TIGHTROPE WALKING
EVERYTHING YOU NEED TO
KNOW ABOUT OCPD
and PERFECTIONISM
This is a handbook, a guide, to a little recognised and often very painful problem. The distress is usually well hidden, both by the people who suffer from the disorder and by those closest to them. We probably all recognise it when we see it. It’s often given nasty labels.


This guide to Obsessive-Compulsive Personality Disorder is for people who think they might suffer from it, and those who need to know. Since it often runs in families, and is perhaps, ‘genetic’, knowing about it could be important or at least useful for:

Husbands, wives, partners, parents, lovers, bosses, subordinates, doctors, teachers lawyers.

The author offers an alternative to the confusing term ‘Obsessive Personality Disorder’ (OCPD): **Tightrope Walking**. This is because sufferers tread a fine line between what’s ‘perfect’ or ‘right’ on the one hand, and their fear of making mistakes (or having to watch while others make them). OCPD is often confused with OCD, the Obsessive-Compulsive Disorder, to do with exceeding hygiene. OCD sufferers usually know something is wrong with them whereas OCPD sufferers seldom do.

This guide includes questionnaires, and suggestions for illuminating reading online. There is considerable evidence recorded here from people who wrote online about their personal views. Tightrope Walkers can be helped if that’s what they want.
TIGHTROPE WALKING
EVERYTHING YOU MAY NEED TO KNOW
ABOUT OCPD AND PERFECTIONISM
We all know one or more. They’re the most decent good-hearted people. But they tread a tightrope, a knife edge, all day every day. It’s hard. It’s stressful. They suffer terribly. But they have to be in CONTROL.

Here are a couple of stereotypes. ‘She’ spends all day polishing and dusting her house, replacing everything EXACTLY where it was when she picked it up to dust under it. She’s fanatical about sorting the washing properly.

No exceptions at all.

You’ll know, too, the bloke who mows the lawn the same way each time, up and down in straight lines. He even has a line strung across it – nice and tight – so he can keep dead square with the edges. His plants are in straight lines at precise intervals.

He’s the one who tells people off in the street for chucking their chip papers on the pavement. In the house, he’s got all his booze on shelves in a cupboard. Wine bottles at the bottom, sorted by vintage. Beer bottles second up, sorted by colour of the label. Cans of beer next shelf up, sorted by brand. Liqueurs on the top sorted by country. The lines must be exactly half an inch from the edge at the front. He’s put a chalk line along the shelves to show where this runs.
If you move an ornament, ‘she’ will tear into you. If you do an errand for her and spend 76p when it could have been 48p, she’s horrified and wants the difference back. And yet you know she’s got teapots full of money stashed away somewhere.

If you have a drink with him, don’t put the empty bottle in the recycling bin until it’s washed out, drained and dried. It has to be tucked alongside the rest so there’s room for the sorted packets of newspapers. They’re all in date order in case he’s missed some out.

As for the bottles. ‘No, idiot, wine bottles here, beer there.’ It’s all very logical. And hygienic too. You can see the reasoning, but you wouldn’t bother yourself, would you?

She’s on the Parish Council and does Meals on Wheels. She takes the left-overs home and freezes them in case there’s a famine. He’s on the school Board of Governors. But they’re all idiots and too sloppy. He’s probably right, but you wouldn’t care. He cares, a lot, so he’s leaving.

In this handbook, I’ve referred to these people as Tightrope Walkers (TR Walkers). This is because they have a terrible balancing act to do. They’re up on their own, doing what is ‘right’.

Treading a fine line between what is perfectly correct in their own minds and what would be a slip-up, a failing, an error. What is more, they’d like other people to be ‘up there’ with them – following their good example. Not wobbling the wire. If you do go along, then if the TR Walker falls off, there’s someone there to kiss it all better.
Work can be hell for TR Walker, unless it’s a job that’s rule based. But only if TR Walker agrees with them.

Sensible rules are fine, as for driving a train along the track. But whatever the job is, it’s going to be a strain. TR Walker is someone who wants to do everything properly, because it is possible to be perfect, isn’t it? We all know it is, but most people can’t be bothered about whether they’re in control or not.

Being perfect all day is stressful and utterly exhausting. So home is where TR Walker can relax. Everything there will be perfect, surely? Everything in its place, no challenges, no problems.

Unless there’s someone else around who does things differently. Then it’s a case of making things happen properly. This might involve a bit of shouting or even a thump to make the point. Who knows what can happen then? If things get out of hand, tears all round.

FRANK SINATRA DID IT HIS WAY.

TR Walker does too. TR Walkers are dead chuffed if people agree to do things their way. Wouldn’t we all be? But it matters, really matters, to Mr and Mrs TR Walker.

Children can suffer from OCPD traits too, as we shall see in Chapters 7 and 11.

This handbook has been written for everyone who needs to know about obsessive-compulsive personality disorder (OCPD).

Note the word ‘personality’. It’s not about hand washing or rituals. It’s about getting things ‘just so’. TR Walker spends a lot of time thinking about the fine detail and how to get it right and the feelings that go along with this. Like saving the pennies while
the pounds look after themselves. But it’s tough and exhausting. TR Walkers find it so taxing, they’re prone to depression.

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HOW TO RECOGNISE OCPD

This is a handbook, a guide, to a little recognised and often very painful problem. The distress is usually well hidden, both by the people who suffer from the disorder and by those closest to them. We probably all recognise it when we see it. It’s often given nasty labels.


This guide to Obsessive-Compulsive Personality Disorder (OCPD) is for people who think they might suffer from it, and those who need to know. Since it often runs in families, and is perhaps ‘genetic’, knowing about it could be important or at least useful for:
Husbands, wives, partners.
Parents.
Best mates. Lovers.
Bosses, subordinates.
Doctors, teachers, lawyers.

