Case Series

COGNITIVE BEHAVIOR THERAPY FOR OBSESSIVE-COMPULSIVE DISORDER WITH CO-MORBID PERSONALITY DISORDER: A CASE SERIES

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Abstract

Background – There have been contrasting results regarding the influence of co-morbid personality disorder (PD) on cognitive behaviour therapy (CBT) outcomes for anxiety disorders. This case series examines the efficacy and challenges of CBT for patients with obsessive-compulsive disorder (OCD) and comorbid PD. **Case Series:** For the present case series, three individuals with the diagnosis of OCD were selected. They also presented with comorbid obsessive-compulsive PD (OCPD), anxious avoidant PD, and dependent PD, respectively, as assessed by the ICD-10 International Personality Disorder Examination (IPDE). The Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) was administered to assess the severity of OCD in the patients. They underwent a variable number of CBT sessions. **Results:** Pre- and post-intervention analyses showed reductions in Y-BOCS scores across the baseline, 2-month, and 4-month follow-ups, along with improvements in functioning, as evidenced by patient and informant feedback pre- and post-intervention. However, the patient with co-morbid OCPD had a fluctuating course of treatment outcome, and his poorer motivation and preoccupation with details interfered with the course of therapy. **Conclusion:** CBT treatment plans of such groups of patients should be individualized to address the issues posed by comorbidity.

Keywords: Obsessive-Compulsive disorder, Personality disorders, Co-morbidity, Cognitive behaviour therapy, Therapeutic Efficacy

INTRODUCTION

Cognitive-behavioral therapy (CBT) is a family of interventions that maintains the basic premise that cognitive factors govern psychological disorders. One of the most influential reviews of CBT, including meta-analyses of 332 clinical trials covering 16 different disorders or populations, showed the efficacy of CBT for a number of psychological disorders.[1] Obsessive-compulsive disorder (OCD) is a serious and debilitating psychiatric condition.[2] Among all anxiety disorders, the risk of having at least one comorbid personality disorder (PD) is the highest for OCD (52%).[3] The prevalence rate of OCD with obsessive-compulsive personality disorder (OCPD) is 15% to 28%, schizotypal personality disorder (SPD) 1%, borderline personality disorder (BPD) around 5%, anxious avoidant personality disorder (AVPD) 5% to 15% and dependent personality disorder (DPD) 7.6%.[4-6]

A recent meta-analysis of randomized controlled trials (RCTs) over the last 30 years has shown that psychotherapy is an effective

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method in reducing OCD symptom severity; however, treatment effects lost significance at 3-6 months and 6-12 months follow-ups, and no significant differences were found in the dropout rates between the treatment and control groups.[7] Internet-based cognitive behavioral therapy (CBT) was as effective as active CBT in managing and lowering OCD symptoms according to a meta-analysis.[8]

Research showing the efficacy of CBT on the impact of personality disorders for anxiety disorders has found limited influence of comorbid PDs.[9,10] Another review showed that whether the presence of PDs adversely affects treatment outcomes could not be certainly determined.[11] According to many clinicians, the presence of comorbid PDs complicates the standard treatment of patients with Axis I disorders;[12] however, another study have shown that patients with depression and co-morbid PD had significant improvement through cognitive therapy of depression.[13]

Thus, there have been contrasting results regarding the influence of comorbid personality disorder (PD) on treatment outcomes for anxiety disorders. Also, little is known about the impact of co-occurring PDs on the delivery of CBT in general practice or in training clinics.[14] The present study examined the implications and challenges of CBT for patients with OCD and comorbid PD with the help of a case series.

CASE SERIES

Case 1: Patient A, a 19-year-old male student with a 3–4-year history of thoughts on need for symmetry and fear that 'something terrible' would happen, along with compulsion to repeat routine activities. (brushing teeth, opening or closing taps, etc.) He would keep repeating the same activity for hours until he felt tired due to fear of terrible events happening. He was hospitalized twice without significant improvement. ICD-10 International Personality Disorder Examination (IPDE),[14,15] which showed comorbid obsessive-compulsive personality disorder (OCPD).

