اضطراب الشخصية الوسواسية

من ويكيبيديا، الموسوعة الحرة

الشخصية الوسواسية (بالإنجليزية: Obsessive-compulsive personality disorder) وتتميز بالدقة ، والنظام ، والنزعة للكمال والاهتمام بأدق التفاصيل.

يختلف مفهوم الشخصية الوسواسية عن مفهوم الوسواس القهري حيث ان الوسواس القهري يعتبر من الامراض البيلوجيهة و التي تحتاج إلى علاج

الشخصية و السمات

Ψ هذه بذرة مقالة عن علم النفس تحتاج للنمو والتحسين، فساهم في إثرائها بالمشاركة في تحريرها (https://ar.wikipedia.org/w/index.php?title=%D8%A7%D8%B6%D8%B7%D8%B1%D8%A7%D8%A8_%D8%A7%D9%84%D8%B4%D8%AE%D8%B5%D9%8A%D8%A9_%D8%A7%D9%84%D9%88%D8%B3%D9%88%D8%A7%D8%B3%D9%8A%D8%A9&action=edit).

يختلف هذا النوع من الشخصيات في طبعه عن غيره من الناس بأنه مغرم بالتنظيم والترتيب ، يعشق الدقة ويتضايق أيما تضايق حينما يختلف ترتيب الأشياء أو عندما تجرى الأمور على غير عادتها.

هو حساس إلى درجة كبيرة من أمور لا يتحسس منها الناس في العادة. ويهتم كثيراً بشكل مقلق بتفاصيل الأمور ودقائقها ويحرص جداً على اتباع روتين النظام مما قد يؤثر سلباً في تطبيق روح ذلك النظام. كما لا تسمح له نفسه بالتخلص من الأوراق غير المهمة كالفواتير القديمة فتجده يقوم بترتيبها وفهرستها وحفظها لربما احتاج إليها بعد حين !!

هو مثالي لدرجة ربما أعاق إكمال أي مشروع يبدأه بسبب تلك المثالية المقيدة لروح العمل من حيث تريد له النقاء والرقي كما تظن.

يشعر أن الأمور يجب أن تقف لأنها تسير بلا ضوابط وعلى غير هدى فالانضباط في حس تلك الشخصية هو التطبيق الأعمى للقواعد وأنظمة ذلك المشروع.

هذا النوع من الشخصيات تتجه للعمل والإنتاجية دون اعتبار لحاجة الإنسان للمتعة والراحة. كما لا يهتم هؤلاء لظروفهم وحاجاتهم الحياتية فاتباع القواعد والثوابت والأنظمة هو الهدف المنشود ولاشيء سواه.

كما تجدهم أيضاً لا يعتدّون لصداقاتهم ولا لذويهم إن اختلفت حاجات أولئك مع روتينهم المعتاد فلا استعداد للتنازل أو تقديم المرونة التي تتطلبها ظروف الحياة.

ضمائرهم حية لدرجة مقلقة تجعلك تشعر أن ذلك ليس تقوى أو أمانة بمقدار ما هو طبع جبلي نظراً لما يصاحب ذلك الضمير من قلق وانزعاج.

مشغول بشكل مبالغ فيه بالمبادئ والقيم والأخلاقيات والمثاليات وقد يخاصم الناس إن رأى منهم مجرد خطأ يسير لا يستدعي عادة ذلك الانفعال وتلك الخصومة. ومن أجل أن يبرر ذلك الانفعال تجده يبالغ في الاستشهاد بالنصوص الشرعية والآثار والأشعار لكنه استشهاد حرفي لا يعتبر متغيرات الزمان والمكان والأحداث والأشخاص من حوله.

يتردد كثيراً في توزيع المهمات على من حوله ما لم يتيقن أنهم سيؤدونها تماماً بكل دقة، ويظل يتابعهم بشكل مزعج ربما يمنعهم من مواصلة إنجازها. كما أنه عنيد في رأيه ولا يقبل رأي الآخر نظراً لانعدام المرونة في ذاته.

في الغالب حريص على حفظ المال أكثر مما يجب، ويسعى إلى ادخاره بشكل مبالغ فيه تحسباً لأي طوارئ مستقبلية.

تجده مزعجاُ بسماته تلك لمن هم تحت مسئوليته من أبنائه وموظفيه إلا أنه ممتع لمديره نظراً لدرجة الدقة والانضباط والتقيد بالأنظمة لديه.

كما أن فيهم الطابع الرسمي في التعامل حتى مع معارفهم وذويهم وترى ذلك أيضاً في مشاعرهم وأحاسيسهم حيث لا دفء في المشاعر. وتنقصهم التلقائية، ويغلب عليهم طابع الجدية وعلى حواراتهم التفصيل الممل.

هذا الصنف من الناس يتحملون ساعات العمل الطويلة شرط أن لا تكثر فيها المقاطعات أو أمور مستجدة على روتينهم المعتاد. كما يتصفون بمحدودية المهارات في التواصل مع الآخرين ، ويصرون على وجوب توافق الآخرين مع طباعهم وحاجاتهم النفسية، فهم يقلقون أيما قلق عند حدوث أي أمر ربما يؤثر على حياتهم أو برنامجهم اليومي.

علاوة على ذلك فإن لديهم الاستعداد لإسعاد من يرونهم أقوى منهم في طباعهم ويتعاملون مع رغبات أولئك وكأنها واجبات وأوامر. كما أن فيهم الخوف من الوقوع في الخطأ وهذا ما يفسر طبع التردد لديهم وضعف القدرة على اتخاذ القرار.

أما حياتهم الزوجية والمهنية فمستقرة إلا أنها غير مسترخية بشكل عام، كما أن صداقاتهم محدودة.