The author offers an alternatives to the confusing term ‘Obsessive-Compulsive Personality Disorder’. **Tightrope Walking**. This is because sufferers tread a fine line between what’s ‘perfect’ or ‘right’ on the one hand, and their fear of making mistakes (or having to watch while others make them).

OCPD is often confused with OCD, the Obsessive-Compulsive Disorder, popularly known as the ‘hand-washing’ problem. OCD sufferers know something is wrong while Tightrope Walkers usually don’t. This guide includes questionnaires and suggestions for reading, as well as many descriptions of the disorder based on statements by family and by Tightrope Walkers themselves. They’re sad reading, but Tightrope Walkers can be helped, if that’s what they want.

**THE PROBLEM**

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Chapter 1
Who is this for?

This has been specially written for people who are actually concerned with OCPD. Many people don’t know it even exists, but might recognise the picture from the introductory pages, or the drawings on the cover.

OCPD isn’t the same as OCD, obsessive-compulsive disorder. OCD has to do with rituals such as hand washing.

On the other hand OCPD is a personality disorder. Freud called it anal retentive. Others call it perfectionism. Or anankastic.

In brief, a TR Walker needs to keep control over her or his life, so is constantly getting bogged down with details and just won’t let things be done in any other way than the way he or she wants it. Like folding up the washing in a set fashion so there aren’t any creases. Or not wasting money by watching over each cent or penny. Balancing the bank account by regular examination of the cheque book or credit card with the statement, even every day. Saving money is a form of hoarding, a favourite TR Walker habit. Being on time. Like the man here, who’s got to get his four timepieces synchronised! Does it matter? Yes, to him it does.

OCPD goes along with being adamant about being right. Some people call this stubbornness or ‘rigidity’.

More, given that no one else is likely to do things properly, TR Walker doesn’t like letting other people do things that TR Walker
can do personally. You may know someone who says, ‘Leave that to me. I’ll do it. I know how to do it properly.’

This handbook is for the following people:

- **People who have to deal** every day at home with someone who seems to be constantly on edge about what has to be done, how it’s to be done, and even when and where, and above all why. This might be at work, or at home. A parent, a partner, a sibling, a child.

- **People who work** with someone who shows OCPD characteristics. TR Walker will either make allies of the bosses or be hypercritical of the way things are run. Subordinates might find it difficult to knuckle under as well.

- **Parents who’re worried** they have a child who’s pernickety, maybe about food. And into organising everything. Maybe even dictates to the grown-ups. A child they’re scared will grow up to have OCPD.

- **Professionals** who might meet OCPD in their work. Doctors, counsellors, psychotherapists, lawyers, teachers, clergy, managers.

- **Tightrope Walkers themselves.** People who’re worried because people keep telling them they’re ‘control freaks’. TR Walkers often get into trouble in a social situation. At home, it’s hard for a wife, husband or partner to understand and cope with the very high standards of a TR Walker. There might be conflict and even domestic violence. TR Walker might lose it and start to feel very angry. Or bottle it up and get depressed and moody.

As a handbook, this is intended to be no more than a guide, an outline, a first step for people wanting to understand obsessive-compulsive personality disorder, OCPD.

Mercifully, there’s more and more information on ‘perfectionism’ becoming available, both on the Internet and in the bookshops. The trouble is, the ‘perfectionist’ description, which is
often how it’s seen, doesn’t necessarily precisely apply. Moreover, the ‘official’
definition, from the DSM-IV, suggests a rather meek and conforming type of
person.

This may be the case for many, but from everyone I’ve seen and those I’ve
studied, they are more often quite bombastic and domineering individuals whose perfectionism isn’t
that obvious to other people. This is because the rules are in the heads of TR Walkers, made up by themselves. *Their* rules, *their* own
idea of what’s right and wrong. These are nearly always nothing like the sets of rules for society as a whole or for other people except over certain moral questions.

I’ll give you an example. A friend told me about one TR Walker who’s unbelievably untidy. Shoes all over the floor. Cupboards that spill their out contents when you open them. The ‘order’ is in other areas of her life and above all inside her head. She lives by what she sees as vitally important to her, even if to no one else.

She fixes her nails every day in a particular way and order. Her hair, this way, not that. Exactly. She collects information on film stars. She’s up half the night on the web looking for material. If anyone touches her computer where she keeps a lot of the stuff she finds, she goes bananas in case her database gets deleted or wrecked in some way.

She hoards DVDs of photos of them, all kept in neat piles in her bedroom with detailed lists of them in tiny hand writing. She keeps these exactly in the middle of her dressing table. Her other lists are arranged round them in a particular way.

And she’s an expert on the limbic system. She won’t allow anyone to question her views. Quite right too – she really is an expert, and she’s truly gifted. Everyone thinks so, but she’s stressed and sometimes freaks out with pretty good tantrums when things don’t go right for her. It’s all too hard.
TR Walkers make up their own rules, crazy as they may seem to other people. It’s all about the detail of their rules, unwritten, but sometimes they break out onto paper they’re so important. Maybe in the form of lists. Lists and lists. Lists everywhere. Like safety belts.

CHAPTER 2
WHAT ARE MY QUALIFICATIONS?
WHY AM I WRITING THIS?


• 15 years work in the mental health field, including in Primary Care as a counsellor and therapist.

• Decades of direct and close observation of several people I know closely who have OCPD. I’m keen to give a higher profile to the dilemma of Tightrope Walkers. They aren’t a serious social problem except to the police because of their tendency to violence, so money isn’t there for much research, except where it can be folded in with other investigations, as in the gene studies which I write about later. So far, I’ve seen no investigation that sets out to catalogue the inner world of OCPD sufferers through exhaustive case histories and qualitative research. This is a pity – they need understanding, sympathy and support.

