Psychogenic Diagnostics and the DSM-5: Distinguishing Idiosyncratic Characteristics from A Clinical Disorder using the Obsessive-Compulsive Designation as an Example

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The field of cross-cultural personality studies was born essentially following World War II and has grown exponentially since that time, particularly as western psychological theories and models have been exported and adopted throughout the scholarly world of research in psychology. The topic is too broad to attempt a serious address here. However, since the British and Australian psychology communities have registered a reasonable criticism of the DSM-5's seeming readiness to label a broad range of behavioral matrices as a "personality disorder" whereas in other societies and cultures such behavior could not possibly be considered a "disorder," it seems only right to make a comment regarding these divergences of opinion. The question posed in the title of this short essay is not to be discounted out of hand for making the distinction between a character trait and a personality disorder constitutes a major challenge owing to the flexible use of the concepts of both trait and disorder.

The range from "interestingly eccentric" to "pathologically diagnosable" is quite a stretch and depending on the social *milieu* in which the terms are applied, the difficulty in determining whose behavior is merely eccentric versus whose behavior is pathological is monumental. Having spent twenty years of teaching in the international summer program of Oxford University and being an alumnus of Harvard, Yale, and Princeton, I can report without hesitancy that a behavioral matrix of university faculty would find that a spectrum of monumental proportions could be described which would challenge any attempt at a consistency of definitional parameters for the distinction between trait and disorder, between eccentric and pathological. Behavior I have observed on the part of an Oxford don going about his regular business as a scholar and teacher in England would, alas, find himself quite isolated from a common acceptance at Harvard, Yale, or Princeton. What at Oxford would be considered quite acceptable, albeit possibly dismissed as merely a personal eccentricity would never pass at the Ivy League institutions. Interesting behavior, in other words, in Oxford would be disconcertingly diagnosable in the American university. Behavior that will gain one a clinical designation as psychopathological in an American university may very well merit admiration for the uniqueness of a behavioral pattern merely designated eccentric in a typical British university.

Given the fact that a research group at the Massachusetts Institute of Technology have identified no less than 638 character traits among humans, expressions of concern on the part of the British and Australian psychological community regarding the ready willingness to label some character traits under the DSM-5 as "personality disorders" surely constitutes the basis for some pausing and deliberating among psychotherapists across the international spectrum. Whereas in one setting a behavioral pattern may constitute a "debilitating impairment" to normal functionality, in another setting such behavior may not only be admissible but acceptable, even productive. I wish only here to register a concern that the psychological community proceed with caution, care, and sensitivity in the eagerness with which we identify a spectrum of

behaviors qualifying the diagnosis of a personality disorder without taking into account social and cultural values and environment across an international range of populations and sub-sets within those population.

In the case of obsessive-compulsive behavior, the term has fallen into popular usage by untrained lay people as a quick dismissive description of individual behavior which, within the professional community, is considered quite a complex matrix of behaviors. Within the professional psychotherapy and in within diagnostic psychopathology, we understand there to be levels of dysfunction which must be included in any diagnostic assessment of this presumed "disorder." We make a formal distinction, for instance, between Obsessive-Compulsive Behavior (OCB), Obsessive-Compulsive Disorder (OCD), and Obsessive-Compulsive Personality Disorder (OCPD). The distinctions, though subtle, are real and crucial in a refined diagnosis and treatment plan. Let us here explore more carefully with due documentation from the researchers in the field as a may of diverting and discouraging supervision layman's analysis.

In dealing with obsessive-compulsive behavior, we come to the individual suffering from an inordinate fixation on rules compliance, regulation enforcement, and the need for a supervised orderliness. This person may suffer from the *Obsessive-Compulsive Personality Disorder* (OCPD) and the drive towards perfectionism is counterbalanced by behavioral traits of inflexibility and extreme efficiency. The OCPD individual is frequently negligent in cultivating and maintaining social relationships owing to an inordinate commitment to "getting the job done." Following a tightly controlled list of duties and obligations in compliance with a pre-set scheduled timetable, this perfectionistic tendency often results in a failure to complete task leads to frustration, disappointment, and depression. The details of compliance commonly overshadow the "big picture" and, consequently, *minutia* trumps accomplishment. "Adequate" is not an acceptable word to describe their agenda or accomplishments and consequently they come across as rigid, controlling, and hardheaded in their dealings with others.