تصنيفان: تشخيص الأمراض النفسية | اضطرابات الشخصية

Obsessive–compulsive personality disorder

From Wikipedia, the free encyclopedia

Obsessive–compulsive personality disorder (**OCPD**), also called **anankastic personality disorder**, is a personality disorder characterized by a pervasive pattern of preoccupation with orderliness, perfectionism, mental and interpersonal control and a need for power over one's environment, at the expense of flexibility, openness, and efficiency. It causes major suffering and stress, especially in areas of personal relationships. Persons afflicted with this disorder may find it hard to relax, always feeling that time is running out for their activities and that more effort is in need to achieve their goals. They may plan their activities down to the minute—a manifestation of the compulsive tendency to keep control over their environment and to dislike unpredictable things as things they can't control.[1] OCPD occurs in about 1% of the general population. It is seen in 3–10% of psychiatric outpatients. The disorder most often occurs in men.[2]

Obsessive–compulsive personality disorder, anankastic personality disorder

Classification and external resources

ICD-10	F60.5 (http://apps.who.int/classifications/icd10/browse/2010/en#/F60.5)
ICD-9	301.4 (http://www.icd9data.com/getICD9Code.ashx?icd9=301.4)
MedlinePlus	000942 (http://www.nlm.nih.gov/medlineplus/ency/article/000942.htm)
MeSH	D003193 (http://www.nlm.nih.gov/cgi/mesh/2014/MB_cgi?field=uid&term=D003193)

This is a distinct disorder from obsessive-compulsive disorder (OCD), and the relation between the two is contentious. Both may share outside similarities — rigid and ritual-like behaviors, for example. Hoarding, orderliness, and a need for symmetry and organization are often seen in people with either disorder. But attitudes towards these behaviors by people afflicted with either of them differ: for people with OCD, for example, these behaviors are unwanted and seen as unhealthy, the product of anxiety-inducing and involuntary thoughts; for people with OCPD, on the other hand, they are experienced as rational and desirable, being the result of, for example, a strong adherence to routines, or a natural inclination towards cautiousness, or a desire to achieve perfection.

Contents

Diagnosis

Symptoms

The main symptoms of OCPD are preoccupation with remembering and paying attention to minute details and facts, following rules and regulations, compulsion to make lists and schedules, as well as rigidity/inflexibility of beliefs or showing perfectionism that interferes with task-completion. Symptoms may cause extreme distress and interfere with a person's occupational and social functioning.[3] Most people spend their early life avoiding symptoms and developing techniques to avoid dealing with these strenuous issues.

Obsessions

Some, but not all, people with OCPD show an obsessive need for cleanliness. This, and an obsessive preoccupation with tidiness, may instead make daily living difficult. Though this kind of obsessive behavior may contribute to a sense of controlling personal anxiety, tension may continue. In the case of a compulsive hoarder, attention to clean the home effectively may be hindered by the amount of clutter that the hoarder resolves to organize later.[4]

Perception of own and others' actions and beliefs tend to be polarised (i.e., "right" or "wrong", with little or no margin between the two) for people with this disorder. As might be expected, such rigidity places strain on interpersonal relationships, with frustration sometimes turning into anger and even violence. This is known as disinhibition.[5] People with OCPD often tend to general pessimism and/or underlying form(s) of depression.[6][7][8] This can at times become so serious that suicide is a risk.[9] Indeed, one study suggests that personality disorders are a significant substrate to psychiatric morbidity. They may cause more problems in functioning than a major depressive episode.[10]

DSM

The *Diagnostic and Statistical Manual of Mental Disorders* fourth edition, (DSM IV-TR = 301.4), a widely used manual for diagnosing mental disorders, defines obsessive–compulsive personality disorder (in Axis II Cluster C) as:[11]

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at

the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
2. shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
3. is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
4. is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
5. is unable to discard worn-out or worthless objects even when they have no sentimental value
6. is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
7. adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
8. shows rigidity and stubbornness

Criticism

Since DSM IV-TR was published in 2000, some studies have found fault with its OCPD coverage. A 2004 study challenged the usefulness of all but three of the criteria: perfectionism, rigidity and stubbornness, and miserliness.[12] A study in 2007[13] found that OCPD is etiologically distinct from avoidant and dependent personality disorders, suggesting it is incorrectly categorized as a Cluster C disorder.

WHO

The World Health Organization's ICD-10 uses the term (F60.5 (http://apps.who.int/classifications/icd10/browse/2010/en#/F60.5)) **Anankastic personality disorder**.[14]

It is characterized by at least three of the following:

1. feelings of excessive doubt and caution;
2. preoccupation with details, rules, lists, order, organization or schedule;
3. perfectionism that interferes with task completion;
4. excessive conscientiousness, scrupulousness, and undue preoccupation with productivity to the exclusion of pleasure and interpersonal relationships;
5. excessive pedantry and adherence to social conventions;
6. rigidity and stubbornness;
7. unreasonable insistence by the individual that others submit exactly to his or her way of doing things, or unreasonable reluctance to allow others to do things;
8. intrusion of insistent and unwelcome thoughts or impulses.

Includes:

- compulsive and obsessional personality (disorder)
- obsessive-compulsive personality disorder

Excludes:

- obsessive-compulsive disorder

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Millon's subtypes

Theodore Millon identified five subtypes of the compulsive personality (2004).[15][16] Any compulsive personality may exhibit one or more of the following:

Subtype	Description	Compulsive Personality Traits
Conscientious	Including dependent features	Rule-bound and duty-bound; earnest, hardworking, meticulous, painstaking; indecisive, inflexible; marked self-doubts; dreads errors and mistakes.
Bureaucratic	Including narcissistic features	Empowered in formal organizations; rules of group provide identity and security; officious, high-handed, unimaginative, intrusive, nosy, petty-minded, meddlesome, trifling, closed-minded.
Puritanical	Including paranoid features	Austere, self-righteous, bigoted, dogmatic, zealous, uncompromising, indignant, and judgmental; grim and prudish morality; must control and counteract own repugnant impulses and fantasies.
Parsimonious	Including schizoid features. Resembles Fromm's hoarding orientation[17]	Miserly, tight-fisted, ungiving, hoarding, unsharing; protects self against loss; fears intrusions into vacant inner world; dreads exposure of personal improprieties and contrary impulses.
Bedeviled	Including negativistic features	Ambivalences unresolved; feels tormented, muddled, indecisive, befuddled; beset by intrapsychic conflicts, confusions, frustrations; obsessions and compulsions condense and control contradictory emotions.

Cause

Researchers set forth both genetic and environmental theories for what causes OCPD. Under the genetic theory, people with a form of the DRD3 gene will probably develop OCPD and depression, particularly if they are male.[18][19] But genetic concomitants may lie dormant until triggered by events in the lives of those who are predisposed to OCPD. These events could include trauma faced during childhood, such as physical, emotional or sexual abuse, or other psychological trauma. Under the environmental theory, OCPD is a learned behavior. People get OCPD by copying others throughout childhood. OCPD comes from constant contact throughout childhood between the child and persons (e.g., parents or teachers) who are inflexible, controlling, and obsess

over the children under their watch.[5]

Comorbidity

OCPD and obsessive-compulsive disorder

OCPD is often confused with obsessive–compulsive disorder (OCD). Despite the similar names, they are two distinct disorders, although some OCPD individuals also suffer from OCD, and the two are sometimes found in the same family,[20] sometimes along with eating disorders.[21] People with OCPD do not generally feel the need to repeatedly perform ritualistic actions—a common symptom of OCD—and usually find pleasure in perfecting a task, whereas people with OCD are often more distressed after their actions.