I’ve been given to understand that some doctors don’t know much about OCPD. For a start, it’s often confused with OCD and treated in the same way. This is almost inevitable, since someone decided to give it a similar name. This doesn’t help because OCPD is often hidden or secret, it could be seriously under-diagnosed (Fineberg et al., 2007). Assuming it’s recognised, given that it’s defined as a Personality Disorder, it’s usually seen as ‘incurable’.
In a way it is, because it’s a constant life-long battle for the TR Walker to fight the urges to stick with the detail, arrange things in a particular way and not let anyone else take over.

What worries me is that there’s no public recognition of – nor discussion about, so far as I’ve been able to trace – the social consequences of untreated OCPD. Nor have I been able to track down any research into this. Who knows just how many ‘closet’ TR Walkers are out there, in doctor’s surgeries, in families, in the work place, going unrecognised – at risk of depression and maybe even suicide? In terrible daily pain because no one understands them. People know something’s wrong but think TR Walkers are just ‘difficult’ or perverse, or eccentric.

In my view, there’s a grave danger that unless OCPD is properly acknowledged and recognised for what it is, it will continue to cause hidden problems.

Have a look on the Internet. Would you want to admit to something that has such a bad press? This is a possible worst-case scenario for the consequences of untreated really serious OCPD:

1. High rates of marital breakdown.
2. Hardship in the home because of stinginess on the part of the OCPD sufferer.
3. Children kept too severely under control.
4. Domestic violence, both towards partners and children who don’t conform to what TR Walker wants.
5. Alcoholism as a retreat from stress.
6. Disruption at work with frequent job changes.
7. Over-reaction to failure can lead to self and/or other harm.
CHAPTER THREE WHAT IS THIS BOOK ABOUT? AN OUTLINE

In Chapter 4, I set out the problems for the person who suffers from OCPD and for people who have to learn to deal with someone who suffers from it. Chapter 5 reflects TR Walkers talking about themselves based on real material. Chapters 6 and 7 offer insights into what it is like to live with children and adults with OCPD.

The image that comes out of this and Chapter 5 is of people who are in a state of near-permanent distress. Chapter 8 sets out what is known about the condition, with questionnaires and checklists, plus one to check for depression. These may flag up whether professional advice is needed but cannot replace a proper diagnosis. This can only be done by a medical professional or a clinical psychologist.

In Chapter 9, I add information from professionals, in particular on how TR Walkers come over in therapy. There is further anecdotal evidence in Chapter 10 about what it means to be or live with a TR Walker.

Chapter 11 comprises a review of the most recent research, including findings from the first gene studies. The implication seems to be that the condition runs in families. It also seems that OCPD is stable over time. In Chapter 12, I take a look at remedies. These include medication and therapy. I also offer advice for the family. Chapter 13 is a brief note on violence.

Last are two appendices – reading and research.

CHAPTER 4 THE PROBLEM TIGHTROPE WALKING [OCPD]

I’ve used the idea of walking a tightrope because this personality disorder is like that for those who suffer from it. They have a fine line to tread. TR Walkers just can’t relax or step to one side or the
other, or there’s trouble. It’s a delicate balancing trick, to get it all ‘just right’ so that life can go smoothly along a narrow path.

So having OCPD is first of all a problem to TR Walker, but there’s ample evidence it goes a lot further than this. TR Walker is often at odds with other people, whether at home or at work. Besides, TR Walker may get so upset that anger spills out into rash and unpredictable action – suicide, violence and taking too much alcohol. Or if anger isn’t the style of TR Walker, frustration can spill out in other ways. TR Walkers have been known to do the daftest things to try to make a point – public demonstrations, posters, banners, letters to the papers. They just can’t see how bizarre this may be and how it might upset other people. TR Walker doesn’t see why people have to react the way they do, so this can cause terrible trouble.

Tightrope Walkers have little space for anything other than things being ‘square’, in order, ‘just so’. Right down to the finest detail. Everything TR Walker does – and thinks – must be perfect. And that isn’t going to change. Once TR Walker has made up her or his mind, that’s it. This means there’s only one way to do things. TR Walker’s way. Everyone around has to fall in with the way she or he wants things.

Children can suffer OCPD-like symptoms too. They are often unusually careful and can seem ‘driven’. They will already show a penchant for arranging things, such as their toys. They might be ultra clean and tidy their own rooms. Or have little rituals for doing things. Lists too, as soon as they can write – things they’ve just got to do. The worry for parents is they may never be able to finish their homework – it’s got to be perfect. As I show in Chapter 11, research suggests there’s a danger such children will turn out to have an eating disorder when they grow up. They make also have ‘tics’ or make odd noises but usually grow out of this.
Being a TR Walker isn’t all negative. Some of their qualities are admirable, and can be a great asset in particular jobs. Their achievements can be something to be really proud of. But it’s an exhausting business, doing everything perfectly. So TR Walkers sometimes sleep a bit more than other people.

Different TR Walkers do different feats in different ways. But they enjoy whatever it is they choose to do. It’s not a problem to them – it’s ‘what they do’. This is by contrast with people suffering from OCD – they hate their rituals.

I’ve already mentioned tics and twitching in OCPD children. Don’t be surprised if you know an adult TR Walker who’s also occasionally like this. Twitching, blinking, or making funny noises, especially when under stress. As with their other habits, they may be unaware of this, but we don’t have a lot to go on. I’ve so far failed to find any research into this little-known aspect of some TR Walkers’ lives. People have commented on it, and there is some interest in the universities into possible links between OCD, OCPD, eating disorders, Tourette’s syndrome and Intermittent Explosive Disorder – violent outbursts of rage.

Being a TR Walker is a pretty difficult thing to have to cope with, especially when they’re the quiet ones, the hard workers. They’re constantly on the look out, on guard, very vigilant, unless they’ve buried themselves in detail so that the world passes them by.

They make good students, but may never finish what they want to do to their own satisfaction. Sometimes, TR Walkers come to the attention of the medical profession for drinking too much or getting too aggressive with people who won’t do what they want.

