

OBSESSIVE-COMPULSIVE PERSONALITY STYLE AND DISORDER

THE OBSESSIVE-COMPULSIVE PERSONALITY TYPE IN A NUTSHELL

“The essential feature of *OBSESSIVE-COMPULSIVE PERSONALITY DISORDER* is a preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency.”¹

The obsessive-compulsive pattern is “a devise for preventing any thought or feeling that could produce shame, loss of pride, a feeling of deficiency or weakness.”²

Compulsive behavior is “a neurotic strategy that protects these individuals from exposure to any thoughts or feelings that could endanger their physical or psychological existence.”³

A CLOSER LOOK

Many people recognize the obsessive-compulsive person as someone who washes their hands five hundred times a day – sometimes separated by only a few minutes. While this may be a “classic” example of a compulsive behavior, it may not be a good example because it is too restrictive in scope.

Before going further, we need to define the terms “obsessive” and “compulsive.” That will begin to shed more light on this disorder and the maladaptations associated with the personality style.

Obsessions are persistent, repetitive thoughts that seem to intrude upon the mind and are either meaningless or frightening to the individual. *Compulsions* are performed to relieve the anxiety caused by the obsessive thoughts. They can be behaviors or thoughts.

Thus, the person who has repetitive thoughts about catching some disease from touching things in their environment will engage in the compulsive behavior of washing their hands every time the obsessive thought comes into their mind.

Over the years, psychological research has broadened the understanding of this personality type. The “classic” compulsive behavior is now only one small facet of the whole scope of obsessive-compulsive behaviors. Many of the obsessive and compulsive behaviors associated with this personality type are much more subtle.

¹ American Psychiatric Association: *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION, TEXT REVISION (DSM-IV-TR)*. Washington D.C., American Psychiatric Association. 2000. p. 725.

² Salzman, L. *TREATMENT OF THE OBSESSIVE PERSONALITY*. Jason Aaronson. New York, 1980. As cited in the *HANDBOOK OF DIAGNOSIS AND TREATMENT OF DSM-IV-TR PERSONALITY DISORDERS* (second edition) by Len Sperry, pg. 180.

³ *Ibid.* p. 181.

The research community now recognizes groups of obsessive thought patterns. They include:⁴

- Obsessive thoughts about sexual issues
- Obsessive thoughts about environmental contamination
- Obsessive thoughts about religion
- Obsessive thoughts about harm, danger, loss, or embarrassment
- Obsessive thoughts about magical practices or superstitions
- Obsessive thoughts about body image
- Obsessive thoughts about perfection

Compulsive behaviors are used by an individual who has obsessive thoughts as a “response” to those obsessive thoughts. The compulsive behavior “answers” the obsessive thought. Thus, if the individual is obsessed with their environment being full of germs (the obsessive thought), they will wash their hands every time the obsessive thought enters their mind (the compulsive behavior).

Compulsive behaviors are a response to an obsessive thought pattern. They include:⁵

- Behaviors associated with eliminating contamination
- Behaviors associated with hoarding useless objects
- Behaviors associated with checking things
- Behaviors associated with magical thinking
- Behaviors associated with perfection
- Behaviors associated with counting things for no reason
- Behaviors associated with touch and movement
- Behaviors associated with self-mutilation and self-hurt
- Behaviors associated with the individual’s body image
- Behaviors associated with grooming
- Behaviors associated with protection

Further research has again broadened the scope of this personality type. Penzel has indicated that the act of compulsion may exist on a continuum from truly compulsive behaviors (e.g. hand washing) to impulsive actions that are not so readily “connected” to the obsessive thought complexes.⁶

At one end of the continuum, we find true compulsivity including over control, avoidance of harm, and fear of one’s impulses. At the other end of the continuum we find purely impulsive behaviors that are under controlled (or even uncontrolled), risky and potentially dangerous behaviors, and complete spontaneity. The key element, however, is that the compulsive/impulsive behavior is always associated with an obsessive thought (or, in some cases, with an obsessive feeling that might not actually be a cognitively

⁴ Penzel, Fred Ph.D. *OBSESSIVE-COMPULSIVE DISORDERS – A complete Guide to Getting Well and Staying Well*. Oxford University Press., New York, New York. 2000. See pp. 211, 212.