Though such conspicuous behavioral characteristics as being a miser and a workaholic are easily detectable in the obsessive-compulsive personality disorder (OCPD). Other strongly appearing traits constitute a behavioral matrix including a fixation on orderliness and cleanliness, perfectionistic and excessive attention to details, a strong sense of mental and interpersonal control over one's own affairs and those within one's social environment. This driving sense of environmental control – emotional, social, and physical – is usually at the expense of a functional capacity for flexibility, openness to new experiences and ideas, and overt efficiency (Pinto et al., 2008). A commitment to formulaic rituals in the performance of one's self-identified duties and obligations which often results in the diminishment of any real capacity for leisure and social relationships beyond superficial sociality and adherence to rituals may result in the necessity of dispensing with leisure activities and the cultivation of personal friendships (Murphy et al., 2009). The OCPD individual usually finds relaxation of a thorough-going sort difficult if not impossible to establish and maintain owing to the feeling that time is actually running out for the performance of their self-identified duties and that, indeed, the expenditure of even more effort is needed in order to meet these demands of duty and obligation. Minute planning of activities is a specific manifestation of the compulsive tendency to stay in control of their environment and a severe avoidance of unpredictable events, ideas, and circumstances is uniquely characteristic of the OCPD individual (Pinto et al., 2008).

A litany of primary symptoms for individuals suffering from obsessive-compulsive personality disorder (OCPD) include

- Preoccupation with minute details and facts

- Compliance with rules and regulations
- Compulsive list-making and schedules
- Rigidity and inflexibility of beliefs and ideas
- Perfectionist tendencies which impede task completion

These symptoms frequently produce acute distress and interfere with an individual's social functioning and a particular trait is that of early denial of symptom acknowledgement as a mechanism for avoidance of stress and anxiety produced by these symptoms.

One common but not pervasive behavioral trait among OCPD sufferers is an obsessive need for cleanliness and this, combined with an obsessive preoccupation with tidiness, sometimes makes daily life extraordinarily demanding and exhausting. Attributed to the strong tendency for control of one's physical and emotional environment and that of members of one's social group, there is the realization that control of one's own personality anxiety and stress levels is an abiding concern and frustration. An interesting characteristic of the compulsion to tidiness and cleanliness is the realization on the part of some OCPD individuals that a failure to maintain this matrix of organization can be countered with a strong tendency at hoarding as a substitute for organizational tidiness. Hoarding and the gathering of one's physical paraphenalia in daily living permits the postponement of planned organization, a plan which may never be implemented due to being overwhelmed by the growing work of hoarding and sorting, all of which increases anxiety and stress for the OCPD individual. Clustering and grouping, stacking and collecting, boxing and bagging, all become exacerbating traits for the sufferer of OCPD (Jefferys and Moore, 2008). The further tendency, dominant in many sufferers, of judging actions of oneself and those of others into right and wrong, good and back, and polarized categories with little room for flexibility often leads to a breakdown in social skills and interpersonal relationships. The rigidity of this formula for right and wrong, good and evil, frequently brings about strained and disruptive relationships within a family or social group dominated by an OCPD individual resulting frequently in frustration, anger, and occasionally violence. This is known within clinical circles as disinhibition (Villemarettte-Pittman, 2004). This tendency among OCPD sufferers is often clinically identified as resulting in various forms of pessimism and depression (Pilkonis and Frank, 1988; Rossi et al., 2000; Shea et al., 1992). Suicidal tendencies rarely but occasionally manifest themselves in these situations and one study has shown that personality disorders generally are a substrata of psychiatric morbidity and such behavioral matrices as manifested in OCPD may actually result in greater problems in functionality than even a major depressive episode (Skodol et al., 2002).