There’s some research on this which I’ll come to later. But mostly don’t. They blend in with other people. But their private life, their inner life, is one of tragic torment. If you’re a TR Walker, you’ll know what I mean. If you’re not, try to imagine how it must feel to wake up every morning, worried about what you have
to do that day. Whether you can find your list.

Whether you’ve got enough time. Will people cooperate? What will happen, what will you feel like, if you can’t do everything you’ve got to do the right way, all through, everything, all day?

Think about it. Dwell there for a while. This is what this book is intended to encourage people to do. Get sympathetic. Even better, discover some empathy. It’s not too hard. All of us, at some point in our lives, have something about to happen that’s so important to us that we just mustn’t mess it up.

TR Walkers feel like this all the time.

CHAPTER 5
TIGHTROPE WALKERS SPEAK

The only source of information available to me directly from TR Walkers themselves was out on web sites. As the authors are anonymous, I’ve picked my way through the material, taken the spirit of it and concocted what follows. Naturally, I’ve altered the vocabulary and mixed up several statements, but hope I’ve got the gist of it. This is how they see themselves.

I get stuck for ever on arranging when to do things, everything at the right time, in the right place. People tell me about it, but I don’t need that. No way!

• When I get home from work, I’m knackered, totally mentally exhausted.

• I’m a bit of an introvert. When I get home, my head’s full of everything that’s gone on during the day. And with my emotions. It all goes round and round in my head.
• I have an issue with my self-esteem. It doesn’t give me any peace of mind.

• I wish I could have a nice easy, relaxed time, but don’t think I deserve to.

• If I relax my routine, I get anxious. And I feel guilty.

• I don’t know what I’d do if I didn’t follow a strict timetable. I’d have huge gaps of time with nothing to do.

• If I lose my lists, my plan for the day, it’s hell and chaos. I’ve got to find them. My ‘ex’ said it’s quicker to sit down and rewrite them. I can’t do that. I just have to find them. They’re my security belt.

• I’m too much of a coward and too under confident to try out new things.

• The stress that builds up during the day is all bottled up. My emotions spill out as anger.

• I need to slow down. My timetable is all pretty urgent. Too little time. Too much to do, so it’s hurry, hurry, hurry.

• My family has tried to convince me for years something’s wrong.

• I thought everyone else had a problem, not me!

• When I was a teenager I was all about having fun. I loved playing soccer... a bit of an obsession, I suppose. But it was my major focus, my let-out, my pleasure, ‘my place’.
• I don’t think I smile much. Frankly, I don’t have any reason to.

• I think I have a pretty good sense of humour. I like telling jokes.

• I love my family but I have a smashing career.
• My life probably looks pretty great to other people, but I don’t get too much real pleasure or joy out of it.

• My idea of having a good time is to take my wife out to a movie, eat out, or go for a drive out in the country.

• I’m terrified my precious things are going to get damaged through some other stupid sod’s carelessness. That’s why I lock things up that I treasure.
• Going out for fun is nice. It’s one time we don’t argue!
• When I want to be alone, I spend time doing gardening or other work outside the house.
• I just love getting on my hands and knees and pulling out some weeds, or turning the soil over.
• I want the front of the house to look perfect. It’s a nice feeling. When I come home I can see the impact of all the work I’ve put in.
• I don’t know why trying to feel pleasure is so much agony. It’s a problem for me. I don’t know how to feel pleasure.
• If people try to get me to talk about my inner thoughts I instantly feel as if it’s all my fault. I’m the problem. My ex said that. Always. I don’t need that.
• If someone tackles me about my behaviour, I immediately get defensive and have a good rant about all the stupid things other
people do.
- All I need is someone to be warm and loving, to hold me. I don’t want, when I feel like that, to have to do the holding. I’m the one that needs to be held.
- If my wife doesn't do something soon, I’ll go back into my shell and lock her out. I'll never let anybody in again. She wants me to open up, but she’s got to get to the point soon. I can’t cope with this, all this opening up.
- I have to be nurtured. I feel like a naked baby. I need someone to cuddle me, comfort me.
- My wife doesn't understand my problem. She talks to me as if I’m making it all up so that I can behave selfishly.
- Inside, I feel as vulnerable as a baby. But no one’s going to come and help because no one really understands me.
- I know I’ve got to look at why I’m so stressed and stop yelling at my wife!
- It’s not fair for my wife to just tell me to get better. How can I? I don’t know what that means.
- I’m a sensitive person. I need a gentle loving person with me. Someone I can trust, and feel safe with emotionally. I don’t have that I close up and put up walls that I can feel safe behind.
- I need to feel safe and comfortable if I’m going to dig down and find out why I get so stressed. Find
out what my issues really are.
• I honestly do my best not to direct anger at my husband.
• I need to be seen as ‘me’... far from perfect, but really trying to
be a better person.
• I would never, ever, set out to hurt my boyfriend. Reminding
myself helps me keep the lid on my temper.
• I don’t know what the word "love" means. I’ve never really
understood what it is or feel it. Is it having a person to make me
feel safe? Someone to hold my hand and help me face the world?
If so, then I’ll be fine.
• The fundamental problem is even when my boyfriend says
things that sound loving, I’m paranoid, suspicious. I do wonder
if he’s having me on and there’s a motive for it.
• The only time I’ll let anyone tell me how much they love me is
when I’m in trouble and feeling helpless.
• People give me up as bad job.
• I don’t like people to see me as helpless. That feels like a
criticism. I’ve just got to hide it. I’ll dodge behind people so no
one can see just how I’m feeling.

What sings out clearly from this sad catalogue is just how puzzled,
afraid, and lost TR Walkers feel. They’re on edge all the time,
always feeling that their world can and will descend into chaos if
they relax their vigilance. They need to feel safe, but they can’t
predict what’s coming, which is why they have to try to keep things
under control, everything they can, that is.