Significantly higher rates of OCPD have been found in subjects with OCD, with estimates ranging from 23 to 32 percent. For example perfectionism, hoarding, and preoccupation in details (3 characteristics of OCPD) were found in people with OCD and not in people without OCD, showing a particular relationship with OCD.[22]

There is significant similarity in the symptoms of OCD and OCPD, which can lead to complexity in distinguishing them clinically. For example, perfectionism is an OCPD criterion and a symptom of OCD if it involves the need for tidiness, symmetry, and organization. Hoarding is also considered both a compulsion found in OCD and a criterion for OCPD in the DSM-IV. Even though OCD and OCPD are seemingly separate disorders there are obvious redundancies between the two concerning several symptoms. Regardless of similarities between the OCPD criteria and the obsessions and compulsions found in OCD, there are discrete qualitative dissimilarities between these disorders, predominantly in the functional part of symptoms. Unlike OCPD, OCD is described as invasive, stressful, time-consuming obsessions and habits aimed at reducing the obsession related stress. OCD symptoms are at times regarded as ego-dystonic because they are experienced as alien and repulsive to the person. Therefore, there is a greater mental anxiety associated with OCD.[1]

In contrast, the symptoms seen in OCPD, though they are repetitive, are not linked with repulsive thoughts, images, or urges. OCPD characteristics and behaviors are known as ego-syntonic, as persons with the disorder view them as suitable and correct. On the other hand, the main features of perfectionism and inflexibility can result in considerable suffering in an individual with OCPD as a result of the associated need for control.[1]

Recent studies using DSM-IV criteria have persistently found high rates of OCPD in persons with OCD, with an approximate range of 23% to 32% in persons with OCD. Some data suggest that there may be specificity in the link between OCD and OCPD. OCPD rates are consistently higher in persons with OCD than in healthy population controls using DSM-IV criteria.[1]

While there are superficial similarities between the list-making, inflexible guidelines, and obsessive aspects of Asperger's syndrome and OCPD, the former is different from OCPD especially regarding affective behaviors and restricted interests, including (but not limited to) empathy, recalling every aspect of a subject of interest, non-verbal communication, social cognition, as well as both conversational and general social skills.

OCPD and eating disorders

There is a great variability in the incidence of OCPD diagnosis in eating disordered samples in studies looking for the incidence of personality disorder among anoretics and bulimics. In the low end, Halmi et al. for example, found in a 2005 study that only a small minorty (9%) of eating disordered women—6% of restricting anorexics, 13% of binging anorexics and no bulimic women of normal weight—met the OCPD diagnosis.[23] A slightly

higher percentage of anorexic women, 18%, met the subthreshold criteria. On the high end, Anderluh et al., in a 2003 study, found that most anorexic women in her sample (61%) and nearly half bulimic women (46%) met the Anankastic personality disorder diagnosis;[24] in a 2009 study, the same team ratified the previous results in a much larger sample: 71.4% of restricting anorexics who never binged or purged; 64% of anorexics who binged and/or purged; 46.7% of bulimic women with an episode of anorexia; and 40% of bulimic women without a record of diagnostic crossover to anorexia, were found to fit the OCPD personality diagnosis.[24] On the middle term, another paper by Halmi in 2005, the biggest study looking for personality disorders among anorexics and bulimics, found that 31% among anorexics without a binging episode fit the OCPD diagnosis, as did 32% anorexics who binged, and 24% bulimic women of normal weight.[25]

Regardless of the prevalence of OCPD among eating disordered samples, the presence of this personality disorder and its over-controlled quality have been found to be positively correlated with a range of complications in eating disorders, whereas more impulsive features—those linked with histrionic personality disorder, for example—by contrast predict better outcome from treatment.[26] OCPD predicts including more severe anorexic symptoms,[27] worse remission rates,[27] and the presence of aggravating behaviors such as compulsive exercising.[28] Compulsive exercising in eating disordered samples also correlates positively and significantly with an important OCPD trait, perfectionism;[29] as do, among women with anorexia nervosa, smaller lifetime BMI and illness duration.[30]

Perfectionism is the personality trait most universally identified with anorexia nervosa throughout decades of research; it's a core feature of eating disorders. Already in 1949 it was noticed in the behavior of the average anorexic that, along with other traits resembling OCPD such as being "rigid" and "hyperconscious", there was also the presence of "[n]eatness, meticulosity, and a mulish stubbornness not amenable to reason [which] make her a rank perfectionist".[31] Perfectionism is a life enduring trait in the biographies of anorexics. This is to say that, along with other OCPD traits,[32] perfectionism is felt in all stages of life of anorexic probands—before the onset of the eating disorder, generally in childhood;[24] and then during the disorder, and also, after remission.[33] Researchers have in fact identified the incessant striving for thinness among anorexic women as being itself a manifestation of this trait, of an insistence upon meeting unattainably high standards of performance.[34] Because of its permanent quality, those with eating disorders also show perfectionistic striving in other domains of life than dieting and weight control. Overachievement at school, for example, has been observed among anorexics.[34] As corroboration, a Swedish study based on samples taken from public files concluded that hospitalization for eating disorders was around twice more common among girls who achieved high average grades than among those who had medium or low grades.[35] The link with overarchievement was particularly high among those hospitalized for anorexia: this disorder was 3.5 times as common among those with high grades as in others.[35] In some individuals with bulimia nervosa, the seemingly conflicting traits of impulsivity and perfectionism are present.[23]

