

# Cognitive Therapy for Obsessive-compulsive Personality Disorder — a Pilot Study in Hong Kong Chinese Patients

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## Abstract

**Objective:** To assess the efficacy of cognitive therapy for outpatients with refractory depression and obsessive-compulsive personality disorder according to the Diagnostic and Statistical Manual of Mental Disorders-IV.

**Patients and Methods:** Patients with refractory depression and obsessive-compulsive personality disorder attending the outpatient department were enrolled in the study. All patients had moderate degrees of anxiety and depression, as well as high levels of hopelessness. The diagnoses were made according to the Structured Clinical Interviews for Diagnostic and Statistical Manual of Mental Disorders-IV Axis I disorder and Axis II personality disorders. All patients completed the following self-report questionnaires: Beck Depression Inventory, Beck Anxiety Inventory, Beck Hopelessness Scale, and Personality Belief Questionnaire prior to commencement of cognitive therapy. At the last session, the Personality Belief Questionnaire, and the Structured Clinical Interviews for Diagnostic and Statistical Manual of Mental Disorders-IV Axis I disorder and Axis II personality disorders were re-administered to assess the severity of the personality disorders after cognitive therapy. Medication doses were kept constant throughout the trial period.

**Results:** There were no significant differences in the clinical outcome parameters (depressive and anxiety scores and personality scores) between intake and commencement of cognitive therapy (3 months), suggesting that the participants were relatively stable in symptoms before commencement of therapy. After a mean of 22.4 sessions, there was a significant drop in all outcome parameters, suggesting that symptoms of depression and anxiety improved with therapy. Nine patients no longer fulfilled the Diagnostic and Statistical Manual of Mental Disorders-IV diagnosis of obsessive-compulsive personality disorder. Eight patients were also free from Axis I disorders.

**Conclusions:** This preliminary study suggested that cognitive therapy might be an effective psychological treatment for obsessive-compulsive personality disorder. However, further large-scale randomised controlled trials are needed before definitive conclusions can be drawn.

**Key words:** Asian continental ancestry group, Cognitive therapy, Hong Kong, Personality disorders

## Introduction

Obsessive-compulsive personality disorder (OCPD) is prevalent in the community<sup>1</sup> and among psychiatric patients.<sup>2</sup> Personality disorders are an overlooked and under-appreciated source of psychiatric morbidity.<sup>3</sup> In a recent multi-site natu-

ralistic collaborative longitudinal personality disorders study, patients with schizotypal and borderline personality disorder were found to have significant impairment in work and social relations.<sup>4</sup> When a traditional Diagnostic and Statistical Manual of Mental Disorders (DSM) categorical model was used to measure personality disorders, each personality disorder was found to have high rates of diagnostic stability.<sup>4</sup> Patients with personality disorders had more extensive histories of psychiatric outpatient, inpatient, and psychopharmacological treatment.<sup>5</sup> Current research data strongly suggest that OCPD remains unchanged in the absence of intervention.

There are some emerging research data that suggest OCPD is amenable to psychological intervention. In a randomised controlled trial, 81 patients with predominantly

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cluster C disorders (70%) showed significant improvement for measures of distress and social functioning after 40 sessions of 2 forms of dynamic psychotherapy.<sup>6</sup> Gains were maintained at follow-up after 18 months. In another uncontrolled study, 38 patients with avoidant and OCPD were treated with brief expressive-supportive psychotherapy.<sup>7</sup> Patients showed significant improvement in measures of distress, interpersonal problems, and personality functioning. In a recent randomised controlled trial that compared the effectiveness of brief psychodynamic psychotherapy and cognitive therapy for cluster C personality disorders, both groups were found to have significant improvement in symptoms, personality functioning, and interpersonal problems.<sup>8</sup>

To date, there is no research data on the prevalence of OCPD in Hong Kong. No study of the effectiveness of psychological intervention on OCPD in Hong Kong has been performed. This study was designed to assess the effectiveness of cognitive therapy for OCPD in Hong Kong Chinese patients.

## Patients and Methods

This was an uncontrolled prospective longitudinal study addressing the efficacy of cognitive therapy for outpatients with refractory depression and DSM-IV-defined OCPD. Psychiatrists in a general psychiatric unit were invited to refer patients for psychotherapy. The referral criteria were as follows:

- patients with depression with limited treatment responsiveness to adequate doses of antidepressants
- refractoriness was likely to be due to personality problems
- patients had expressed an interest in exploring their condition through psychotherapy.