The picture is of high levels of stress everywhere except
when there’s a distraction – playing soccer, going out for a meal, just
going out to drive around, being head-down over the weeds in the
garden. If they raise their eyes, they’ll see trouble. Worst for them,
they don’t feel anyone understands just how weak and helpless they
feel, although they probably find it hard to admit to that. The people
whose statements I based this chapter on had all ‘come out’ in a
sense, admitted they suffered from OCPD.
Maybe this terrible anxiety is the reason TR Walkers tend to work along such narrow tracks. Focussing on little things, the fine detail, helps them batten down their anxiety. If they can just get the little things right and the ‘whole’ will be all right too. Interestingly, one therapeutic technique for anxious patients is to encourage them to focus on little details.

Say, go into the garden, look at each petal on a rose, take ages over it. It’s an effective distraction.

We have seen how tender some TR Walkers feel. But the evidence of people who know or live with TR Walkers makes them look tough, forceful and quite cold in manner. Domineering and tyrannical. At best they’re a bit distant without being cold – reserved and shy about opening up. It’s possible to have a tender relationship but there’s not much chance of getting really close – they’ll shy away from showing their ‘soft underbelly’ as someone put it. That’s a step too far.

So unless you know a TR Walker very well indeed, and you’re a trusted person, you’ll get the impression they’re maybe cold and not that nice to know. But the truth is they’re often unhappy so whinge a lot. It seems some TR Walkers, especially when they’re at home, don’t mince words over things they are unhappy about. Here are examples of the kind of verbal attack some TR Walkers make on ‘close’ others, based on material from the same Internet support-group source:

**What I DO or don’t do.** She says I lack bodily control – the way I sneeze (I should stop myself), cough too loud, don’t blink often enough, yawn too much, burp too much, go to the toilet too often, clean my teeth the wrong way.

**How I look.** He says I *always* wear ugly earrings. My shirt makes me look like a policewoman. I’m not tall enough. I shouldn’t wear green nail varnish. My toes are ugly, my nose too long, I have too much facial hair.

**Extrapolations to character.** I don’t respect property. I have no backbone.
I am too nice to him. I do things to draw attention to myself. My explanations are all lies. I can’t possibly ‘know’ myself – only he can know me.

The criticisms TR Walkers level at those closest to them focus on what they DO and how they LOOK. My own research into people who get into ‘problems with living’ suggested that a tendency to concentrate on what other people do and how they look is typical of those who just can’t figure out what is really going on.

They particularly can’t read facial expressions. So they generate a ‘theory’ – based purely on appearances – then extrapolate to judge personality and character. This opinion then becomes ‘fact’, even though based on only a partial impression. So TR Walkers can come over as bossy, despotic and contemptuous even though they don’t feel this way underneath. It’s just so hard to keep things going their way. If they can’t, they’re soon overwhelmed.

This feeds into depression. The trouble is ‘weakness’ is something they won’t admit to. They’re not keen on it in other people either. This is what can make TR Walkers, however basically sweet natured, hard to live with.

They may even think they do understand others, but they don’t. Some manage to work out they upset others, but can’t understand why.
LIVING WITH A TIGHTRope WALKER

The diagnostic criteria for this personality disorder, which we shall come to, sound pretty harsh and negative. However, the online MSN support group has some wonderful eulogies to the welcome qualities of OCPD husbands, wives and partners. So before I describe the tougher side of TR Walkers, the hardest things for others to live with, I’ll give some space to the ‘nice’ side.

The table shown later comprises the results of a short analysis carried out on 27 May 2008. The material was a ‘positives’ thread on the MSN message board. This started on 16 August 2005. Ninety-six messages had been posted. The text was sorted, yielding a total of 451 phrases, adjectives and verbs to describe a TR Walker as seen by someone who knew that individual well. The percentages for each category are shown in the table. Some of these comments might have been provoked by seeing what other people had written so they might not be a true picture. It’s also important to recognise that this is how others, who were close saw a particular TR Walker.

Attentive, considerate 60 15.3%
Does a good job helping in house 54 12.0%
Helps others 54 12.0%
Reliable & dependable 35 7.8%
Values obvious to those around 34 7.5%
Financially responsible 27 6.0%
Sense of humour 26 5.8%
Intelligence and capabilities 25 5.5%
Good with children 19 4.2%
Strength of character 18 4.0%
Good lover 16 3.5%
Prepared to fix self/relationship 16 3.5%
Loyal 15 3.3%
Calls, rings to keep touch and informed 8 1.8%
Fixes things 8 1.8%
Hard working 8 1.8%
Committed 8 1.8%
Fun to be with 6 1.3%
Generous 5 1.1%
SURVEY SUMMARY: PERCEIVED OCPD POSITIVE ATTRIBUTES

There were so many ‘good’ things I decided to cluster them into groups, to give a more general picture. Interestingly, folding together groups of qualities and behaviours into clusters mirrored a defining characteristic of OCPD.

Highly moral and perfectionist. Our TR Walkers really are good goodies!

A 56% reliable and dependable, has positive values obvious to those around, is loyal, committed, has strength of character, is prepared to work at fixing problems.

B 34% attentive, considerate, helps others, good with children, a good lover, rings home when away to keep in touch and informed, generous and companionable

C 20% gives practical help in the house, is financially responsible, fixes things

D 7% has sense of humour, fun to be with

E 6% intelligent and capable

F 2% hard working

In total this is an image of a thoroughly decent and caring individual who helps others and makes life easier at home. With a dash of fun and humour.

So what goes wrong? A good starting point is the most commonly used diagnostic tool, the DSM-IV. It’s a thorough description of the disorder, backed up by years of clinical experience. The manual is updated and reissued from time to time and is probably just about due for a rethink on OCPD. Many argue it doesn’t fit with the cluster of other personality disorders they’ve put it in with. Nor should it have the OC label. There are not usually compulsions and obsessions of the kind seen in OCD, unless there is a mixed picture – both present, as can happen.
WHAT ABOUT CHILDREN?