Case 2: Patient B, a 21-year-old male graduate with intrusive thoughts such as fear of being responsible for something terrible happening and blasphemous thoughts, along with compulsions of praying and hand-washing for a year. He also had low mood and crying spells along with feelings of guilt. His premorbid personality traits included fearfulness, apprehension, avoidance of social situations, and low self-confidence, and preoccupation with being criticized in social situations. IPDE assessment showed comorbid anxious avoidant personality disorder (AVPD).

Case 3: Patient C, 35 years old, female, graduate, housewife, presented with blasphemous obsessions and compulsions of washing and checking behavior. Her premorbid personality traits were being submissive, having difficulty in making decisions for herself, seeking assurance, being fearful, and being avoidant of social situations and interpersonal contacts. Upon assessment, her IPDE showed comorbid anxious, avoidant, and dependent personality disorders (AVPD and DPD).

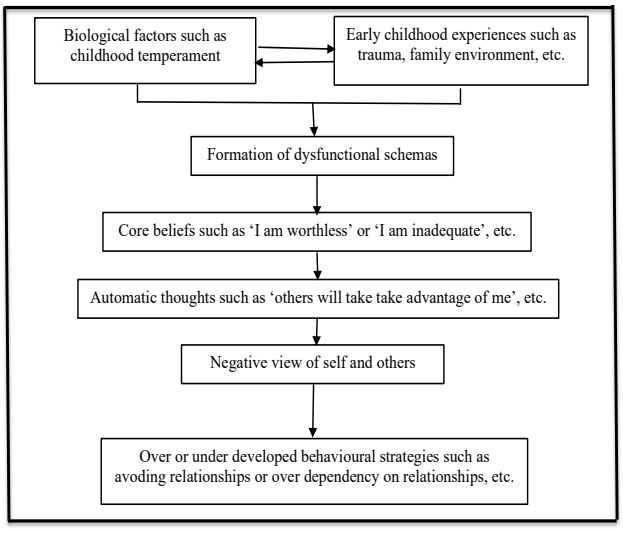
Case Formulation and Treatment Plan

The CBT paradigm was used to formulate each of these cases. According to CB model, intrusive thoughts or worries have responsibility and thought-action fusion as factors crucial in their development in OCD. The patients in the current case series felt an exaggerated sense of responsibility for harm or its prevention. For instance, patients A and B felt accountable for a terrible event, and

patients B and C had recurrent morally objectionable thoughts before compulsions. Additionally, the patients exhibited elevated cognitive self-consciousness. Patient A, with the thought of 'something terrible happening,' made him engage in the safety behavior of repeating the daily routine perfectly. On the other hand, both patients B and C had blasphemos obsessions, with guilt, and repeated hand-washing. Thus, the patients had triggers, which would lead to avoidance and performing safety behaviors.

The CB model of PD predicates that people with PD have dysfunctional thought processes, emotional dysregulation, and behavioral problems that stem from early life events. They form certain deeply embedded, inflexible basic ideas that shape their interpersonal patterns and sense of self. They may lead to coping mechanisms or behaviors to deal with or avoid dysfunctional thoughts. (Figure 1)

Figure 1. Cognitive Behavioural Model for Personality Disorder



Treatment Plan and Goals

The treatment plan involved administering CBT in conjunction with Exposure and Response Prevention (ERP). The target behaviors were reducing repeated thoughts, reducing compulsive behaviours, improving mood, and reducing guilt. Common therapeutic techniques used for the three patients included ERP along with various CBT techniques like: Psychoeducation, thought stopping, cognitive restructuring, self-monitoring, and activity scheduling. In addition to the standard CBT techniques mentioned above, some individualized techniques were also used. For patient A, his parents were involved in the therapy sessions to help him fill in the automatic thought record form, as he was unable to fill it out due to the severity of his symptoms. Also, his parents acted as enablers, reinforcing his compulsive behaviors. Thus, a separate session of psychoeducation was done for his parents as well. For patients B and C, mindfulness techniques such as meditative breathing and progressive muscle relaxation techniques were used to help them reduce the overall anxiety. Also, for patient B, assertiveness training was used to help him improve interpersonal relationships. It helped him to identify beliefs and attitudes that led him to be passive. Role-playing exercises were used as part of this technique.