Perfectionism is also seen in the relationship of eating disorders with a third disorder: OCD. Eating disorders are also largely comorbid with OCD; some studies, for example, show that OCD symptoms are nearly as severe among anorexics as among a classic OCD sample, and that this remains true even if obsessions and compulsions about food and weight are discounted.[36] And, as in OCPD's case, debate rages as to the nature of this relationship[37]—for example, whether it has a causal character or not is a question often asked. What the many studies looking into the link between OCD and ED have found in common is the following: While OCD symptoms may be as elevated among eating disordered samples as in OCD samples, the range of OCD symptoms in eating disordered samples is more restricted than that found in a typical OCD sample. In the latter,

symptoms related with a multitude of objects—sex, violence, washing, religion etc.—are endorsed, whereas in both anorexic[38] and bulimic[39] samples the OCD symptoms endorsed are more restricted, namely, to ordering and arranging themes, which have perfectionistic undertones, and reflect OCPD attention to orderliness. At least one paper has made an explicit link between OCPD and the OCD symptoms endorsed by anorexics, noticing that, in the samples studied—one suffering from both anorexia and OCD and another from OCD but no present eating disorder—those with both anorexia and OCD were significantly more likely to be diagnosed with OCPD than those with OCD only (38.1% vs 8.7%).[40] Non-eating disordered samples suffering from both OCPD and OCD are also more likely to harbor obsessions and compulsions about symmetry and order than those suffering from OCD only.[41] Such concerns—with orderliness—remain elevated in women after recovery from anorexia compared to those without a record of eating disorder.[33]

Apart from perfectionism, other OCPD traits are commonly found in studies of personality and cognition among those with eating disorders. Anderluh et al. looked for the presence of five different OCPD traits in the childhoods of anorexics and bulimics—perfectionism, inflexibility, being rule-bound, expressing excessive doubt and cautiousness, and being driven for order and symmetry—and found that they were significantly more common among them than among healthy controls.[24] The traits had a frequency of 38.5 to 76.9% among restricting anorexics; 31.3 to 77.8% among anorexics who binged or purged; 10.7 to 50.0% among bulimics; and 0 to 17.9% among healthy controls.[24]

The obsessive compulsive personality traits of over-attention to details and inflexibility have also been found in cognitive testing of anorexics;[42] this group, compared to healthy controls, will display average to above average performance in tests requiring accuracy and the avoiding of errors[42] but poorly on tests requiring mental flexibility and central coherence, i.e., the ability to integrate details of information into a bigger narrative.[43] Over-attention to details among anorexics and weak central coherence are linked with a well-known cognitive failure in this group, that of missing "the big picture", a characteristic also of the cognitive style of those suffering from OCPD.[44]

Both anorexics and non-eating disordered OCPD samples have also been found to share increased self-control, an above average ability to delay gratification, i.e., to control impulses for immediate gratification in the name of a greater good to be received in the future. Among anorexics specifically, this trait is clearly manifested in their capacity to repress a key natural urge, that of satisfying hunger, in order to be rewarded in the future with a thin body.[45] A 2012 study has been able to verify the presence of this capacity among anorexics also regarding items not related with food and weight themes.[45] The study found that anorexics saved money handled to them by researchers more persistently than did a control sample of healthy women. This ability was more pronounced among anorexics who only restrict than among those who binge or purge.[45] A 2014 study comparing four non-eating disordered samples—one with people suffering from OCPD only, another from OCD only, a third afflicted with both OCPD and OCD, and a sample of healthy controls—found this very same capacity among those with OCPD but not those with OCD only or the control samples, who were not distinguishable from one another.[46] This ability, they found, was highly correlated with the severity of OCPD, i.e., the greater the capacity to delay gratification in a person afflicted with OCPD, the more impairing was the personality disorder.[46] The authors noticed that, whereas a great many psychiatric disorders—substance abuse, for example—may be marked by impulse deregulation, by impulsivity, OCPD and anorexia nervosa by contrast stand out as the only disorders that have been proven to suffer from the opposite quality, namely excessive self-control.[46]

Some family studies have also found a close genetic link between OCPD and anorexia. Lilenfeld et al. 1998,

compared for a variety of psychiatric diagnoses three sets of women—one suffering from the restricting type of anorexia nervosa, another from bulimia nervosa, and a group of control women without an eating disorder—plus their respective relatives unaffected by eating disorders. They found a much higher incidence of OCPD among anorexics and their relatives (46% and 19%, respectively) than in the control samples and the latter's own relatives (5% and 6%, respectively). What's more, the rates of OCPD among relatives of Anorexics with that personality disorder and those without it were about the same—evidence, in the authors' words, "suggesting shared familial transmission of AN and OCPD".[47] In this study, bulimics and their relatives were not found to have elevated rates of OCPD (4% and 7%, respectively). In any case, Strober et al. 2007, in a similarly intentioned study, also found much higher incidence of OCPD among relatives of restrictive anorexics than among relatives of a normal control sample (20.7% vs. 7%). Along with diagnoses of OCD and Generalized Anxiety Disorder, OCPD was the one that best distinguished between the two groups.[48]

Treatment

Treatment for OCPD includes psychotherapy, cognitive behavioral therapy, behavior therapy or self-help. Medication may be prescribed. In behavior therapy, a patient discusses with a psychotherapist ways of changing compulsions into healthier, productive behaviors. Cognitive analytic therapy is an effective form of behavior therapy.[49][50]

Treatment is complicated if the patient does not accept that they have OCPD, or believes that their thoughts or behaviors are in some sense correct and therefore should not be changed. Medication in isolation is generally not indicated for this personality disorder, but fluoxetine has been prescribed with success.[51] Selective serotonin reuptake inhibitors (SSRIs) may be useful in addition to psychotherapy by helping the person with OCPD be less bogged down by minor details and to lessen how rigid they are.

Certain psychiatric medications can help control the obsessions and compulsions of OCD. Most commonly, antidepressants are tried first. Antidepressants may be helpful for OCD because they may help increase levels of serotonin, which may be lacking where OCD exists.