During a 2-year recruitment period, 20 patients were referred. Inclusion criteria were age between 18 and 65 years and DSM-IV criteria for OCPD. All diagnostic evaluations were performed by the author using the Structured Clinical Interviews for DSM-IV Axis I disorder (SCID-I)<sup>9</sup> and Axis II personality disorders (SCID-II).<sup>10</sup> Exclusion criteria were current and past psychotic disorder, current substance abuse or dependence, organic brain disorder, active suicidal behaviour, and refusal to discontinue other active psychological therapy.

Ten patients fulfilled the inclusion criteria and were recruited for the study after providing informed consent. All patients completed the following self-report questionnaires: Beck Depression Inventory (BDI),<sup>11</sup> Beck Anxiety Inventory (BAI),<sup>12</sup> Beck Hopelessness Scale (BHS),<sup>13</sup> and Personality Belief Questionnaire (PBQ).<sup>14</sup> As cognitive therapy was provided solely by the author, there was a mean delay of approximately 3 months before patients could start therapy. At commencement of cognitive therapy, all participants were required to repeat the self-report questionnaires to confirm the stability of the symptoms. Three self-report questionnaires — BAI, BDI, and BHS — were completed weekly by the participants to assess their response to the intervention. For the purpose of this study, only the data from the last session were used for analysis.

At the last session, PBQ, SCID-I and SCID-II were re-administered to assess the severity of the personality disorders after cognitive therapy. Medication doses were kept constant throughout the trial period.

## Cognitive Therapy

The cognitive therapy sessions extended for 60 minutes and were held once weekly. The therapist had extensive experience and training in cognitive therapy for personality disorders. The treatment provided was based on the cognitive therapy manual on personality disorders.<sup>15</sup> The therapist taught participants to identify and evaluate key negative automatic thoughts and applied schema restructuring techniques to dispute core beliefs and to develop more adaptive beliefs and behaviours. Special attention was given to the development of a collaborative and trusting therapeutic alliance with the participants. Where appropriate, some modification in cognitive therapy techniques was made in order to enhance acceptability for Chinese patients.<sup>16</sup>

## Assessment and Outcome Measures

A measure of depressive symptoms was provided by the BDI and BHS. The BDI is a self-administered depressive scale measuring the extent of depressive symptoms. The BHS is a force-choice true/false dichotomous scale containing 20 items. Both scales have been well validated in Hong Kong.<sup>16,17</sup> A measure of anxiety symptoms was provided by the BAI. Axis I disorder was measured with the SCID-I. Personality disorder was measured with the SCID-II. Both the number of personality disorders and the number of criteria fulfilled in the diagnosis of the OCPD were recorded. The PBQ is a 126-item self-report measure to assess the degree of severity of clusters of dysfunctional beliefs compatible with various DSM-IV personality disorders. This scale was translated into Chinese for the purpose of this study.

The obsessive-compulsive sub-scale was the main focus of interest. This sub-scale measures beliefs reflecting themes of rigidity, stubbornness, and perfectionism. The Global Assessment of Functioning (GAF) Scale was used as an observer-rated scale that assessed the level of functioning in the previous 3 months.

## Statistical Analysis

Continuous data were analysed by using paired *t* tests to assess change over time. The *p* value was set at 0.05. The analyses were conducted by using the Statistical Package for the Social Sciences version 11.0.

## Results

Table 1 shows the baseline clinical and demographic data of the participants. The participants were predominantly women with a high level of education (university level). Two were married and 2 were unemployed. The patients had had depressive illness for a mean duration of more than 2 years

**Table 1. Clinical and demographic characteristics of the study population (n = 10).**

Characteristic	Value
Men:women	2:8
Mean age (range) [years]	36.5 (28-45)
Mean time in education (years)	16.0
Mean duration of depressive illness (range) [years]	2.9 (1-10)
Mean number of Axis I disorders/patient	1.5
Mean number of Axis II disorders/patient	2.5

and had been receiving antidepressant treatment for a mean duration of 1.5 years. All patients were taking therapeutic doses of selective serotonin reuptake inhibitors. Most patients had more than 1 personality disorder. The most common comorbid personality disorder was another cluster C personality disorder; 5 patients had dependent personality disorder, 2 had narcissistic personality disorder, 1 had borderline personality disorder, and 1 had paranoid personality disorder. All participants had a diagnosis of OCPD confirmed by the SCID-II interview. All patients also had major depressive disorder. The most common comorbid Axis I disorder was generalised anxiety disorder (n = 5), followed by panic disorder (n = 3), and obsessive-compulsive disorder (n = 2). Two patients had previously undergone psychodynamic psychotherapy.

The study participants received a mean of 22.4 sessions (range, 18 to 35 sessions) over a period of approximately 18 months (range, 9 to 24 months). There were no reports of self-harm, suicide, or violence to others. No patients withdrew from the trial.