Patients also continued with their pharmacotherapy. Selective serotonin reuptake inhibitors (SSRIs) doses remained stable unless clinically indicated. Ethical approval was obtained from the ethics committee.

Then, the patients underwent a variable number of CBT sessions. Patient A underwent 17 weekly sessions of CBT for 60-90 minutes. Patient B completed a regimen of 16 weekly CBT sessions of each lasting 45-60 minutes. Patient C completed a regimen of 10 sessions of CBT for 45-60 minutes. For the first month, the sessions were weekly, and for the next three months, she had one session every two weeks. The patients underwent a variable number of sessions because Patient C dropped

out after 10 sessions, and Patient B was unable to continue due to financial constraints. However, for Patient A, he had to stop the session as his father had a health emergency.

Treatment progress was assessed using the Yale-Brown Obsessive Compulsive Scale (Y-BOCS).[17] The patients were assessed with Y-BOCS at baseline and 2-month and 4-month follow-ups. Y-BOCS was assessed at baseline, at the 2-month follow-up, and at the 4-month follow-up. The percentage reduction of score on the Y-BOCS at 2- and 4-month follow-ups was analysed.

Feedback from the informants and patients, pre- and post-intervention, was also taken into consideration to understand the treatment outcome.

Patient A had a 16.7% reduction in Y-BOCS scores after 2 months of follow-up, but no improvement after 4 months of follow-up. However, for patient B, there was a 14.3% reduction in Y-BOCS score after 2 months of follow-up and a 22.2% reduction in Y-BOCS score after 4 months of follow-up. Lastly, for patient C, there was a 30% reduction in Y-BOCS scores after 2 months of follow-up, but a 21.4% reduction after 4 months of follow-up. (Table 1)

Also, when comparing the severity of the symptoms, patient A's Y-BOCS scores were in the severe range, while those of patients B and C were in the moderate range at baseline. After the completion of the sessions, patients B and C had scores in the mild range. However, for patient A, after 2 months of follow-up, the score had decreased to the moderate range, but after 4 months of follow-up, there was no further reduction in the score. (Table 1)

The feedback from the informants and patients at pre- and post-intervention is summarized. (Table 2)

Table 1 - Quantitative Analysis of the Pre-and Post-intervention Therapy Outcome

Patient	Pre-intervention	Post-intervention		Percentage (%) of Score Reduction Across Follow-ups	
	Baseline	2-months	4-months	2-months	4-months
A	24	20	20	16.7	0
B	21	18	14	14.3	22.2
C	20	14	11	30	21.4

Table 2 – Pre-intervention and Post-intervention feedback from Informants and Patients.

Patient	**Pre-intervention**	**Post-intervention**
A	Due to his repetitive thoughts and behavior, he was unable to carry out his daily activities and required help from his parents even for opening a tap, bathing, or eating.	There was a reduction in the compulsive behavior of repeating the daily activities. He was able to eat and bath by himself. He was able to control the repetitive behaviours on few occasions in the public places. He would try to control his thoughts of something terrible happening.
B	Due to his repetitive thoughts of blasphemy, excessive praying, and repeated hand-washing behavior, his educational and interpersonal functioning was hampered. He also had low mood and crying spells along with feelings of guilt.	The compulsive behavior of excessive praying had reduced completely. There was a reduction in the frequency of the hand-washing behavior and the repetitive intrusive thoughts. His low mood and feelings of guilt had reduced. He was able to concentrate on his studies, and his interpersonal relationships with his family and friends had also improved.
C	Due to her repeated and intrusive thoughts of blasphemy and repeated hand washing and compulsive checking behavior, she was not able to perform her daily household chores which would make her feel guilty and had low mood. Her interpersonal relationship with her husband and children was also hampered.	The compulsive behaviors had reduced although on a few occasions, she had compulsive checking. She was able to stop her intrusive thoughts on few occasions, especially when she would go out or stay with her family members. She was also able to perform her household chores and her interpersonal functioning also improved. Her low mood had improved and she had reduced feelings of guilt.