⁵ Ibid, p. 237, 238.

⁶ Ibid, p. 7.

recognizable thought).⁷ The bottom line is that these compulsions are a response to a perceived threat from the environment. They are an effort to do away with that perceived threat.

It is my own belief that the determining factor that regulates whether compulsive reactions will be true compulsive behaviors or more impulsive behaviors is associated with the psychosocial phase of childhood development in which the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* developed. If the imprinting on the individual's psyche occurred early in child development (pre-vocal) then the tendency will be toward impulsiveness.⁸ If, however, the imprinting on the personality occurred later – in the post-verbal stage of development – then the behaviors will be more traditionally compulsive in nature.

THE BOTTOM LINE

Control of the environment is a key element associated with the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*, especially when the individual is in crisis. The individual will be preoccupied with “orderliness, perfectionism, and mental and interpersonal control” in frantic efforts to avoid losing control over whatever obsesses them. Their “compulsion of choice” will be a direct response to their fear of losing control (as dictated by the obsession). Thus, personality crisis “trigger events” are all associated with environmental factors that present situations in which the individual perceives they could lose control. Usually, there is a “breakdown” in the effectiveness of the compulsive behavior so that the behavior no longer functions effectively to protect them in their environment.

Another essential factor associated with the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* in distress is their need to avoid affective expression. These individuals reject softer emotions, sometimes even to the point of revulsion. Any environmental factor that presents charged emotions may precipitate a crisis in this personality type.

The emotional response of choice for this individual will be hostilities – including anger and rage. They will use hostilities to “push away” significant others with whom they must interact emotionally. When the individual is no longer able to avoid emotions that they cannot face, they may physically remove themselves from the place or places wherein those emotions are engendered.⁹

In summary, Penzel says,

⁷ It appears that if the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* was imprinted prior to vocalization abilities in childhood that the obsessive “thinking” may be more “feeling” than actual logical thought processes.

⁸ When research concerning personality development is examined, it appears that those issues that were imprinted on the personality structure of a child prior to the time that the child could talk seem to be more “automatic” and non-conscious in performance. The imprint on the child is not associated with verbal reasoning abilities – only with “pictures” and images. This presents a potential complexity in therapy since the use of reason with a client may not be as effective as the therapist might hope.

⁹ The inability for individuals to face “softer” emotions is a common element in most maladaptations in personality style. Softer emotions demand vulnerability. These individuals are unable to be placed in situations of emotional vulnerability since that would mitigate a loss of control. Loss of control is not acceptable. The therapist must understand that avoidance of these emotions will disallow progress in therapy. Furthermore, in the case of the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*, if the crisis in which the client is engaged is disruptive enough to the psyche of the client, psychosis may be the result (likely *Brief Reactive Psychosis*). The potential onset of psychosis in the client may be indicated by their use of more maladaptive defense mechanisms (especially those from level #4 or above). This is largely due to *decompensation* (the breakdown of previously working methods of defense or, in this case, failure of their compulsive behaviors to protect them from environmental changes).

Compulsive “activities are unpleasant, repulsive, senseless, or even disgusting to the person doing them, even from the beginning. They do not seem natural or appearing in any way, and *they are done in order to relieve anxiety and doubt* – not to give the person some kind of ‘high,’ lift, or pleasure....”¹⁰

Compulsive behaviors are used for the purpose of relieving both anxiety and doubt. The behavior reassures the individual that they are in control of their environment. When the prospect of compulsive behaviors failing is apparent to the individual, a crisis will likely ensue.

TECHNICAL DSM-IV-TR CRITERIA FOR DIAGNOSIS OF A FULL PERSONALITY DISORDER

The official DSM-IV-TR diagnostic criteria for *OBSESSIVE-COMPULSIVE PERSONALITY DISORDER* are: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 over-conscientious, 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.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by early adulthood. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

¹⁰ Penzel, *OBSESSIVE COMPULSIVE DISORDERS*, p. 293.