Clinicians are quick to point out that the causality and etiology of obsessive-compulsive personality disorder is unknown (Murphy et al., 2009) and it is considered by one school of clinical thought to be decidedly different from obsessive-compulsive disorder (OCD). This, alas, is a major source of contention within the metal health care professional community. Since the cause of both OCD and OCPD is uncertain, there is much latitude in the interpretation, description, diagnosis and treatment of this matrix of behavioral disorders, both sharing striking similarities, leading some clinicians and therapists to argue that they are insufficiently distinct to merit distinction! They share such behavioral traits as rigidity and ritual-like behaviors, hording, orderliness, and a need for symmetry and organization to characterize their physical environment. The differences between individuals suffering from OCD versus OCPD include the sense among the OCD person that these distinguishing traits are unwanted and undesirable and seen as unhealthy and the result of anxiety-induced and involuntary thoughts. On the other

hand, the OCPD individual is considered clinically "egosyntonic" (seeing themselves as both rational and desirable) and having a strong sense of the need for adherence to routines and a desirable inclination towards cautiousness and the pursuit of perfection in their tasks. Occurring more frequently among men (MedlinePlus), OCPD has been clinically determined to occur between 2% and 8% of the general population and upwards of 9% among psychiatric outpatients (Cain et al., 2014).

The irony of the relationship between OCD and OCPD, given their similarities while yet being diagnosably distinct, is that not infrequently some individuals actually suffer from both OCD and OCPD and are found in the same family according to clinical reports (Samuels et al., 2000), complicated by the frequent presence of an eating disorder as well. While OCD individuals feel a compulsion to continually repeat certain ritualistic acts, OCPD sufferers do not necessarily but do find distinct pleasure in completing and particularly perfecting a specially identified task while OCD sufferers more often than not are actually more stressed after completing a ritual action. Shared traits between the OCPD and OCD sufferer, however, commonly include such things as a perfectionistic drive, hoarding, and a conspicuous obsession with compliance to detail maintenance (which are three traits of OCPD) according to a major study of OCD-OCPD comparisons (Calvo et al., 2009). However, the reverse is also true, viz., certain identified OCD symptoms frequently are closely paralleled with OCPD symptoms and this similarity is particularly the case in what are referred to as symmetry symptoms. Both OCPD and OCD individuals are inclined to validate obsessions and compulsions which reflect symmetry and organization (Lochner, 2011) but a specifically characteristic symptom among OCD sufferers such as "washing" does not show signs of linkage to OCPD.

The complexity of the diagnostic distinction between OCD and OCPD is exacerbated clinically owing to significant similarities in symptomology when, for example, perfectionism is both an OCPD and OCD criterion involving the need for tidiness, symmetry, and organization while, according to the DSM-IV, hoarding is both a compulsion for OCD individuals as well as for OCPD sufferers. These redundancies of symptoms between the two disorders is a perpetual source of controversy and frustration within the treatment community (Pinto et al., 2008). It is at the point of functional symptomology that the distinctions between these two disorders are more easily identified. For example, OCD is often clinically described as invasive, stressful, time-consuming obsessions with habitual forms of behavior directed toward the reduction of obsession-induced stress. This is not the case with OCPD sufferers. Again, OCD symptoms sometimes are designated ego-dystonic owing to the experience of these actions as repulsive and alien to the sufferer, thus producing a greater mental anxiety among OCD individuals. However, OCPD individuals quite commonly find relief in such behavioral formulas which, for them, brings relief from OCPD symptoms, even though repetitive. They are not experienced by or seen to be repulsive but the thoughts, images, and their experience often brings relief from anxiety and offers stress reduction. We know clinically that OCPD behavior is classified as ego-syntonic owing to the fact that the OCPD sufferer views this behavioral matrix as suitable and correct. Perfectionism and inflexibility can produce anxiety and stress when not linked to the need of the OCPD individual for control over self and environment (Pinto et al., 2008).

A 2014 clinical study found also that a significant difference between the OCPD and the OCD sufferers had to do with the presence of behavior rigidity. The OCPD individual has a greater delayed gratification response than do both OCD individuals and those with health control capabilities (Pinto, 2014). As we know, delayed gratification is a measure of self-control and it demonstrates an individual's ability to suppress or restrain the impulse to seek more

immediate gratification in order to garner greater rewards for such behavior in the future. Interestingly enough, clinical studies using the criteria set by the DSM-IV have consistently found that high rates of OCPD traits appear in individuals with OCD with as much as 23% to 32% in those individuals. And, some clinical studies are now reporting that the specificity of linkage between OCPD and OCD is verifiably higher in individuals with OCD than in the healthy population using DSM-IV criteria.