There are two situations to deal with in this chapter:
1. A child who has the symptoms of OCPD.
2. The ‘normal’ child of an OCPD parent.

How can you tell if a child is likely to develop into an adult with the symptoms of OCPD?

Sadly children with obsessive-compulsive characteristics stand a chance of developing full-blown OCPD in adulthood or of having eating disorders if girls. But what does this mean in practical terms for parents?

The MSN message board offers many examples of what parents and others have seen as worrying behaviour in families where OCPD has been identified. Here is a selection, paraphrased, some showing up in children as young as under 3:

- Insists on having things her or his own way.
- Struggles socially.
- Refuses to share with other children.
- Insists other children do what he or she wants, so no flexibility.
- May refuse being cuddled.
- Impossible to take out for a meal because of constant screaming.
- Makes a fuss in public if things go wrong.
- Complains a lot about things.
- Tends to become preoccupied with one thing obsessively, day in and day out, such as a computer game, or Game Boy, or if a girl, with dolls.
- May focus on a task in such detail that it is not finished – homework checked and rechecked for errors, or repeatedly redone so never completed.
- Fearful and anxious, often irrationally in case something goes wrong outside the house, so refuses to go outside.
- Scared of the things most children enjoy, such as fair grounds.
- Can’t stand a lot of other people around, or too much noise.
- OPTs out of things to avoid stress.
- Insists on eating just one food for all meals.
• Generally excessively picky about foods.
• May dictate how a meal is to be presented – what food in what order, how it is arranged on the plate.
• May be fussy about one type of food touching another and want them separately.
• Finds it harder than most other children to master skills such as tying shoe laces.
• Unusually fussy about dirt.
• May go round picking up bits of rubbish and dumping them.
• Neat and tidy in personal appearance.
• Keeps own room unusually well organised for a child.
• Organises own possessions into groups or colours.
• Preoccupied with the detail of things in the immediate context.
• Shows an interest in order and arranging things, eg squaring things up, or insisting on things being only in even numbers or pairs, or in a particular structure or arrangement.
• Argumentative about definitions. For example, insists that a jacket is given the right name, not called a coat and will deliver a lecture on the difference between a coat and a jacket.
• There is only one way to do everything.
• Fixed ideas about what is right and what is wrong. For example, might insist that lunch is at 1 pm and if it’s at 2 pm it’s afternoon tea and you don’t eat sausages for afternoon tea.
• Shows complete confidence in personal knowledge and beliefs.
• Fussy about being on time. Watches the clock.
• Likes a routine, and gets upset if there has to be a change to it.
• Prefers the day to be planned out so there are no surprises, including what is to be on the menu.
• May show symptoms of sensory processing disorders – eg feels physically uncomfortable in particular clothes, or is hypersensitive to particular sights or sounds or textures.
• May resist being strapped in to a seat when small.

The first thing to do if a parent notices persistent patterns of behaviour of these kinds is to start keeping a diary. If it continues for more than, say, a year, it would be a good idea to ask the doctor for a referral to a specialist.

It is especially important for parents and others involved, such as
grandparents and childminders, to be alert to how they are behaving themselves, when with them. Insisting too heavily on perfection or getting things right is likely to underscore the traits the child may already have, so the task is one of teaching flexibility.

Offering affection and showing a close interest in what the child is doing will help to break down the invisible emotional barriers such children appear to place between themselves and others when they are so preoccupied with how things should be. As for a child being raised inside a family where one or both parents have been diagnosed with OCPD, there are no golden rules to follow except perhaps to be as open – safely – as possible about what is going on. As already suggested, there is no substitute – where only adults are concerned – for getting the topic aired, and offering support to TR Walker, even if this is rejected.

When it comes to being as open with a child or the children of TR Walker, it’s important to make sure there isn’t a confrontation about it in front of the child.

As we know, TR Walker can be touchy, so opening the topic is best done after a) TR Walker acknowledges the problem and b) agrees – probably in the presence of a therapist – on how to deal with the issue as family. If he or she won’t go to therapy, then there is a dilemma. The MSN support group previously mentioned has a fair quantity of ‘chatter’ about the difficulties for children in an OCPD household. So what’s to be done?

There is a lot of advice about drawing ‘boundaries’ consistently, fairly and firmly. This means pointing out, if necessary gently and even in front of other members of the family, that it’s just not acceptable to other people to behave in that way. So, if for example TR Walker bawls out his daughter for leaving her shoes in the hallway when they ought to be (in his view) up in her bedroom, it would be all right to comment to both parties along these lines.

• ‘Julie, Dad’s right in a way. Someone might trip over them. Can you take them up with you when you go to bed or put them somewhere safe?’
• ‘Dad, I really wouldn’t worry about it too much. After all, we all leave things around sometimes just temporarily, don’t we? We all make occasional mistakes, don’t we?’

If Dad continues to rant on about it and upsets Julie too badly, it would be a good idea when she’s not around to say something to him along the lines of:
• ‘I was really embarrassed by that outburst. Can’t you ask her quietly to move her shoes rather than attack her as if she’s committed a major crime?’

Now that so much more is known about the disorder and the way it affects families, it can only benefit everyone to address it as a family. People readily talk about such problems as bulimia, anorexia and attention deficit disorder where these occur among close ones, as well as many other difficulties that families encounter in everyday living. So why not be just as open about OCPD? Why not feel free to talk to the children about the problem? This might be healthy for a very special reason.