Antidepressants that have been specifically approved by the Food and Drug Administration (FDA) to treat OCD include:

Clomipramine (Anafranil) Fluvoxamine (Luvox) Fluoxetine (Prozac) Paroxetine (Paxil, Pexeva) Sertraline (Zoloft)

However, many other antidepressants and other psychiatric medications on the market also may be used to treat OCD off-label. Off-label use is a common and legal practice of using a medication to treat a condition not specifically listed on its prescribing label as an FDA-approved use. When choosing a certain medication in general, the goal of OCD treatment with medications is to effectively control signs and symptoms at the lowest possible dosage. Which medication is best depends on each individual situation. It can take weeks to months after starting a medication to notice an improvement in symptoms.[52][53] With obsessive-compulsive disorder, it's not unusual to have to try several medications before finding one that works well to control symptoms. Medical practitioners also might recommend combining medications, such as antidepressants and antipsychotic medications, to make them more effective in controlling symptoms. It is unwise to make changes to medication without talking to the medical practitioner who prescribed it, even where some improvement has come about. Relapse of OCD symptoms may occur if medication is changed or abandoned. For best effects, medication should ideally be reduced gradually. It may take up to two years to bring symptoms under control so that dosages of medication can be reduced. If symptoms recur on a lower dose of medication, it might be necessary

to continue medication indefinitely, or at least until the condition is under control.[54]

Moreover medication is not the only way of treatment, some find that relaxation techniques help to reduce anxiety and the sense of urgency that are sometimes symptoms of OCPD (Noppen, 2010) Where psychotherapy is not available, reading about it to gain self-insight may help, as well as seeking the cooperation of families and friends in helping to bring OCPD behaviour under control. Self-help may be crucial for a swift accommodation to having to deal with people and situations in what may seem an unfamiliar manner. Self-help techniques may include keeping a diary for noting down anything that is upsetting, anxiety-provoking, or that overwhelms and depresses the OCPD individual. Family members can help by making a note of their observations and sharing them in a non-confrontational manner.

People with OCPD are three times more likely to receive individual psychotherapy than people with major depressive disorder.[55][56] There are higher rates of primary care utilization.[57][58] There is no treatment for OCPD that has been thoroughly validated. There are no known properly controlled studies of treatment options for OCPD.[1][59][60] More research is needed to explore better treatment options.[1]

Epidemiology

A University of Colorado Colorado Springs study comparing personality disorders and Myers-Briggs Type Indicator types found that the disorder had a significant correlation with the Introverted (I), Sensing (S), Thinking (T), and Judging (J) preferences.[61]

History and theoretical models

Psychoanalytic

In 1908, Sigmund Freud named what is now known as obsessive–compulsive or anankastic personality disorder "anal retentive character". He identified the main strands of the personality type as a preoccupation with orderliness, parsimony (frugality), and obstinacy (rigidity and stubbornness). The concept fits his theory of psychosexual development.

OCPD was first included in DSM-II, and was in large based on Sigmund Freud's notion of the obsessive personality or anal-erotic character style characterized by orderliness, parsimony, and obstinacy.[1]

The diagnostic criteria for OCPD have gone through considerable changes with each DSM modification. For example, the DSM-IV stopped using two criteria present in the DSM-III-R, constrained expression of affection and indecisiveness, mainly based on reviews of the empirical literature that found these traits did not contain internal consistency.[1] Since the early 1990s, considerable research continues to characterize OCPD and its core features, including the tendency for it to run in families along with eating disorders[62] and even to appear in childhood.[63] According to the DSM-IV, OCPD is classified as a 'Cluster C' personality disorder. There was a dispute about the categorization of OCPD as an Axis II anxiety disorder. It is more appropriately for OCPD alongside OC spectrum disorders including OCD, body dysmorphic disorder, compulsive hoarding, trichotillomania, compulsive skin-picking, tic disorders, autistic disorders, and eating disorders.[64]

Although the DSM-IV attempted to distinguish between OCPD and OCD by focusing on the absence of obsessions and compulsions in OCPD, OC personality traits are easily mistaken for abnormal cognitions or values considered to underpin OCD. Aspects of self-directed perfectionism, such as believing a perfect solution

is commendable, discomfort if things are sensed not to have been done completely, and doubting one's actions were performed correctly, have also been proposed as enduring features of OCD.[65] Moreover, in DSM-IV field trials, a majority of OCD patients reported being unsure whether their OC symptoms really were unreasonable.[66]

See also

- Analysis paralysis
- Compulsive hoarding
- Germaphobia
- Scrupulosity

References

1. ^ *a b c d e f g h* Pinto, Anthony; Jane Eisen; Maria Mancebo; Steven Rasmussen (2008). *Obsessive-Compulsive Disorder Subtypes and Spectrum Conditions: Obsessive-Compulsive Personality Disorder* (http://ac.els-cdn.com/B9780080447018500164/3-s2.0-B9780080447018500164-main.pdf?_tid=3484d0a64d2603d9d72884c8ca17a943&acdnat=1338219604_e4904db18137c1a98445aed04742a90e). Rhode Island: Elsevier Ltd. pp. 246–263.
2. ^ MedlinePlus: A service of the U.S. National Library of Medicine NIH National Institutes of Health – Obsessive–compulsive personality disorder (http://www.nlm.nih.gov/medlineplus/ency/article/000942.htm)
3. ^ Taber's Cyclopedic Medical Dictionary 18th ed 1968
4. ^ Jefferys, Don; Moore, KA (2008). "Pathological hoarding" (http://www.racgp.org.au/afp/200804/23717). *Australian Family Physician* **37** (4): 237–41. PMID 18398520 (https://www.ncbi.nlm.nih.gov/pubmed/18398520). Retrieved October 7, 2009.
5. ^ *a b* Villemarette-Pittman, Nicole R; Matthew Stanford; Kevin Greve; Rebecca Houston; Charles Mathias (2004). "Obsessive-Compulsive Personality Disorder and Behavioral Disinhibition" (http://journals2.scholarsportal.info.myaccess.library.utoronto.ca/details-sfx.xqy?uri=/00223980/v138i0001/5_opdabd.xml). *The Journal of Psychology* **138** (1): 5–22. doi:10.3200/JRLP.138.1.5-22 (http://dx.doi.org/10.3200%2FJRLP.138.1.5-22). PMID 15098711 (https://www.ncbi.nlm.nih.gov/pubmed/15098711).
6. ^ Pilkonis PA, Frank E. (1988). Personality pathology in recurrent depression: nature, prevalence, and relationship to treatment response. *Am J Psychiatry*. 145: 435–41
7. ^ Rossi A et al. (2000). Pattern of comorbidity among anxious and odd personality disorders: the case of obsessive–compulsive personality disorder. *CNS Spectr*. Sep; 5(9): 23–6.
8. ^ Shea MT et al. (1992). Comorbidity of personality disorders and depression; implications for treatment. J Consult Clin Psychol. 60: 857–68.
9. ^ Raja M, Azzoni A. (2007). The impact of obsessive–compulsive personality disorder on the suicidal risk of patients with mood disorders. *Psychopathology*. 40(3): 184–90
10. ^ Skodol AE et al. (2002). Functional Impairment in Patients With Schizotypal, Borderline, Avoidant, or Obsessive–Compulsive Personality Disorder. *Am J Psychiatry* 159:276–83. February.