¹¹ *DSM-IV-TR*, p. 729.

DIFFERENTIAL DIAGNOSIS

There are a number of other disorders that contain similar characteristics to *OBSESSIVE-COMPULSIVE PERSONALITY DISORDER*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

NARCISSISTIC PERSONALITY DISORDER. The *NARCISSISTIC PERSONALITY TYPE* contains elements of perfectionism. That personality type posits the belief that the individual has already achieved perfection, whereas the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* is self-critical of their lack of perfection and is on an endless quest to achieve it.

ANTISOCIAL PERSONALITY DISORDER. The *ANTISOCIAL PERSONALITY TYPE* will indulge themselves while the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* is generally miserly concerning everyone, including themselves.

SCHIZOID PERSONALITY DISORDER. Both of these disorders tend toward detachment from social situations. With the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* this detachment stems from discomfort with emotions (especially emotions that leave the individual emotionally vulnerable) and excessive devotion to work while with the *SCHIZOID PERSONALITY TYPE* there is a fundamental lack of capacity for intimacy.

PERSONALITY DISORDER DUE TO GENERAL MEDICAL CONDITION. These two conditions/disorders may co-exist. However, the *OBSESSIVE-COMPULSIVE PERSONALITY DISORDER* must exist prior to the change in medical condition.

CHRONIC SUBSTANCE ABUSE. These two conditions/disorders may co-exist. However, the *OBSESSIVE-COMPULSIVE PERSONALITY DISORDER* must exist prior to chronic substance abuse.

COMMONLY ASSOCIATED AXIS I DISORDERS

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*. The therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

ANXIETY DISORDERS. Since the core of the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* seeks to control the environment in order to prevent shame, the loss of pride, and feelings of weakness, these individuals are often overly vigilant. Their over vigilance many result in a number of anxiety disorders.

OBSESSIVE-COMPULSIVE DISORDER. *OBSESSIVE-COMPULSIVE DISORDER* is an *Axis I Disorder*. It is slightly (but significantly) different in diagnosis than *OBSESSIVE-COMPULSIVE PERSONALITY DISORDER* (an *Axis II Disorder*). The therapist is encouraged to examine the criteria for *OBSESSIVE-COMPULSIVE DISORDER* since many times both Disorders co-exist. Furthermore, an individual with an *OBSESSIVE-COMPULSIVE PERSONALITY STYLE* (and not a *Personality Disorder*) many exhibit *OBSESSIVE-COMPULSIVE DISORDER*.

SOCIAL PHOBIAS AND OTHER PHOBIAS. The *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* fears rejection and loss of control. This is one of the components associated with its etiology. This fact may be one of the reasons for the formation of anxiety states. In addition, it may result in social phobias or phobias associated with a variety of other issues that might be considered threatening to the individual's ability to control their environment.

MOOD DISORDERS. Various *Mood Disorders* may be present with the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*. These may include *Major Depression Disorder*, *Cyclothymic Disorder*, *Dysthymic Disorder*, and (less likely) *Bipolar Disorder*.

EATING DISORDERS. Since the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* is associated with issues of control, there is a potential for these individuals to exhibit eating disorders. This is especially true if their obsessions are related to body image issues. Usually, the eating disorders associated with the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* will be either *Bulimia* or *Anorexia*.

Some recent research, however, has indicated that morbid obesity¹² may also be associated with the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*.¹³ Technically, obesity is not considered as a *DSM-IV-TR Disorder* on any *Axis* other than *Axis III* (Medical Condition).¹⁴ There are indications, however, that morbid obesity may have significant psychological associations.

One of the most significant maladaptations of the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* is emotional isolation. Individuals with this personality type usually do not exhibit softer emotions as part of their usual emotional expression. Furthermore, these individuals typically reject those same emotions when they are demonstrated by others. They may even do so with substantial vigor – using anger or some other form of hostile behavior to stem off softer emotions.