As if there were not enough controversy about the relationship of OCD and OCPD already, clinical studies have verified the considerable similarities between OCPD and Asperger's syndrome (Gillberg and Billstedt, 2000) including such obvious behavioral characteristics as list-making, inflexibility in rule adherence, and obsessive aspects of Asperger's syndrome such as affective behaviors, worsening social skills, and intensity of intellectual interests. A 2009 study focusing on adult autistic individuals found that 40% of individuals diagnosed with Asperger's syndrome presented the same diagnostic requirements needed for a clinical co-morbid OCPD diagnosis (Hofrander et al., 2009). Comparative studies of OCPD and eating disorders, on the other hand, are considerably more extensive and filled with findings relevant to a more thorough treatment of such sub-sets of eating disorders as Anorexia Nervosa (AN). Early on researchers have been aware that personality rigidity and interactional stiffness have been linked to eating disorder, especially AN (Dubois, 1949; Helmi, 2005) and that differences between various studies as to the frequency of OCPD among anorexics and bulimics have been clinical verified. However, there is still some question as to the variance in methodology used for clinical assessment and the complexities of diagnosing personality disorders, and in this case, that of OCPD (Halmi, 2005).

Treatment outcomes for OCPD have proven most helpful when drawn from studies of eating disorders owing to the high prevalence of the overlapping of these personality disorders and their vulnerability to control issues (Lilenfield, 2006). OCPD sufferers manifest more severe anorexic symptoms (Crane, 2007), a worse remission rate, and the presence of aggravating behavioral matrices such as compulsive exercising (Davis, 1998). These two behavioral matrices, i.e., compulsive exercising and an eating disorder, show a longer duration of illness among anorexics (Halmi, 2000) and a conspicuous correlation between OCPD and eating disorder individuals, viz., that of perfectionism (Shroff, 2006). For years, researchers have recognized the linkage between perfectionist tendencies and Anorexia Nervosa and as early as 1949 studies indicate that the behavioral matrix among average anorexic girls showed them as "rigid" and "hyperconscious," tending towards "neatness, meticulosity, and a mulish stubbornness not amenable to reason (which) makes her a rank perfectionist" (Duboix, 1949).

Since the mid-1900s, researchers have known that perfectionist tendencies among anorexic individuals is a life-long behavioral trait and that actually before the onset of the eating disorder itself, generally in childhood (Anderluh, 2009), and often during an extended illness, perfectionism is clinically identifiable (Srinivasagam, 1995). A characteristic insistence upon "thinness" among anorexic girls and women is itself a manifestation of this behavioral trait of perfectionism characterized by the persistently unattainable goal of the ultimate performance of the perfectly thin person (Dura et al., 1989). Owing to the chronic nature of this obsession, individuals suffering from an eating disorder have a strong inclination to perfectionist traits in other regions of their personal lives besides dieting and weight loss and control. Such things as over-achievement at school and in the work place have been a consistently observed clinical

behavior among anorexics (Dura et al., 1989; Strober, 1981; Norris, 1979) attributed to their "over-industrious" behavior (Bruch, 2001; Vialettes, 2001).

A shocking study done in Sweden reports that hospitalization for eating disorders among girls was twice as frequent for those suffering from anorexia who took the advanced courses in school and had high achievement records above the average over against the average-performing girls (Ahren-Moonga, 2009). This link with over-achievement was reportedly extremely high among girls hospitalized for AN, reaching three and a half times greater percentages than commonly found among girls with average academic achievement levels (Ahren-Moonga, 2009). There is some indication that at least among individuals suffering from Bulimia Nervosa, there is a stress confliction between a tendency to impulsive behavior and perfectionism resulting in clinically diagnosable anxiety (Halmi, 2005).

Clinicians are quick to point out that, not unlike other personality disorders, there is no immediately identifiable cause of OCPD (Murphy et al., 2009) but it is felt by researchers that OCPD is linked in some fashion to both genetic and environmental factors. Genetic research suggests that individuals with a form of what is known as the DRD 3 gene will more likely develop OCPD as well as depression, particularly if they are male, than within the general population (Joyce et al., 2003). However, geneticists emphasize that these genetic propensities may actually remain inactive throughout early life until stimulated by some life-changing events or circumstances among those who are predisposed to OCPD, and then they emerge fully visible to the trained clinical professional. These behavioral "triggers" may include such things as a childhood trauma such as physical, emotional or sexual abuse. Environmental research suggests that OCPD is also a learned behavior and the family circumstances must not be discounted as a potential causation factor.