Table 2 shows the change in clinical data during the trial period. There were no significant differences in clinical outcome parameters between intake and the commencement of cognitive therapy, suggesting that the participants had relatively stable symptoms before commencement of therapy. Patients had moderate degrees of anxiety and depression, as well as high levels of hopelessness. The level of global functioning before therapy was fair. The patients fulfilled a mean of 7 of 8 diagnostic criteria for OCPD.

**Table 2. Changes in clinical data during the study period.**

Outcome parameters	Enrolment	Pretreatment (3 months after enrolment)	Post-treatment
Beck Anxiety Inventory	21.4	20.6	11.4*
Beck Depression Inventory	27.0	27.2	10.9*
Beck Hopelessness Scale	16.6	16.2	5.7*
Global Assessment of Functioning Scale	55.6	55.4	80.0*
Personality Belief Questionnaire (OCPD)	41.8	39.8	10.9*
Number of DSM-IV criteria for OCPD	7.1	6.8	3.2*

Abbreviations: *DSM-IV* = *Diagnostic and Statistical Manual of Mental Disorders-IV*; *OCPD* = *obsessive-compulsive personality disorder*.

\*  $p < 0.05$ .

After a mean of 22.4 sessions, there was a significant decrease in all outcome parameters, suggesting that symptoms of depression and anxiety improved with therapy. Only 1 participant still fulfilled 4 of the diagnostic criteria of OCPD. Six participants were free from an Axis II diagnosis although 3 still retained 1 Axis II diagnosis: borderline personality disorder (1), narcissistic personality disorder (1), and dependent personality disorder (1). Eight patients were free from Axis I disorder while 2 still retained 1 Axis I disorder; generalised anxiety disorder (1) and major depressive disorder (1).

## Discussion

This is the first reported study of cognitive therapy for OCPD in Hong Kong. This was intended to be a pilot study to stimulate further interest in investigating the effectiveness of psychotherapy for Hong Kong Chinese people with personality disorders. The efficacy of cognitive therapy for anxiety disorder and depressive disorder has been well documented.<sup>18,19</sup> The value of combining cognitive behavioural therapy with antidepressants for improving response rates for chronically depressed patients has also been confirmed in a recent multicentre trial.<sup>20</sup> The improvements in depressive and anxiety symptoms in this study were therefore not surprising. The reduction in the severity of OCPD as measured by the SCID-II and PBQ is encouraging. This preliminary study adds to the evidence about the effectiveness of cognitive therapy for OCPD. A recent meta-analysis of published studies of psychotherapy for personality disorders reported that a mean of 52% of patients undergoing therapy recovered after a mean of 1.3 years of treatment.<sup>21</sup>

In a recent study of functional impairment in patients with various personality disorders, schizotypal and borderline personality disorders were found to be more associated with impairment at work and in social relationships than OCPD and avoidant personality disorders.<sup>3</sup> This study also highlighted the fact that more than 90% of patients with OCPD had poor functioning in at least 1 area or received a global assessment of functioning of 60 or less at enrolment. Social functioning is a complex of expectations that people have as to the behaviour of a person who holds a certain

position in society.<sup>22</sup> In a culture that emphasises cooperation, compromise, integration, and saving face in interpersonal relationship,<sup>23</sup> it is not difficult to envisage that patients with OCPD, or personality disorders in general, have worse social functioning compared with their western counterparts. To date, no local study has attempted to address this hypothesis.

This was a pilot study with several methodological flaws. The sample size was small ( $n = 10$ ). The participants were referred by psychiatrists so patients more suited to psychotherapy might have been preferentially selected. The treatment was provided by a single therapist in a single centre, raising doubt as to the generalisability of the findings. The assessment and outcome measures (SCID-I, SCID-II, GAF) were not administered by an independent blind researcher, so therapist expectation bias could not be entirely ruled out. However, the improvement in these measures was supported by self-administered outcome questionnaires — BAI, BHS, BDI, and PBQ — providing some evidence of subjective improvement of the participants. The chance of spontaneous remission with time could not be entirely ruled out given that the study did not have a control group. However, the stability of symptoms and personality measures from first assessment to the first therapy session suggested that spontaneous remission was unlikely. There was also a possibility that improvement in mood and global function was due to the effect of antidepressants. This was considered to be unlikely because the antidepressant doses were maintained throughout the trial period. The lack of a comparable psychotherapy for direct comparison was another drawback of this study. This pilot study was conducted to stimulate further enquiry into the effectiveness of cognitive therapy for OCPD in Hong Kong Chinese patients. Further large-scale randomised controlled trials are needed before definitive conclusions can be drawn about the efficacy of cognitive therapy for personality disorders.

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