It is probable that food consumption could be used as a compulsive behavior under certain circumstances. This is likely under two conditions: 1) when the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* was formulated during the oral stage of psychosocial development,¹⁵ and 2) the primary obsession is avoidance of emotional vulnerability.

¹² In medical terms, morbid obesity is excess weight above 120% of suggested normal weight. That would mean that an individual who should weigh 150 pounds actually weighs 180 pounds. The presence of significant health compromises directly associated with excess weight acts to confirm the diagnosis of morbid obesity. Health compromises would include *Type II Diabetes*, *hypertension*, and *heart disease*.

¹³ These topics related to obesity, sexual abuse, revulsion from emotion, and *OBSESSIVE-COMPULSIVE PERSONALITY* are discussed by Dr. Raymond Richmond. See *A Guide to Psychology and its Practice* (available by searching the Internet). The discussion here is a synopsis of his thoughts.

¹⁴ This is likely to change with the next edition of the DSM.

¹⁵ Thus, an orally satisfying agent will be chosen for the compulsive behavior. Oral agents would be any substances that directly involve the mouth -- food, drugs, alcohol, etc. A typical parental behavior that might aid in the development of the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* would be the over pacification of the infant. Many parents use a pacifier to stop all vocal emotional expressions of an infant. This prospect instills within the infant two maladaptive imprints: 1) emotion must always be stopped, and 2) the primary means of stopping emotional response is by putting something in the infant's mouth. Therefore, when the adult who was over pacified as an infant encounters emotion, they respond by putting something in their mouth. Whatever emotion the adult feels, it is an occasion to eat! If this is the case, the obesity cannot be resolved until the individual learns to encounter their emotions.

In this case, the primary obsessive “thought” would be more “feeling-based.”¹⁶ When the environment of the individual demands significant (expected) interaction that involves emotional vulnerability (the obsession) the individual might respond with an oral fixation as a primary compulsion (intake of food). This compulsion serves two purposes: 1) it acts as a “placebo” to pacify the obsessive feeling, and 2) it creates body mass for the purpose of insulating an individual from other people. In essence, the individual perceives that obesity makes them less appealing. Since they perceive that they are less appealing, they “believe” that the demands for emotional vulnerability will be lessened.¹⁷

THE OBSESSIVE-COMPULSIVE PERSONALITY CONTINUUM

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the “triggers” that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting “value” for each person. A stressor that might cause significant personality disruption in one person might not effect another at all.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,¹⁸ the optimally functioning *OBSESSIVE-COMPULSIVE PERSONALITY STYLE* contains nine elements. Correspondingly, there are nine elements that indicate the breakdown of each of those nine optimally functioning elements. As an individual “trades off” each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical manifestation of *OBSESSIVE-COMPULSIVE PERSONALITY DISORDER* traits. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *OBSESSIVE-COMPULSIVE PERSONALITY STYLE* without allowing for diminution toward more maladaptive traits.

¹⁶ See the discussion above under “A Closer Look” regarding pre-vocal onset of the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*.

¹⁷ The therapist should understand that when a female (especially) uses morbid obesity as a defense against emotional vulnerability, this might be an indication of child sexual abuse that is not cognitively recognized by the individual. If this is the case, it only complicates the issue of emotional vulnerability. Other key indicators of child sexual abuse may be present (although those indicators are not an “acid test” of sexual abuse). Those indicators are associated with sexual dysfunctions including sexual frustration, lack of sexual desire, and inability to achieve orgasm with their partner (but not necessarily a complete inability to achieve orgasm). The therapist should not assume that these indications absolutely prove sexual abuse. That is not the case. These are only secondary (but yet important) indicators.

¹⁸ Sperry, Len, M.D., Ph.D. *HANDBOOK OF DIAGNOSIS AND TREATMENT OF DSM-IV-TR PERSONALITY DISORDERS* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 177.