11. ^ Obsessive–compulsive personality disorder (http://www.behavenet.com/capsules/disorders/o-cpd.htm). Diagnostic and Statistical Manual of Mental Disorders Fourth edition Text Revision (DSM-IV-TR) American Psychiatric Association (2000)
12. ^ Grilo CM. (2004). Diagnostic efficiency of DSM-IV criteria for obsessive compulsive personality disorder in patients with binge eating disorder. *Behaviour Research and Therapy* 42(1) January,57–65.
13. ^ Reichborn-Kjennerud T et al. (2007). Genetic and environmental influences on dimensional representations of DSM-IV cluster C personality disorders: a population-based multivariate twin study. *Psychol Med*. May; 37(5): 645–53
14. ^ Anankastic personality disorder (http://www.mentalhealth.com/icd/p22-pe10.html). International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)
15. ^ Millon, Theodore (2004). *Personality Disorders in Modern Life*. John Wiley & Sons, Inc., Hoboken, New Jersey. ISBN 0-471-23734-5.
16. ^ Millon, Theodore – Personality Subtypes (http://millon.net/taxonomy/summary.htm)
17. ^ Fromm, E Man For Himself, 1947
18. ^ Joyce et al. (2003). Polymorphisms of DRD4 and DRD3 and risk of avoidant and obsessive personality traits and disorders. *Psychiatry Research*. 119(2):1–10.
19. ^ Light et al. (2006). Preliminary evidence for an association between a dopamine D3 receptor gene variant and obsessive–compulsive personality disorder in patients with major depression.
20. ^ Samuels J et al. (2000). Personality disorders and normal personality dimensions in obsessive–compulsive disorder. *Br J Psychiatry*. Nov. 177: 457–62.
21. ^ Halmi, KA; et al (December 2005). "The relation among perfectionism, obsessive–compulsive personality disorder, and obsessive–compulsive disorder in individuals with eating disorders" (http://www.ncbi.nlm.nih.gov/pubmed/16231356). *Int J Eat Disord* **38** (4): 371–4. doi:10.1002/eat.20190 (http://dx.doi.org/10.1002%2Feat.20190). PMID 16231356 (https://www.ncbi.nlm.nih.gov/pubmed/16231356). Retrieved 14 March 2013.
22. ^ calvo, rosa (2008). *Science direct* (24): 201–206 http://journals2.scholarsportal.info.myaccess.library.utoronto.ca/tmp/9620815981947081411.pdf `|url=` missing title (help).
23. ^ ***a b*** Halmi, Katherin A (2005). "Obsessive-Compulsive Personality Disorder and Eating Disorders" (http://journals1.scholarsportal.info.myaccess.library.utoronto.ca/tmp/449736540341158159.pdf). *Eating Disorders* **13**: 85–92. doi:10.1080/10640260590893683 (http://dx.doi.org/10.1080%2F10640260590893683). PMID 16864333 (https://www.ncbi.nlm.nih.gov/pubmed/16864333).
24. ^ ***a b c d e*** Anderluh, Marija Brecelj (2003). "Childhood Obsessive-Compulsive Personality Traits in Adult Women With Eating Disorders: Defining a Broader Eating Disorder Phenotype" (http://journals.psychiatryonline.org/data/Journals/AJP/3745/242.pdf). *Eating Disorders* **13** (Am J Psychiatry 2003; 160:242–247).
25. ^ Halmi, Katherin A (2005). "The Relation among Perfectionism, Obsessive-Compulsive Personality Disorder and Obsessive-Compulsive Disorder in Individuals with Eating Disorders" (http://onlinelibrary.wiley.com/doi/10.1002/eat.20190/abstract?deniedAccessCustomisedMessage=&userIsAuthenticated=false). *Int J Eat Disord* **38** (4): 371–374.
26. ^ Lilenfield, LR (2006), "Eating disorders and personality: a methodological and empirical review." (http://www.ncbi.nlm.nih.gov/pubmed/16330138), *Clin Psychol Rev* **26**: 299–320

27. ^ **a b** Crane, Anna (2007). "Are Obsessive-Compulsive Personality Traits Associated with a Poor Outcome in Anorexia Nervosa? A Systematic Review of Randomized Controlled Trials and Naturalistic Outcome Studies". *International Journal of Eating Disorders*. doi:10.1002/eat (http://dx.doi.org/10.1002%2Feat).
28. ^ Davis, Caroline (1998). "Obsessionality in Anorexia Nervosa: The Moderating Influence of Exercise" (http://www.ncbi.nlm.nih.gov/pubmed/9560869). *Psychosomatic Medicine* **60** (2): 192–7.
29. ^ Shroff, Hemal (2006). "Features Associated With Excessive Exercise in Women with Eating Disorders" (http://eatingdisorders.ucsd.edu/research/pdf_papers/2006/shroff2006features.pdf). *International Journal of Eating Disorders* **39** (6): 454–461. doi:10.1002/eat (http://dx.doi.org/10.1002%2Feat).
30. ^ Halmi, Katherine A. (2000). "Perfectionism in Anorexia Nervosa: Variation by Clinical Subtype, Obsessionality, and Pathological Eating Behavior" (http://journals.psychiatryonline.org/article.aspx?articleid=174426). *Am J Psychiatry* **157**. doi:10.1176/appi.ajp.157.11.1799 (http://dx.doi.org/10.1176%2Fappi.ajp.157.11.1799).
31. ^ DuBois, F.S. (1949). *Compulsion neurosis with cachexia (anorexia nervosa)* (http://journals.psychiatryonline.org/article.aspx?articleid=143894) **106**. pp. 107–115.
32. ^ Southgate, Laura (2008). "The Development of the Childhood Retrospective Perfectionism Questionnaire (CHIRP) in an Eating Disorder Sample" (http://www.ncbi.nlm.nih.gov/pubmed/18444228). *European Eating Disorders Review*: 451–62. doi:10.1002/erv.870 (http://dx.doi.org/10.1002%2Ferv.870).
33. ^ **a b** Srinivasagam (1995). "Persistent perfectionism, symmetry, and exactness after long-term recovery from anorexia nervosa" (http://www.ncbi.nlm.nih.gov/pubmed/7485626). *Am J Psychiatry*.
34. ^ **a b** JR, Dura (1989). "Differences between IQ and school achievement in anorexia nervosa" (http://www.ncbi.nlm.nih.gov/pubmed/2745732). *Journal of clinical psychology* **45**: 433–5.
35. ^ **a b** Ahre´n-Moonga, Jennie (2009). "Association of Higher Parental and Grandparental Education and Higher School Grades With Risk of Hospitalization for Eating Disorders in Females" (http://aje.oxfordjournals.org/content/170/5/566.full). *American Journal of Epidemiology*.
36. ^ Kaye, Walter (1992). "Patients with anorexia nervosa have elevated scores on the Yale-Brown obsessive-compulsive scale" (http://onlinelibrary.wiley.com/doi/10.1002/1098-108X(199207)12:1%3C57::AID-EAT2260120108%3E3.0.CO;2-7/abstract). *International Journal of Eating Disorders*.
37. ^ Serpell, Lucy (2002). "Anorexia nervosa: Obsessive–compulsive disorder, obsessive–compulsive personality disorder, or neither?". *Clinical Psychology Review*.
38. ^ Halmi, Katherine (2003). "Obsessions and Compulsions in Anorexia Nervosa Subtypes". *Int J Eat Disord*.
39. ^ H, Matsunaga (1999). "Prevalence and symptomatology of comorbid obsessive-compulsive disorder among bulimic patients". *Psychiatry Clin Neurosci*.
40. ^ Matsunaga, H (1999). "Clinical characteristics in patients with anorexia nervosa and obsessive±compulsive disorder". *Psychological Medicine*.
41. ^ Lochner, Christine (2011). "Comorbid obsessive–compulsive personality disorder in obsessive–compulsive disorder (OCD): A marker of severity". *Progress in Neuro-Psychopharmacology & Biological Psychiatry*.
42. ^ **a b** Southgate, Laura (2008). "Information processing bias in anorexia nervosa" (http://www.ncbi.nlm.nih.gov/pubmed/18579218). *Psychiatry Research*. doi:10.1016/j.psychres.2007.07.017 (http://dx.doi.org/10.1016%2Fj.psychres.2007.07.017).
43. ^ Van Autreve, Sara (2013). "Do Restrictive and Bingeing/Purging Subtypes of Anorexia Nervosa Differ on Central Coherence and Set Shifting?" (http://www.ncbi.nlm.nih.gov/pubmed/23674268). *Eur. Eat. Disorders Rev*. doi:10.1002/erv.2233 (http://dx.doi.org/10.1002%2Ferv.2233).