As I have suggested, there is some evidence OCPD ‘runs in families’. This is no conclusive proof that there is a definite genetic basis for OCPD because family ‘systems’ – ways of behaving that are passed down generations – can perpetuate patterns that are seen as perfectly normal in one family, but not by other people. It is also possible that these styles of behaviour may act as triggers to a genetic tendency, kicking it into action so that it is expressed in full. A good example of a personality disorder where this probably happens is antisocial personality disorder, believed to have a biological or genetic basis (Moran, 1999). The way a child with the disorder is raised may allow the genetic tendency either to emerge fully, or on the other hand to lie dormant and never become much of a problem.

This is possibly also the case for OCPD if it turns out that recent gene research is correct – suggesting there is a biological/genetic basis for the disorder. So, raising awareness in the family of the kind of influences that are likely to aggravate any tendency that exists, and that may bring it out, is going to be vital.

What are these influences? It has generally been thought that faulty upbringing is the cause of OCPD. This helps explain why some children show the symptoms, even though rarely – OCPD tends to show up in late adolescence or early adulthood. Although this can hardly be levelled at parents as a fault, TR Walkers often said one or both parents were emotionally unavailable. This meant they felt they weren’t valued or even loved. Now that we know OCPD runs in families, and that one of the symptoms is the tendency to stay out of reach emotionally, parents who withhold affection and reward for their children could perhaps be TR Walkers themselves. Or at least share some of the characteristics that define OCPD. So if you spot symptoms of OCPD in your children, take a look at the way the adults in the family interact with the children. Do the kids get enough cuddles and affection? Is it
spontaneous and generous and unconditional? Are the children punished severely or over-controlled, beyond what is reasonable and normal, for example to teach good manners, safe ways of doing things, and so forth?

If this nurturing behaviour is present, then maybe there is little to be done except watch carefully for a while, then if things look bad enough, get a clinician to take a look at the child. There is research that helps to underpin this advice. Aycicegi, Harris and Dinn (2002) conducted an analysis of research into ‘normal’ students. They were surprised by what they found – that a controlling parenting style wasn’t linked only with obsessive compulsive disorder or OCPD. They found it was a pretty pervasive backdrop to a wide range of other clusters of symptoms.

The team offered an intuitively sensible suggestion: that underlying generalised features such as anxiety and depression are ‘shaped’ by family and cultural patterns. This means that anxious moody children will grow to be like, and behave like, the anxious and depressed people around them, genetics or not. In short, if you’ve got a child who is prone to anxiety and depression and there is OCPD-like behaviour around, then that’s what the child will pick up. This does not, of course, mean that in any event there isn’t a ‘gene’ for OCPD, since parental controlling behaviour may well be a manifestation of a tendency to OCPD-like traits in the first place. It would also be true for narcissistic or passive-aggressive parents.

This underlines the advice usually offered to parents – to watch out that these are not reinforced by the adults around them. It is of course not possible to persuade teachers not to insist on perfection and instant obedience, but a more flexible style can be fostered at home – warm, loving and validating of the child.

**CHAPTER 8**

**HOW CAN YOU BE SURE?**

**QUESTIONNAIRES**

In the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), OCPD is defined as "a chronic, pervasive pattern of inflexibility and preoccupation with orderliness, perfectionism, and interpersonal and mental control that impedes flexibility, openness, and efficiency."

For a diagnosis, which must be conducted for certainty by a clinical
psychologist or a psychiatrist, four or more of the following ... will be present:

- Preoccupation with details, rules, lists, order, organization, or schedules, to the extent that the major point of an activity is lost
- Perfectionism that interferes with the completion of tasks
- Excessive devotion to work and productivity (not accounted for by obvious financial need), at the expense of leisure activities and friendships
- Excessive conscientiousness, inflexibility, and scrupulousness about matters of morality, ethics, and values
- Inability to throw out worn or useless items, even when they have no sentimental value.
- Reluctance in delegating tasks to others unless they agree exactly with his or her way of doing them.
- View of money as something to be hoarded; a tendency to be stingy
- Rigidity and stubbornness

The trouble with this definition is that it has already been overtaken by research and needs revision. The Russian Institute of Psychology lists on its website ‘possessiveness’ as one characteristic. According to the DSM-IV inventory, the disorder begins in early adulthood but we know similar symptoms can start in childhood.

As research is beginning to show, some of these characteristics are more complicated than they appear. For example, hoarding can also go along with chucking out things that others might hang onto (Jefferys and Moore, 2008). TR Walker will obsess about what to keep and what not to keep. What to hoard is the problem. TR Walkers are known to be indecisive.

Omitted from the DSM summary list are the tendency to depression (sometimes suicidal), the sometimes seriously violent flare-ups of temper, the fact that OCPD is now thought to run in families, and the descent into alcoholism noted in. These traits are, however, also common to other disorders. This could be why they are omitted from the summary since they do not uniquely ‘define’ OCPD.

Two questionnaires exist that people find useful in helping to decide whether a formal diagnosis of OCPD would be a good idea. I include them here.

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CAMMER’S OCPD TEST

Each statement below is rated on a scale of 1 to 4:
TRUE 1= None or a little of the time
2= Some of the time
3= Good part of the time
4= Most or all of the time
1. I prefer things to be done my way.
2. I am critical of people who don't live up to my standards or expectations.
3. I stick to my principles, no matter what.
4. I am upset by changes in the environment or the behaviour of people.
5. I am meticulous and fussy about my possessions.
6. I get upset if I don't finish a task.
7. I insist on full value for everything I purchase.
8. I like everything I do to be perfect.
9. I follow an exact routine for everyday tasks.
10. I do things precisely to the last detail.
11. I get tense when my day's schedule is upset.
12. I plan my time so that I won't be late.
13. It bothers me when my surroundings are not clean and tidy.
15. I think that I worry about minor aches and pains.
16. I like to be prepared for any emergency.
17. I am strict about fulfilling every one of my obligations.
18. I think that I expect worthy moral standards in others.
19. I am badly shaken when someone takes advantage of me.
20. I get upset when people do not replace things exactly as I left them.
21. I keep used or old things because they might still be useful.
22. I think that I am sexually inhibited.
23. I find myself working rather than relaxing.
24. I prefer being a private person.
25. I like to budget myself carefully and live on a cash and carry basis.