Sperry's continuum includes the following nine elements:

Optimal Functioning	Maladaptation
<ul style="list-style-type: none"> • This person has a desire to complete tasks and projects without flaws or errors. • This person takes pride in doing all jobs and tasks well, including the smallest details. • This individual tends to want things done “just right” with some tolerance for things being done another way. • This individual is dedicated to working hard and is capable of intense, single-minded effort. • This person carefully considers alternatives and their consequences while making decisions. • This person tends to have strong moral principles and strongly desires to do the right thing. • This person is a no-nonsense individual who does work without much emotional expenditure. • This person is generally careful, thrifty, and cautious but able to share from their abundance. • This person tends to save and collect objects and may be reluctant to discard objects. 	<ul style="list-style-type: none"> • This person is a perfectionist to the point of interference with job completion. • This person is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost. • This individual has an unreasonable insistence that others submit exactly to their way of doing things because of the conviction that they will not be done correctly otherwise. • This individual has an excessive devotion to work and productivity to the exclusion of leisure activities and friendships. • This person is indecisive – decision-making is either avoided, postponed, or protracted. • This person is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values. • This individual displays a restructured or manufactured affection (emotional state). • This individual displays a lack of generosity in giving time, money, or gifts when no personal gain is likely to result. • This individual is unable to discard worn-out or worthless objects even when they have no sentimental value.

THE OBSESSIVE-COMPULSIVE STYLE IN CRISIS

The following behaviors will likely manifest when an individual with an *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* faces a triggering event. In the case of the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*, triggering events will be those events that cause anxiety

and/or doubt that cannot be solved by compulsive behaviors. These events will likely be associated with loss of environmental control and disruption of the meticulous security system that the individual has created.

- Obsession with their “compulsion of choice” in an attempt to regain environmental control.
- Unreasonable, unrealistic, irrational and overbearing demands on others in order to “prove” to themselves that they can control their environment.
- Defensiveness, aggression and hostility toward “targets of opportunity” when external threats are perceived.
- Anger and/or rage in situations that are obviously out of their control.
- Discomfort with, avoidance of, and aggression toward individuals, relationships, or situations that illicit or demand emotional vulnerability and expression of softer emotions.
- Manifestation of *Axis I Disorders* when anxiety states cannot be managed through compulsive behaviors or other defense mechanisms.
- Bending of reality through use of defense mechanisms that involve image distortion. [The therapist must recognize that this event may be a precursor to psychosis.]
- Potential *Brief Reactive Psychosis* if/when decompensation occurs.

DISORDER ETIOLOGY AND TRIGGERS

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with an *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*.

PSYCHOSOCIAL ETIOLOGY OF THE OBSESSIVE-COMPULSIVE PERSONALITY TYPE

The formulation of personality (and, consequently, the potential for personality disorder) occurs during child development. No parent and no family environment is perfect. Thus, the imperfections of that home environment will lead to the development of some personality “skew.” That skew is called a personality style.

In cases where the home environment was significantly maladaptive, traumatic, or damaging to the psyche of the child, the potential for development of a full-blown personality disorder increases with the onset of early adulthood.

The following list contains likely issues that arose during childhood precipitating the formulation of the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*. Many of these issues will not be cognitively accessible to the client and there is a likelihood that many of these issues will be denied by the client. In spite of client denial (a common defense mechanism) these are the most commonly accepted reasons for the development of the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*.

The therapist must recognize the difference between an optimally functioning personality style and a personality that is moving (or has moved) toward disorder. The personality that is not in a state of disorder but skews toward the personality style may contain a few of the events from this list, some items may be repressed, or less severe family behaviors that follow the same “theme” may have existed (but not necessarily with the same intensity).

The therapist should not “automatically” assume that each of these items was a reality in the person’s home of origin. This list should be used for investigation and exploration in order that the therapist might understand the dynamics of the home of origin.