44. ^ Blaney, Paul (2008). *Oxford Textbook of Psychopathology, 2nd edition* (http://books.google.com.br/books?id=5bAPxqDyFxUC&pg=PA672&dq=ocpd+bigger+picture&hl=pt-BR&sa=X&ei=ZueOU6zVIbe2sAS8tYCIBA&ved=0CCkQ6AEwAA#v=onepage&q=ocpd%20bigger%20picture&f=false). Oxford University Press. p. 672. ISBN 0195374215.
45. ^ *a b c* Steinglass, Joanna (2012). "Increased Capacity to Delay Reward in Anorexia Nervosa". *Journal of the International Neuropsychological Society* **18**: 1–8. doi:10.1017/S1355617712000446 (http://dx.doi.org/10.1017%2FS1355617712000446).
46. ^ *a b c* Pinto, Anthony (2014). "Capacity to Delay Reward Differentiates Obsessive-Compulsive Disorder and Obsessive-Compulsive Personality Disorder". *Biol Psychiatry* **75** (8): 653–659. doi:10.1016/j.biopsych.2013.09.007 (http://dx.doi.org/10.1016%2Fj.biopsych.2013.09.007).
47. ^ Lilenfeld, Lisa (1998). "A controlled family study of anorexia nervosa and bulimia nervosa: psychiatric disorders in first-degree relatives and effects of proband comorbidity." (http://www.ncbi.nlm.nih.gov/pubmed/9672050). *American Medical Association*.
48. ^ Strober, Michael (2007). "The Association of Anxiety Disorders and Obsessive Compulsive Personality Disorder with Anorexia Nervosa: Evidence from a Family Study with Discussion of Nosological and Neurodevelopmental Implications". *International Journal of Eating Disorders*.
49. ^ Protogerou et al. (2008). Evaluation of Cognitive-Analytic Therapy (CAT) outcome in patients with Obsessive–Compulsive Personality Disorder *Annals of General Psychiatry* 2008, 7(Suppl 1):S109
50. ^ Ryle, A. & Kerr, I. B. (2002) Introducing Cognitive Analytic Therapy: Principles and Practice. Chichester: John Wiley & Sons.
51. ^ Fluoxetine (http://www.ocduk.org/fluoxetine), OCD-UK. Accessed March 12, 2012
52. ^ ["Practice guideline for the treatment of patients with obsessive-compulsive disorder.]
53. ^ [". American Psychiatric Association].
54. ^ ["Treatments and drugs]" (http://www.mayoclinic.com/health/obsessive-compulsive-disorder/DS00189/DSECTION=treatments-and-drugs). Mayo Clinic. Retrieved 11 December 2013.
55. ^ Bender, D; Dolan R; Skodol A (2001). "Treatment utilization by patients with personality disorders". *Am J Psychiatry 2001*. 158 **158** (Am J Psychiatry 2001): 295–302. doi:10.1176/appi.ajp.158.2.295 (http://dx.doi.org/10.1176%2Fappi.ajp.158.2.295).
56. ^ Bender, D; Skodol, A. E., Pagano, M. E., Dyck, I. R., Grilo, C. M., Shea, M. T., Sanislow, C. A., Zanarini, M. C., Yen, S., McGlashan, T. H., Gunderson, J. G., (2006). "Prospective assessment of treatment use by patients with personality disorders". *Psychiatr Serv*. 57 **2** (Psychiatr Serv): 254–257. doi:10.1176/appi.ps.57.2.254 (http://dx.doi.org/10.1176%2Fappi.ps.57.2.254).
57. ^ Sansone, R.A.; Hendricks, C. M.; Gaither, G. A.; Reddington, A. (2004). "Prevalence of anxiety symptoms among a sample of outpatients in an internal medicine clinic: a pilot study". *Depress Anxiety*. 19 **2** (2): 133–136. doi:10.1002/da.10143 (http://dx.doi.org/10.1002%2Fda.10143).
58. ^ Sansone, R.A.; Hendricks, C. M.; Sellbom, M.; Reddington, A. (2003). "Anxiety symptoms and healthcare utilization among a sample of outpatients in an internal medicine clinic". *Int J Psychiatry Med*. 33 **2** (2): 133–139. doi:10.2190/EYJ9-UVF4-RGP8-WK88 (http://dx.doi.org/10.2190%2FEYJ9-UVF4-RGP8-WK88).

