for errors, or leave home without a list of what to bring on vacation.

Discussion

This section provides an overview of some of the controversies and concerns that involve Obsessive-Compulsive Personality Disorder (OCPD).

Uncertainty Regarding the Nature of the Relationship between OCPD and OCD

Many people, including those seeking treatment, have long been confused about Obsessive-Compulsive Personality Disorder (OCPD) and Obsessive-Compulsive-Disorder (OCD) due to their shared nomenclature and strong historical affiliation. In informal settings, the term "OCD" is frequently used by the public to characterize rigid behavioural patterns or perfectionism is usually linked to presentations of OCPD. Classical historical accounts, such as some theorists[27,52] established a connection between the traits currently related to OCPD and the onset of OCD. However, according to the current theories, OCPD and OCD are separate disorders, and OCPD is not a "minor" form or prior to OCD, even if the two can co-occur.[53]

Even though both involve doing the same things over and over again, taking a lot of time, and following a set pattern (for example, composing and revising essays, putting everything in order, and creating lists), OCD is different because it involves disturbing and intrusive obsessions.[53,7] OCPD has ego-syntonic traits and behaviours, while OCD has ego-dystonic traits and behaviours. This difference is because the person with OCPD thinks these things are fitting and right (with their sense of self). Comorbidity studies highlight the uniqueness of both disorders by showing that few individuals who suffer from one of the illnesses also experience the other.[53,7] More public awareness and education campaigns about obsessive-compulsive disorder and other related disorders are needed to clear up the persistent misunderstandings about these two different disorders.

Is it more effective to conceptualize OCPD as a dimensional or categorical construct?

A large body of literature on Obsessive-Compulsive Personality Disorder (OCPD) and similar illnesses has taken a classificational approach, looking specifically for instances of distinctive personality disorders as they are now described in the DSM-5-TR. However, there are evolving theories in the field that place an emphasis on dimensional approaches to personality diseases. There is a hybrid dimensional-categorical model of personality pathology in Section III of the DSM-5-TR appendix. This model is made up of new measurements and models. This model could be looked into in more research in the future. Moreover, this model signifies an extensive revision of the OCPD construct. In particular, the new model states that in order to diagnose OCPD, one has to show rigid

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perfectionism as a core trait.

Other distinctive characteristics of OCPD, which are not mandatory but are recommended, include perseverance, restricted affectivity, and intimacy avoidance.[54,11] The extent to which this novel model enhances the current understanding of OCPD remains an open topic for future investigation. The recently suggested OCPD criteria seem to be more stringent, emphasizing perfectionism as a necessary trait while eliminating two previous diagnostic symptoms the unwillingness to let go of worn-out or useless things and miserliness. Validation of the other possible OCPD criteria introduced by the alternative conceptualization such as reduced affectivity and intimacy avoidance requires further research.

The comprehensive evaluation of these models to ascertain whether they enhance the current categorical system may take some time, as dimensional approaches to OCPD are still in the early stages. Even in cases where a person does not fully show the symptoms of a personality disorder, their dimensional personality features can impact their functioning, highlighting the greater therapeutic relevance of this perspective. For example, even in people who have been diagnosed with OCPD, perfectionism can cause a lot of stress and make it hard to do things. This has been called a transdiagnostic phenomenon.[54,47] Treating OCPD and other mental health issues more effectively requires paying attention to characteristics like perfectionism.

Does OCPD Affect OCD Intervention?

A significant body of research has examined Obsessive-Compulsive Personality Disorder (OCPD) within the framework of Obsessive-Compulsive-Disorder (OCD). Whereas OCPD is a common co-occurring disorder, research on its influence on the treatment of obsessive-compulsive disorder has been completely inconsistent.[55] Treatment guidelines for adults with OCD suggest that SRI medications or Cognitive Behavioral Therapy (CBT), specifically Exposure with Response Prevention (EX/RP), is the most effective option. The efficacy of each treatment approach containing OCPD is in disagreement[56]. One study looking at SRIs found that individuals with OCD and concurrent OCPD had considerably fewer improvements in their OCD symptoms than those with OCD only.[55,56] However, a study on the treatment of OCD found a more favourable response to fluvoxamine in comorbid OCPD.[57] While CBT is widely endorsed for its focus on restructuring perfectionistic thinking, psychodynamic therapy provides a depth-oriented approach that could be better suited for personality-level restructuring. Critics argue that CBT oversimplifies the underlying emotional drivers of OCPD, whereas proponents cite its empirically measurable outcomes.[57]

Furthermore, further experiments of the medication suggested that comorbid OCPD did not correlate with outcomes in OCD.[58] The literature shows mixed results regarding the impact of comorbid OCPD on psychotherapy for OCD. For example, a study found in one EX/RP trial that comorbid OCPD was associated with worse outcomes in OCD.[59] EX/RP studies found that people with more severe OCPD symptoms who stuck to the 25 standard treatment sessions of the EX/RP course had a lower chance of getting better with their OCD symptoms.[60,2]. Patients who also had OCPD did better in cognitive-based CBT (which changes deeply held beliefs through cognitive restructuring and behavioral experiments) than patients who did not have OCPD[61]. These mixed and sometimes opposing results demonstrate the need for more research into how OCPD relates to the treatment of OCD. Future studies could consider the variation in OCPD traits for the outcome of various treatments.

Limitations and Recommendations

This review did not apply a systematic review methodology and have introduced selection bias. Literature was restricted to English language sources, and studies with small sample sizes or without control groups were included, which could affect generalizability. Future studies should implement standardized treatment protocols, use larger samples, and compare therapy modalities (e.g., CBT vs. psychodynamic therapy) via randomized controlled trials. Research on long-term treatment outcomes and dimensional assessments of OCPD traits is also recommended.

Conclusions

This review synthesized available evidence on psychiatric and psychological interventions for OCPD. While CBT holds the most empirical support,

emerging therapies like ACT and RO-DBT also showed significance. The review emphasizes the need for future trials with strong methodologies to compare treatment modalities, develop innovative interventions, and guide standardized care pathways. The findings highlight the complexity of OCPD and emphasis the need of multi-modal, individualized treatment approaches aligned with patients' unique personality profiles and emotional regulation needs. The review suggests that clinical practitioners should consider integrating emotion regulation training into CBT for OCPD to target rigid perfectionism and interpersonal dysfunction. There is a pressing need to increase OCPD awareness among clinicians and develop population-specific intervention manuals. These findings could inform training programs, clinical decision-making, and future guideline development for personality disorders.

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CONFLICT OF INTEREST

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DATA SHARING STATEMENT

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