OCPD being characterized as an extensive complex of preoccupation behaviors with perfectionism, orderliness, and interpersonal and mental control even at the cost of actual efficiency, flexibility, and openness, the DSM-5 places OCPD in Cluster C of personality disorders (anxious and fearful) along with avoidant and dependent personality disorders. It suggests that symptoms indicating OCPD may appear in early adulthood and in a variety of contexts and situations. At least four of the following characteristics must be present in order for a clinically valid diagnosis of OCPD to be established (DSM-5, 2013: 678-682):

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.

Since 2000 at the time of the publication of the American Psychiatric Association's DSM-IV-TR edition of the diagnostic manual, there have been conflicting reports of clinical studies which have faulted the OCPD treatment. Four years later in 2004, there was a significant study challenging five of the eight criteria, the four which were not questioned were perfectionism, rigidity, stubbornness, and miserliness. Again in 2007, a study found that OCPD is etiologically distinct from the other two Cluster C disorders, i.e., avoidant and dependent personality disorders, and therefore accused the category of being adulterated by an unassociated disorder (Grilo, 2004; Reichborn-Kjennerud et al., 2007). On the other hand, the World Health Organization's ICD-10 listing of OCPD used the term anankastic personality disorder (F60.5), anankastic being a Greek derivative of the word for "compulsion." For the WHO's F60.5 label, at least three of the following must be present in any clinically diagnosed case of OCPD, called by the WHO APD. Here is the listing of those required traits and, as always, the requirement of the ICD-10 is that a diagnosis of any specific personality disorder must also satisfy a set of general personality disorder criteria:

- feelings of excessive doubt and caution;
- preoccupation with details, rules, lists, order, organization, or schedule;
- perfectionism that interferes with task completion;
- excessive conscientiousness, scrupulousness, and undue preoccupation with productivity to the exclusion of pleasure and interpersonal relationships;
- excessive pedantry and adherence to social conventions;
- rigidity and stubbornness;
- 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;
- intrusion of insistent and unwelcome thoughts or impulses.
- compulsive and obsessional personality (disorder)
- obsessive-compulsive personality disorder
- obsessive-compulsive disorder

Beyond the APA's DSM-5 and the WHO's ICD-10, the most recognized alternative or supplement to these two major world sources is the work of psychologist Theodore Millon who, in 2004, identified five subtypes of the compulsive personality found in the obsession-compulsive personality disorder individual. They are listed here (Millon, 2004):

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,	Empowered in formal organizations; rules of group provide identity and security; officious, high-handed, unimaginative,

	sadistic features	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, avoidant features	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.

The key to successful treatment of OCPD, and clinical evidence shows substantial success in its treatment, is for the sufferer to be willing and accepting of the treatment protocol. The traditional treatments include psychotherapy, cognitive behavioral therapy, and behavior therapy. In some instances and upon consultation with a psychiatric assessment, medication may be used. In the case of the use of behavior therapy, the OCPD client will discuss with the psychotherapist ways whereby the client may engage in the actual changing of identified compulsive behavior into a more productive, less stress-inducing behavioral pattern. Clinical reports have shown that cognitive analytic therapy (CAT) has a particularly attractive success record in threating OCPD individuals (Protogerou et al., 2008; Ryle and Kerr, 2002). However, in instances where the diagnosed individual is not willing to either accept the fact of their disability or refuse to adhere to a treatment protocol, the psychotherapist's work becomes extremely complicated and difficult. Often these individuals believe that their presenting symptoms are suggestive of some other factor or that their thoughts and behaviors are correct and not in need of altering or discarding. As mentioned above, in some psychiatrically diagnosed cases some types of medication have been experimented with but clinical evidence suggest that medication itself is relatively useless in the treatment of this personality disorder. In some instances, clinical reports indicate that possibly Serotonin Reuptake Inhibitors (SSRIs) have been marginally useful as a supplement to psychotherapy. In such cases, the client is aided with medication which allows them to be less burdened with a fixation on minor details and even less rigid in their compliance with rules and regulations and insistence that others likewise comply. Of course, such medications address the symptoms rather than the cause of the disorder.