DISCUSSION

The current case series shows the implications and challenges of CBT for patients with OCD and comorbid personality disorders. Each of the three patients showed a decrease in their symptoms and improvement in their functioning, which is consistent with previous research findings that show the efficacy of CBT for OCD.[16] The combination of CBT and medication demonstrated effectiveness in reducing compulsions and obsessive symptoms. However, although the patients improved, each had a different course during the treatment. Patient A, although showing improvement at the 2-month follow-up, had no substantial improvement at the 4-month follow-up. This could be due to the inability to complete the regimen. Further, the plateau stage observed from 2- to 4-month follow-up for patient A may suggest a partial response to treatment rather than a significant improvement.

For Case 1, the presence of OCPD traits significantly shaped the CBT treatment outcome. The plateau at 2-4 months may be due to the patient's need to perform tasks perfectly, which possibly interfered with ERP, relaxation exercises, compliance, and outcome. Overall, OCPD traits lead to poorer CBT response due to rigidity and perfectionism. This conforms with earlier studies, which show that compared to those without comorbid OCPD, OCD with comorbid OCPD has severe cognitive inflexibility and lower chances of OCD remission after two years. and significantly lower global functioning and social functioning. [17-21] Also, those with more severe symptomatology were more likely to undergo a greater number of sessions,[22] which was seen in this case series.

For Case 2, AVPD traits posed challenges for the formation of therapist-patient rapport. His anxious feelings towards his symptoms motivated him to comply with ERP, and assertiveness training helped in identifying cognitions for his passivity. So, AVPD traits may affect rapport-building; once trust develops, it contributes to consistency, cooperation, and openness to therapist guidance. This is in accordance with the diagnostic criteria of the AVPD in the Diagnostic and Statistical Manual 5 – TR (DSM-5-TR), which state that they are unwilling to get involved in new relationships unless they are sure of being liked.[23] Study also shows that they are more willing to communicate and take responsibility for their problems compared to cluster B personality.[23]

For Case 3, the presence of combined AVPD and DPD traits suggested a high therapist dependency. The case shows that while dependency could risk over-dependency on the therapist, DPD traits could also help by increasing treatment adherence. The reduction of the Y-BOCS score was less at 4 months than at 2 months, possibly due to the gradual increase in the interval between sessions, reducing the direct therapist's support on which the patient was dependent. Studies on patients with OCD and comorbid AVPD or DPD showed no effect of comorbid PDs on the treatment outcome for OCD.[24] But study shows that in DPD, developing autonomy in a safe therapeutic environment, and also focusing on fears of being judged, can help in the symptom management through cognitive therapies [24] In those with DPD, research suggests that structured autonomy building is essential in maintaining progress.[23] Also, in the present case series, the treatment process encouraged patients to express their concerns and the stressors and provided a safe and supportive environment. This also helped

in developing a therapeutic alliance. This is consistent with earlier literature on the treatment of PDs. [25]

The case series nature limits the generalizability of the results. Patient dropout limits understanding of CBT's efficacy in these conditions. However, despite these limitations, the case series highlights the implications and challenges of CBT for OCD with comorbid PDs. Thus, future studies should further focus on the impact of comorbid PDs on the treatment outcome of OCD and other anxiety-related disorders and also develop any therapeutic module for these groups of patients to improve recovery rates.

CONCLUSION

The current case series shows the implications and challenges of CBT for patients with OCD and comorbid personality disorders. In the present case series, behavioral techniques, especially ERP, helped reduce symptoms and normalize day-to-day activities, and cognitive techniques helped replace negative thoughts with positive ones. Thus, it is important that the treatment plans of such patients be individualized to address the issues posed by comorbidity.

Conflict of interest: None

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The authors attest that there was no use of generative artificial intelligence (AI) technology in the generation of text, figures, or other informational content of this manuscript.

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