59. ^ Bender, D; Skodol AE, Dyck IR, Markowitz JC, Shea MT, Yen S, Sanislow CA, Pinto A, Zanarini MC, McGlashan TH, Gunderson JG, Daversa MT, Grilo CM. (2007). "Ethnicity and Mental Health Treatment Utilization by Patients with Personality Disorders" (http://wesscholar.wesleyan.edu/cgi/viewcontent.cgi?article=1161&context=div3facpubs&sei-redir=1&referer=http%3A%2F%2Fwww.google.com%2Furl%3Fsa%3Dt%26rct%3Dj%26q%3D%2522Ethnicity%2Band%2BMental%2BHealth%2BTreatment%2BUtilization%2Bby%2BPatients%2Bwith%2BPersonality%2BDisorders.%2522%26source%3Dweb%26cd%3D2%26ved%3D0CDkQFjAB%26url%3Dhttp%253A%252F%252Fwesscholar.wesleyan.edu%252Fcgi%252Fviewcontent.cgi%253Farticle%253D1161%2526context%253Ddiv3facpubs%26ei%3DhCJCUeSxLdKp4AOj94GIAw%26usg%3DAFQjCNEHAOCcYXuhcMnTmlXnhzHAK87_wA%26bvm%3Dbv.43287494%2Cd.dmg#search=%22Ethnicity%20Mental%20Health%20Treatment%20Utilization%20by%20Patients%20Personality%20Disorders.%22). *Journal of Consulting and Clinical Psychology*. 75 **6** (6): 992–999. doi:10.1037/0022-006X.75.6.992 (http://dx.doi.org/10.1037%2F0022-006X.75.6.992).
60. ^ De Reus, Rob J.M.; Paul M.G. Emmelkamp (February 2012). "Obsessive–compulsive personality disorder: A review of current empirical findings" (http://dx.doi.org/10.1002/pmh.144). *Personality and Mental Health* **6** (1): 1–21. doi:10.1002/pmh.144 (http://dx.doi.org/10.1002%2Fpmh.144). Retrieved 14 March 2013.
61. ^ "An Empirical Investigation of Jung's Personality Types and Psychological Disorder Features" (http://www.uccs.edu/Documents/dsegal/An-empirical-investigation-Jungs-types-and-PD-features-JPT-2.pdf). *Journal of Psychological Type*/University of Colorado Colorado Springs. 2001. Retrieved August 10, 2013.
62. ^ Lilenfeld et al. (1998). A Controlled Family Study of Anorexia Nervosa and Bulimia Nervosa. *Arch Gen Psychiatry*. 55:603–10.
63. ^ Anderluh MB et al. (2003) Childhood obsessive–compulsive personality traits in adult women with eating disorders: defining a broader eating disorder phenotype. *Am J Psychiatry*. Feb. 160: 242–47.
64. ^ Fineberg, NA; Punita Sharma; Thanusha Sivakumaran; Barbara Sahakian; Sam Chamberlain (8 May 2007). "Obsessive-Compulsive Disorder and the Anal Character: A Historical Perspective". *Does Obsessive-Compulsive Personality Disorder Belong Within the Obsessive-Compulsive Spectrum*. 12 **6** (CNS Spectr): 467–474, 477–482.
65. ^ Rheaume, J; , Freeston MH, Dugas MJ, Letarte H, Ladouceur R (1995). "Perfectionism, responsibility and obsessive-compulsive symptoms". *Behav Res Ther*. 33 **33** (7): 785–794. doi:10.1016/0005-7967(95)00017-R (http://dx.doi.org/10.1016%2F0005-7967%2895%2900017-R). PMID 7677716 (https://www.ncbi.nlm.nih.gov/pubmed/7677716).
66. ^ Foa, EB; Kozak MJ; Goodman WK; Hollander E; Jenike MA; Rasmussen SA (1995). "obsessive-compulsive disorder". *DSM-IV field trial*. 152 (Am J Psychiatry): 90–96.

Further reading

- Baer, Lee. (1998). "Personality Disorders in Obsessive–Compulsive Disorder". In Obsessive–Compulsive Disorders: Practical Management. Third edition. Jenike, Michael et al. (eds.). St. Louis: Mosby.
- Cheeseman, Gwyneth D. (2013). "All You Need To Know About OCPD and Perfectionism". Willows Books Publishing. UK. OCPD Tightrope Walking (http://www.lendingtheway.com/tightrope/OCPD3.pdf)
- Freud, S. (1959, original work published 1908).*Character and Anal Eroticism*, in The Standard Edition of the Complete Psychological Works of Sigmund Freud, 9, 170–71. James Strachey, ed. London: Hogarth.

ISBN 978-0-7012-0067-1 ISBN 0-7012-0067-7

- Jenike, Michael. (1998). "Psychotherapy of Obsessive–compulsive Personality". In Obsessive–Compulsive Disorders: Practical Management. Third edition. Jenike, Michael et al. (eds.). St. Louis: Mosby.
- Kay, Jerald et al. (2000). "Obsessive–Compulsive Disorder". In Psychiatry: Behavioral Science and Clinical Essentials. Jenike, Michael et al. Philadelphia: W. B. Saunders.
- MacFarlane, Malcolm M. (ed.) (2004). *Family Treatment of Personality Disorders. Advances in Clinical Practice*. Binghamton, NY: The Haworth Press.
- Penzel, Fred. (2000). *Obsessive–Compulsive Disorders: A Complete Guide to Getting Well and Staying Well.* Oxford University Press, USA. MPN 0195140923
- Ryle, A. & Kerr, I. B. (2002). *Introducing Cognitive Analytic Therapy: Principles and Practice*. Chichester: John Wiley & Sons. ISBN 978-0-470-85304-7.
- Salzman, Leon. (1995).*Treatment of Obsessive and Compulsive Behaviors*, Jason Aronson Publishers. ISBN 1-56821-422-7

External links

- DSM IV-TR year 2000 criteria for OCPD (http://www.behavenet.com/capsules/disorders/o-cpd.htm)
- MedlinePlus Encyclopedia *Obsessive–compulsive personality disorder (http://www.nlm.nih.gov /medlineplus/ency/article/000942.htm)*

Categories: Cluster C personality disorders | Psychiatric diagnosis | Personality disorders | Habit and impulse disorders

---