

OCPD: Understanding the Pursuit of Perfection

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Obsessive-compulsive personality disorder (OCPD) is a personality disorder characterized by a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control at the expense of flexibility, openness, and efficiency.

Signs and symptoms

The primary symptoms of OCPD can include preoccupation with remembering and paying attention to minute details and facts, following rules and regulations, compulsion to make lists and schedules, as well as rigidity/inflexibility of beliefs, and/or exhibition of perfectionism that interferes with task-completion. Symptoms may cause extreme distress and interfere with a person's occupational and social functioning. According to the National Institute for Mental Health:

OCPD has some of the same symptoms as obsessive-compulsive disorder (OCD). However, people with OCD have unwanted thoughts, while people with OCPD believe that their thoughts are correct.

Most patients spend their early life avoiding symptoms and developing techniques to not deal with these issues.

Obsession

Some, but not all, patients with OCPD show an obsessive need for cleanliness. This OCPD trait is not to be confused with domestic efficiency, and, in fact, over-attention to related details may make these (and other) activities of daily living difficult to accomplish. Though obsessive behavior is in part a way of controlling anxiety, tension often remains. In the case of a hoarder, attention effectively to clean the home may be hindered by the amount of clutter that the hoarder resolves later to organize.

Whilst there are superficial similarities between the list-making and obsessive aspects of Asperger's syndrome and OCPD, the former is different from OCPD especially regarding affective behaviours, including (but not limited to) empathy, social coping, and general social skills.

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

Causes

Research into the familial tendency of OCPD may be illuminated by DNA studies. Two studies suggest that people with a particular form of the DRD3 gene are highly likely to develop OCPD and depression, particularly if they are male. Genetic concomitants, however, may lie dormant until triggered by events in the lives of those who are predisposed to OCPD. These events could include trauma faced during childhood, such as physical, emotional or sexual abuse, or other types of psychological trauma.

Diagnosis

DSM

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

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

Criticism

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

WHO

The World Health Organization's ICD-10 defines a conceptually similar disorder to obsessive-compulsive personality disorder called (F60.5) Anankastic personality disorder.

It is characterized by at least three of the following:

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.

Includes:

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

Excludes:

obsessive-compulsive disorder

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

Millon's subtypes

Theodore Millon identified five subtypes of compulsive. Any individual compulsive may exhibit none or one of the following:

conscientious compulsive--including dependent features
puritanical compulsive--including paranoid features.
bureaucratic compulsive--including narcissistic features
parsimonious compulsive--including schizoid features. Resembles Fromm's hoarding orientation
bedeviled compulsive--including negativistic (passive-aggressive) features

Differential diagnosis

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

OCPD is often thought to be the same as mood disorders, such as depression and generalized anxiety disorder.

Treatment

Treatment for OCPD normally involves psychotherapy and self-help. However, in some cases, there can be an impediment to change in that the patient does not accept that they have OCPD, and/or believes (at least at some level) that their thoughts and/or behaviours are in some sense "correct" and therefore should not be changed. Medication in isolation is generally not indicated for this personality disorder, but fluoxetine has been prescribed with success. Anti-anxiety medication may reduce feelings of fear while SSRIs (anti-depressants) can ease frustration, reducing stubbornness and negative rumination.

Psychotherapy

Cognitive behavioral therapy

Behavior therapy: Discussing with a psychotherapist ways of changing compulsions into healthier, productive behaviors. An effective form of this therapy has been found to be cognitive analytic therapy.

Psychotherapy: Discussion with a trained counsellor or psychotherapist who understands the condition.

Psychopharmacology: A psychiatrist may be able to prescribe medication to facilitate self-management and also enable more productive participation in other therapies.

Epidemiology

Obsessive-compulsive personality disorder occurs in about 1 percent of the general population. It is seen in 3-10 percent of psychiatric outpatients. It is twice as common in males as females.

History

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

Since the early 1990s, considerable new research continues to emerge into OCPD and its characteristics, including the tendency for it to run in families along with eating disorders and even to appear in childhood.

Obsessive Compulsive Personality Disorder: Summarized

Obsessive-Compulsive Personality Disorder

Obsessive-Compulsive Personality Disorder is characterized by a preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency.

When rules and established procedures do not dictate the correct answer, decision making may become a time-consuming, often painful process. Individuals with Obsessive-Compulsive Personality Disorder may have such difficulty deciding which tasks take priority or what is the best way of doing some particular task that they may never get started on anything.