The obsessive-compulsive personality disorder individual is, however, three times more likely to actually seek out and undergo psychotherapeutic treatment than individuals suffering from other major forms of depressive disorders (Bender, Doland and Skodol, 2001; Bender et al., 2006). Owing to the nature of this disorder which drives the individual, often, to actively seek help professionally, these individuals have a much higher rate of primary care utilization than the general population though, alas, there are to date no significant clinical studies of OCPD to suggest a consistent treatment resulting in measurable success across the spectrum (Bender et al., 2007; DeReus et al., 2012). Therefore, there is a continuing need for much more clinically controlled studies of OCPD in order to establish a measured rate of success in the treatment of

this disorder. The fact that upwards of 8% of the national popular has a prevalence of OCPD (DSM-5, 2012: 678-682) makes it the most common personality disorder within the national population (Grant et al., 2014). Occurring at a rate of upwards of 9% within psychiatric outpatient populations, OCPD occurs twice as frequently among men as among women (Cain et al., 2014).

The history of this disorder, traced from as early as Sigmund Freud, is a fascinating study of the evolution of psychological studies and the accelerating sophistication of the labeling agenda of the profession. In 1908, it was Freud who named what is now called obsessive-compulsive or anankastic personality disorder, giving it the name at the time of "anal retentive character." Freud was a consummate clinician and tracking this disorder over time with his patients he eventually proposed a series of traits characterizing this personality type. These included a preoccupation with orderliness, parsimony and frugality, and obstinacy including rigidity and stubbornness and these traits fit nicely with his overall concept of the theory of psychosexual development. OCPD as we know it today was first included in the DSM-II and was essentially based on Freud's concept of the obsessive personality or, in his terms, the anal-erotic character style which suggested orderliness, parsimony, and obstinacy (Pinto et al., 2008).

However and as anticipated in the historical development of psychological science, OCPD has experienced major transformational changes in description, etymology, and etiology since first introduced in the DSM-II. An illustration of these evolving developments is found in the DSM-IV which actually stopped using the two criteria system initially presented in the DSM-III-R, i.e., constrained expression of affection and indecisiveness, owing to clinical reviews based on empirical data which had established the fact that these particular traits did not, as a matter of fact, contain internal consistency (a major criterion for utilization in diagnosis). Since the early 1990s, there has been an increase in the data-based studies of clinical cases of OCPD and the discovery that it is a corollary to eating disorders and tends to run in families (Lilenfeld et al., 1998). A new discovery is that it quite commonly appears in childhood (Anderluh et al., 2003) and not just early adulthood.

Classified as a Cluster C personality disorder (anxious and fearful) in the DSM-IV, there is some controversy as to whether or not the categorization of OCPD should have been listed in that edition of the DSM as an Axis II anxiety disorder. There is some justified argument that it is more likely to be listed alongside obsessive-compulsive spectrum disorders including obsessive-compulsive disorder, body dysmorphic disorder, compulsive hoarding, trichotillomania (hair-pulling disorder), compulsive skin-picking, tic disorders, autistic disorders, and eating disorders (Fineberg et al., 2007). As we have discussed in some detail earlier, the DSM-IV tried unsuccessfully to make a clinically verifiable distinction between OCPD and OCD by shifting the description to the absence of obsessions and compulsions in OCPD because obsessive-compulsive personality traits are easily mistaken for abnormal cognitive processes or values presumed to undergird OCD. Some features, for example, of self-directed perfectionism including a belief in a perfect solution is possible and desirable, a feeling of discomfort if things have not been done correctly, and a tendency to doubt one's actions when something goes wrong, all are features of an enduring OCD (Rheaume et al., 1995). Predictably and in conclusion, it should be mentioned that in clinical studies of OCD patients, the DSM-IV reported

that a majority of these individuals actually doubted whether or not their obsessive-compulsive symptoms were not actually justified and, indeed, not unreasonable after all (Foa et al., 1995).

REFERENCES

(For complete reference citations, consult Dr. John H. Morgan's 2018 book titled, *Psychopathology: A Clinical Guide to Personality Disorders* (Mishawaka, IN: GTF Books).