- Insufficient valuing by at least one parent. Compulsions are used to prevent shame, loss of pride, and feelings of deficiency or weakness. Perfectionism is an effort to gain the approval of the under valuing parent. Control becomes a key factor in the child’s behavior.
- Parental over control. Control is learned by the child through overly firm and punitive behaviors on the part of at least one parent. Sometimes the punitiveness is subtle and not necessarily vocalized. In this situation, the child learns which behaviors are acceptable and repetitively performs those behaviors.
- An obsessive-compulsive parent. A child who grows up in a home where at least one of the parents is *Obsessive-Compulsive*, may themselves develop an *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* as an adult. This child does not develop options in life but simply learns to do what they have already seen in the home. This presents a problem in life when the adult is faced with decisions that must be made that were not part of the home experience.
- An emotionally restricted environment. This home is focused on productivity and hard work. Emotions (especially softer emotions that mandate emotional vulnerability) are strongly discouraged. There may be subtle punitiveness for expression of those emotions. Emotions associated with vulnerability are considered dangerous and a sign of weakness.
- Family behavior patterns to investigate at the disorder level include relentless coercion to perform correctly; discouragement of emotions that lead to vulnerability; emphasis on orderliness; harsh moralism or rule-keeping; condemnation and persecution of others who are different; racism; at least one cold and controlling parent; no rewards for success; unmoderated power on the part of at least one parent; focus on child’s mistakes; child was given enormous responsibility with no rightful power; and, the desire of the child not to rebel and face punishment as observed with one or more siblings.¹⁹ This was a cold, calculated, controlled, emotionless, environment with no rewards.

[The above inventory *does not* contain biochemical considerations associated with the etiology of the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*. The therapist should understand

¹⁹ Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same “theme” may be indicated.

that there might be biochemical issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

DISORDER TRIGGERS

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with an *OBSESSIVE-COMPULSIVE PERSONALITY STYLE*. Each of these relates to loss of environmental control or elevation of anxiety.

Issues with Authority. A wide variety of issues associated with authority structures can act as a triggering event for the onset of *OBSESSIVE-COMPULSIVE PERSONALITY STYLE* maladaptations. The issues may range from confrontation by an authority figure or the need for the individual to confront an authority figure. Generally, any conflict with authority can precipitate the escalation of maladaptive traits. Authority figures may include everyone from superiors at work to the individual's spouse.

Unstructured Situations. Since the core of the *OBSESSIVE-COMPULSIVE PERSONALITY STYLE* demands order, structure and ability to control the individual's environment, any unstructured situation or event may trigger maladaptation. The potential for an unstructured situation to trigger maladaptive behaviors will depend on the perceived threat to the individual's ability to control their environment. If the unstructured situation presents significant potential for loss of control or the need to "face the unknown" the risk of crisis greatly increases.

Relationship Demands. Significant demands from intimate relationships or very close friendships may precipitate a movement toward maladaptive behaviors. This is especially true if those relationships mandate emotional vulnerability. The prospect of emotional vulnerability is very likely to precipitate an active crisis

TREATMENT COURSE FOR OBSESSIVE-COMPULSIVE PERSONALITY ISSUES

The following is a summary of treatment objectives when a therapist is dealing with an *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*. As is the case with any client engagement, when the therapist feels that they are not capable of dealing with a specific case, the case should be referred to another therapist. Furthermore, in the event that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should be referred.

POTENTIAL MALADAPTIVE DEFENSE MECHANISMS

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are maladaptive defense mechanisms that certain personality styles "favor" over others. The therapist should thoroughly research all defense mechanisms that the client might be using.

There are seven major defense mechanisms that are commonly used by individuals with the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*. Three of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

Intellectualization. This mechanism involves the excessive use of abstract thinking or intellectual reasoning to minimize emotional discomfort. This is a mechanism of choice for the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* since these individuals usually reject softer emotions and emotional vulnerability in favor of a constricted affective range. [Level #2 – Mental Inhibitions Level]

Isolation of affect. This mechanism involves the segregation of cognitive “facts” from the feelings that were originally associated with them. Only the cognitive elements remain and the emotions are disposed of. This mechanism is used for the same reason as *Intellectualization*. [Level #2 – Mental Inhibitions Level]

Undoing. With this mechanism, the individual uses words or behaviors in order to negate or make amends symbolically for unacceptable thoughts, feelings, or actions. For example, when an *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* uses anger to stem off the appropriate softer emotions of a spouse, they may later buy something for the spouse to “make up” for the angry outburst. This action enables the person’s behaviors by allowing them to “fix” their negation of the spouse’s emotions. [Level #2 – Mental Inhibitions Level]