They are prone to become upset or angry in situations in which they are not able to maintain control of their physical or interpersonal environment, although the anger is typically not expressed directly. For example, a person may be angry when service in a restaurant is poor, but instead of complaining to the management, the individual ruminates about how much to leave as a tip. On other occasions, anger may be expressed with righteous indignation over a seemingly minor matter.

People with this disorder may be especially attentive to their relative status in dominance-submission relationships and may display excessive deference to an authority they respect and excessive resistance to authority that they do not respect.

Individuals with this disorder usually express affection in a highly controlled or stilted fashion and may be very uncomfortable in the presence of others who are emotionally expressive. Their everyday relationships have a formal and serious quality, and they may be stiff in situations in which others would smile and be happy (e.g., greeting a lover at the airport). They carefully hold themselves back until they are sure that whatever they say will be perfect. They may be preoccupied with logic and intellect.

Symptoms of Obsessive-Compulsive Personality Disorder

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:

Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost

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)

Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)

Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)

Is unable to discard worn-out or worthless objects even when they have no sentimental value
Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
Shows significant rigidity and stubbornness

As with all personality disorders, the person must be at least 18 years old before they can be diagnosed with it.

Obsessive-Compulsive personality disorder is approximately twice as prevalent in males than females, and occurs in about 1 percent of the general population.

Like most personality disorders, Obsessive-Compulsive personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the time they are in the 40s or 50s.

How is Obsessive-compulsive Personality Disorder Diagnosed?

Personality disorders such as obsessive-compulsive personality disorder are typically diagnosed by a trained mental health professional, such as a psychologist or psychiatrist. Family physicians and general practitioners are generally not trained or well-equipped to make this type of psychological diagnosis. So while you can initially consult a family physician about this problem, they should refer you to a mental health professional for diagnosis and treatment. There are no laboratory, blood or genetic tests that are used to diagnose obsessive-compulsive personality disorder.

Many people with obsessive-compulsive personality disorder don't seek out treatment. People with personality disorders, in general, do not often seek out treatment until the disorder starts to significantly interfere or otherwise impact a person's life. This most often happens when a person's coping resources are stretched too thin to deal with stress or other life events.

A diagnosis for obsessive-compulsive personality disorder is made by a mental health professional comparing your symptoms and life history with those listed here. They will make a determination whether your symptoms meet the criteria necessary for a personality disorder diagnosis.

Causes of Obsessive-compulsive Personality Disorder

Researchers today don't know what causes obsessive-compulsive personality disorder. There are many theories, however, about the possible causes of obsessive-compulsive personality disorder. Most professionals subscribe to a biopsychosocial model of causation -- that is, the causes of are

likely due to biological and genetic factors, social factors (such as how a person interacts in their early development with their family and friends and other children), and psychological factors (the individual's personality and temperament, shaped by their environment and learned coping skills to deal with stress). This suggests that no single factor is responsible -- rather, it is the complex and likely intertwined nature of all three factors that are important. If a person has this personality disorder, research suggests that there is a slightly increased risk for this disorder to be "passed down" to their children.

Obsessive-Compulsive Personality Disorder Treatment

Introduction

Individuals who suffer from this personality disorder often are characterized by their lack of openness and flexibility in not only their daily routines, but also with interpersonal relationships and expectations. The overwhelming preoccupation with orderliness, perfectionism and control of their lives and relationships means that most types of treatment are going to be, at best, difficult. Treatment options which do not fit within the client's cognitive schema will likely be quickly rejected rather than attempted.

Individuals who suffer from this disorder have difficulty in incorporating new and changing information into their lives, so new learning takes place only over a great deal of time and with as much effort on both the clinician's and client's part. Their ability to work with others is equally affected, since they see the world as black and white -- their way of doing things and the wrong way of doing things. Naturally, this faulty logic will also be translated into their therapeutic relationship with the clinician and their treatment. It is therefore unlikely the clinician will have much success in using techniques or treatment modalities which haven't first been approved by the patient for use. Sometimes this may be done simply by stating the effectiveness of a given treatment for a specific problem, citing relevant research studies. More often, though, this technique won't be effective.

When this disorder is combined with the presentation of a medical illness, physicians should expect a logical and coherent presentation of troubling symptoms with little emotionality attached to their physical discomfort. Treatment is most effective when the nature of the disease process is first discussed with the individual, as well as typical and accepted treatments. A physician in this instance is best sticking with the facts of the presenting problem and underlying disorder rather than offering vague impressions of their opinion. Since the individual with this disorder tends to be meticulous and concerned with details, the treatment regimen -- once accepted -- will likely be adhered to rigorously, without incident.