Reaction Formation. In this case, the client substitutes their “real” behaviors, thoughts, and/or feelings with behaviors, thoughts, and/or feelings that are not from their reality. This is usually done out of fear of loss of social acceptability. For example, someone with “secret” homosexual desires openly espouses hatred toward homosexuality. [Level #2 – Mental Inhibitions Level]

Projection. The client falsely attributes their own unacceptable feelings, impulses, or thoughts onto another person without justification. This is usually a guilt-based reaction to their own perceived negative aspects. Rather than deal with those aspects in themselves, they *project* them onto someone for purposes of judgment. [Level #4 – Disavowal Level]

Acting Out. The client commits physical actions directly in response to internal reflections and feelings of affective states. These actions may be dangerous actions at times including attempted suicide and acts of violence toward others. Another likely form of acting out related to an *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* crisis might be the client removing themselves from the environmental situation that they perceive is causing their distress. They may quit their job or suddenly abandon their family. [Level #6 – Action Level]

Apathetic Withdrawal. The client withdraws from any attempts to deal with the internal or external stressing events or the affective states associated with those stressors. The client no longer wishes to discuss the stressor nor do they desire to work toward resolution. The client is now “frozen” in their crisis. [Level #6 – Action Level]

THE TREATMENT PROCESS

Prior to Therapeutic Intervention

The first course in treatment for the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The *Addictions and Dependency Scale* may also be an important tool since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the 50% threshold. This is not abnormal.²⁰ Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to all personality type elevations will likely be significant issues for the client

Objectives of Therapy

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

Early in the treatment phase, the therapist should inventory the obsessions and compulsions of the client. The therapist should determine the "benefit" that the obsessions and compulsions have to the client. When the therapist correlates all of this data, they will be able to focus treatment. Based on the previous client interview, the therapist may be able to determine the relative etiology of the maladaptation in the client's home of origin.

If the client is in extreme crisis, the therapist should investigate the locus of that crisis. There will likely be issues of control that have been threatened. The client will be suffering from specific threats to their security. These will be unacceptable to the client and will result in continued escalation of the crisis unless the therapist helps the client reconcile those issues.

Since the client is deeply influenced by anxiety, guilt and insecurities about loss of control, the client will not open up to the therapist until there is some elevation in the self esteem of the client. Although the client may portray themselves as quite self-assured, the

²⁰ If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET COUNSELING AND ASSESSMENT PERSONALITY STYLE ANALYSIS*. The therapist should carefully examine those results.

therapist should realize otherwise. The client is in fact threatened by everything in their environment. Boosting the client's self-esteem must be the first order of therapy.

Once the therapist has the confidence of the client, the therapist should begin to help the client understand the functionality of their obsessions and their compulsions. This is a frightening prospect for the client since the client will recognize the immediate threat to their control. This will likely increase the client's anxiety level.

The client will make attempts to forestall therapy. This will often be done creatively by using long and elaborate discussions that contain minute details that are unnecessary. The therapist should realize this tactic and cut it off. The client may also change the subject in the midst of discussion to something that they have more control over.

One of the key elements in the client moving forward in therapy is the recognition that their personality structure is a defense against accepting their own weaknesses. Little or no progress can be made in therapy until a client understands that their compulsions are a defense against their own weaknesses.

The client must realize that their behaviors defend against deep feelings of insecurity and uncertainty. It is for this reason that their environment must be filled with structure and security. All situations in which the client will not have complete control will arouse anxiety. (The arousal of anxiety feelings associated with unstructured environmental issues is a good place to begin unmasking of the client's maladaptive affective state.)

The therapist should uncover the client's unrelenting standards. During the interview process, the therapist will uncover the client's unrealistic goals for both themselves and for others. These unrealistic goals are all control-based.

The therapist will also note that the client is excessively punitive toward others. This was likely a key element in the client's home of origin. The client will "punish" both themselves and others for making errors. This is a common tactic when the client feels that emotions associated with vulnerability might be exposed.

The main issue with the client is affective restraint. Emotions that center around hostility are the core of the client's emotions. However, the client may not recognize or admit this fact. They will use *intellectualization* and *isolation of affect* to disprove this fact. When the therapist begins to unmask the client's hostility base, the client may react with hostile affects.

The therapist will discover that the client is largely unable to express emotions that might make them emotionally vulnerable to others. Salzman says that this is the core of the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*.²¹ Tender emotions are both dangerous and threatening. They are a sign of weakness and must be avoided – even condemned in others when they are seen.

The therapist should understand that the client may have a distorted concept of an "intimate" relationship. It is likely that the client views an intimate relationship as a relationship built on loyalty and trust and not on tender emotions that would lead to mutual emotional vulnerability. The client will have a hard time understanding the benefit of an emotionally vulnerable relationship since emotional vulnerability is strongly viewed as a weakness.

The therapist will need to spend considerable time and effort helping the client come in contact with those emotions experientially.

²¹ Salzman, L. *Compulsive Personality Disorder*. In Karasu, T. (Ed.), *Treatment of Psychiatric Disorders* (pp.2771-2782). Washington, DC: American Psychiatric Press. 1989.

Dangers of the Therapeutic Process

There are significant obstacles and potential dangers associated with the therapeutic process for the *OBSESSIVE-COMPULSIVE PERSONALITY TYPE*. These include the following:

- This client will exhibit significant anticipatory anxiety that might not be overtly evident to the therapist. Remember, the client needs to be in control of every situation – including their therapy. Anticipatory anxiety will be a constant reason for sudden termination of therapy. The therapist might not be aware of the anticipatory anxiety since it might surface after a session and result in the client never returning.
- The client may creatively terminate therapy by shifting the therapy from themselves to a spouse. The therapist must be aware that the client will do everything to shift the blame to someone else. The inexperienced therapist may fall prey to this tactic.
- If the therapist is successful in bringing about *decompensation*,²² the client may experience a *Brief Psychotic Reaction*.²³ The therapist needs to be prepared for this eventuality since it will be quite traumatic to the client and may be another reason for early termination of the therapy process. This is especially true if the client is currently engaged in a crisis that has significantly disrupted their ability to control their environment.
- In the case of a current crisis that is familial in nature, the therapist should realize that there is a potential for *acting out* on the part of the client. If the client cannot release their need for control and security, there is a possibility of them doing something rather extreme as a result of their psychological distress. This *acting out* may or may not be associated with a psychotic episode. *Acting out* may result in this individual suddenly abandoning their family unit in favor of maintaining control and preserving security.

Successful Completion of Treatment

Termination of treatment for *OBSESSIVE-COMPULSIVE PERSONALITY TYPE* maladaptation is indicated when the therapist has moved the individual substantially or completely to the optimal functioning side of the personality structure.

The key elements that must be accomplished are:

- Cessation of obsessive thinking and feeling styles.

²² *Decompensation* is the failure to maintain defense mechanisms that have been useful to the individual in the past. When these defense mechanisms are removed, the client is often faced with stark realities that they have never been able to see. Thus, there is the possibility of psychotic symptomology associated with the successful removal of defense mechanisms. This should be viewed as a positive step forward by the therapist. However, the therapist must earnestly seek to reconstruct the client's motivations so that the defense mechanisms are not re-engaged and so that the disconnection from reality is eliminated.

²³ This is especially true on two accounts: 1) if the client is currently in a crisis situation, or 2) if the client's *Disorder Score* is significantly elevated toward *Disorder* rather than *Style*.

- Cessation of the compulsive behavior.
- Release of unrelenting standards for self and others.
- Ability to accept “unsecure” situations in life without extreme emotional distress or need to control.
- Cessation of punitiveness toward others.
- Removal of inappropriate use of hostile emotional expressions.
- Expression of a full range of emotions including the softer emotions and engagement in a mutually satisfying emotional relationship of vulnerability.

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