Psychotherapy

As with most personality disorders, individuals seek treatment for items in their life which have become overwhelming to their existing coping skills. These skills may be somewhat limited, in the first place, because of their disorder. While they may be generally effective enough in most instances to shield the client from stress and emotional difficulties, during times of increased stress, work pressure, family problems, etc. the underlying disorder will become more evident in day-to-day behaviors.

As with most personality disorders, treatment is often focused on short-term symptom relief and the support of existing coping mechanisms while teaching new ones. Long-term or substantive work on personality change is usually beyond most clinician's skill levels, and patient's budgets. Obsessive-compulsive personality disorder is especially resistant to such changes, because of the basic makeup of this disorder.

Short-term therapy will be most likely to be beneficial when the patient's current support system and coping skills are examined. Those skills which are not currently working could be reinforced with additional skill sets. Social relationships can also be examined, reinforcing strong, positive relationships while having the client re-examine negative or harmful relationships. One important aspect is to try and have the individual examine and properly identify their feeling states, rather than just intellectualizing or distancing themselves from their emotions. This can be accomplished through a variety of techniques, such as feeling identification (e.g., the "feeling faces") at the onset of every therapy session. Homework might include writing feelings down in a journal, especially as they notice them. Proper identification and realization of feelings can bring about much change in and of itself.

Individuals suffering from obsessive-compulsive personality disorder often are not in touch with their emotional states as much as their thoughts. Leading the client away from describing situations, events, and daily happenings and to talking about how such situations, events and daily happenings made them feel may be helpful. Sometimes the patient may complain he or she doesn't remember or know how he or she felt at the time; the journal becomes a useful tool at this point.

Therapy with people who have this disorder can sometimes be trying, since they can see the world in a very "all-or-nothing" manner. Beck's cognitive therapy doesn't seem to be all that effective in treatment, and cognitive approaches in general probably aren't useful in this case. Clinicians must be willing to undergo verbal attacks on their professionalism and knowledge, as such skepticism about a therapist's treatment approach from the client with this disorder can be expected. Clinicians should also be careful about engaging the client within these verbal attacks or intellectual discussions, as they continue to distance the patient from his or her feelings. And take the focus off of the client and onto unrelated matters (e.g., a therapist's professional training).

Most people who suffer from this personality disorder (and the different, but related, obsessive-

compulsive disorder) lead relatively normal lives, may have a family, friends, and work regularly. Clinicians should be careful not to overgeneralize psychopathology and look to change aspects of the patient's personality he or she is not ready or willing to change. This means, in effect, that if the way they relate to others in their environment (which a clinician might characterize as a personality disorder) is working for them, a clinician should not seek to change it 180 degrees without the client's purposeful consent. Therapy will most often be most effective when it focuses on correcting short-term difficulties currently being experienced. It will become increasingly less effective when the goal of therapy is complex, long-term personality change.

Although a group therapy modality may be helpful and an effective treatment option, most people who suffer from this disorder will not be able to withstand the minimum social contact necessary to gain a healthy group dynamic. They may quickly become ostracized by the group for pointing out other people's deficits and "wrong-headed" ways of doing things.

Hospitalization

Hospitalization is rarely needed for people who suffer from this disorder, unless an extreme or severe stressor or stressful life event occurs which increases the compulsive behaviors to an extent where regular daily activities are halted or present possible risks of harm to the patient. Hospitalization may also be needed when the obsessive thoughts do not allow the individual to conduct any usual activities, paralyzing them in bed or with their accompanying compulsive behaviors.

Medications

In most cases, medication for this disorder is not indicated unless the individual is also suffering from a clearly delineated Axis I diagnosis as well. However, newer medications such as Prozac, an SSRI, have been approved for the treatment of obsessive-compulsive disorder and may provide some relief to individuals with the personality disorder. Long-term use, though, is rarely indicated, appropriate, or beneficial.

Self-Help

Self-help methods for the treatment of this disorder are often overlooked by the medical profession because very few professionals are involved in them. Support groups, though, offer an excellent adjunct to continuing medication check-ups once a month, and a way to gain emotional and social support through the community. These groups also allow others to ensure the client is doing well and promotes the client's independence and stability. Many support groups exist within communities throughout the world which are devoted to helping individuals with this disorder share

their common experiences and feelings.

Such support groups are recommended to individuals suffering from this disorder, especially if they have found therapy unhelpful or too expensive.

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