**Scoring:** Most people fall in the middle band between about 50 and 75, but anywhere above 70 means you’re having a problem. It’s important to get other people who know you well to share in this rating – it can be illuminating and even fun.

25-45 = not uptight;
46-55 = usefully;
56-70 = moderately;
above 70, danger zone!

The second test is taken from pages 11-13 of *Too Perfect* (1992) by Mallinger and DeWyze.

**A SELF TEST**

The first step is recognising and understanding the cluster of traits ... To help you determine if you (or a loved one) are obsessive ... tick if it applies to you.

1. Do you get caught up in details, whether you're preparing a report for work or cleaning out the garage at home?

2. Is it hard for you to let go of a work project until it's just right – even if it takes much longer than it should?

3. Have you often been called picky or critical? Or do you feel you are?

4. Is it important to you that your child, spouse, or subordinates at work
perform certain tasks in a specific manner?

5. Do you have trouble making decisions? (For example, do you go back and forth before making a purchase, planning a vacation, or choosing what to order from a menu?)

6. After you do make a decision, do you find yourself second-guessing or doubting your choice?

7. Do you find it embarrassing to "lose control" and be emotional (e.g., to look nervous, weep, or raise your voice in anger)?

8. At the same time, do you sometimes find yourself wishing it were easier for you to show your feelings?

9. Do you have a particularly strong conscience, or do you often feel guilty?

10. Is self-discipline important to you?

11. Are you especially wary of being controlled, manipulated, overpowered, or "steam-rolled" by others?

12. Is it important for you to get a "good deal" in your financial transactions, or are you often suspicious of being "taken"?

13. Do you think you're more guarded than most people about sharing your possessions, time, or money?

14. Do you tend to be secretive? That is, are you reluctant to reveal your motives or feelings?

15. Is it hard for you to let yourself be dependent on others, rather than self-reliant? (For instance, are you uneasy about delegating tasks at work or hiring help with taxes or home repairs?)

16. Do you have trouble putting a problem out of your mind until it's resolved, even when you're doing other things?
17. In thinking about some future event, such as a vacation, a dinner party, or a job report, do you dwell upon the things that might go wrong?
   18. Do you worry more than most people you know?
   19. Do you derive a great deal of your sense of worth from being able to perform your job flawlessly?
   20. Do you get extremely upset when someone is unhappy with or critical of a piece of work you have done, even when the criticism is mild or valid?
   21. Do you feel that your family life, social life, or leisure-time enjoyment is being damaged or compromised by the amount of worry, time, or energy you put into work?
   22. Do you feel guilty when you aren't getting something done, even in your time off (no matter how hard you've worked all week)?
   23. Do you make lists of things you "should" do, even in your spare time?
   24. Do even occasional "white lies" bother you?
   25. Do you find it hard to trust that things will probably turn out for the best?

Interpreting Your Responses

If you find yourself answering "yes" to more than just a few of these questions, you (or your loved one) are probably at least somewhat obsessive.

Now look once again at the questions to which you answered "yes," and for each one, answer a second question: Does this characteristic cause difficulties in relationships, work, or leisure activities, or does it interfere with your ability to enjoy life in general? If you answer "yes" to this even once, you will benefit from learning more about obsessiveness and about the possibility for change.

Before going further, however, I offer this cautionary note: If you are strongly obsessive, you're a careful person who finds security in sameness and predictability. You're more wary of change and newness than the average person – and changing isn't easy for anyone!

But change is always possible. It may involve time and a struggle. It may occasionally be painful. But it can be a journey toward a happier, more relaxed and fulfilling life.
I noted no evidence that either of these scales has been validated against the DSM-IV criteria, but they give the flavour of issues that might be a problem for TR Walker. [DSM is the Diagnostic and Statistical Manual of Mental Diso. The most recent is Verson V. The author contributed to DSM IV].

The trouble is TR Walkers are as varied and as individual as any other members of the population. It’s obvious from looking at the web sites and the way people complain about or praise them.

There is an argument that says - as Mallinger suggests – OCPD is only a problem if your behaviour is causing a problem in your life. But you may have to listen to other people’s opinions on this!

The tricky bit comes in deciding how close a TR Walker is to suffering from a real ‘personality disorder’ rather than being a touch eccentric or bossy. This is when it’s a good idea to go back to the DSM-IV definition. As I show in a later chapter on research into OCPD, this is the gold standard for sorting out subjects for research. The Manual itself has several pages of closely written information about how OCPD presents, and how to distinguish it from other personality disorders, and indeed from OCD, the ‘hand washing’, ritual-driven disorder.

A final and very important point is that until a TR Walker has seen the light, there is no insight. A sufferer from OCD on the other hand, knows something is wrong and wants to get better. TR Walker’s major handicap is certainty of being right, always, so anyone trying to convince her or him that there’s a problem is going to be resisted.

One more checklist. Zimmerman (1994) suggests the following questions in the assessment of individuals with OCPD. The trouble with this is that this checklist focusses too closely, in my view, on the ‘perfectionist’ and ‘passive-aggressive’ qualities of some TR Walkers rather than their bossiness and wacky ways. Let’s not forget where the original research was probably conducted – in someone’s office! TR Walkers were out of their
own kingdom, away from their home patch, and on their best behaviour.

The MSN OCPD support group tells a markedly different story – of some people who are, however nice and sweet and thoughtful, regularly tyrannical and bolshie at home:

• Have you ever been told that you spend too much time making lists and schedules? Do you think you do?
• When you have something that needs to be done, do you spend so much time getting organised that you have trouble getting it finished on time?
• Have you been so involved in the small details of what you were doing that you lost sight of the main thing you were involved in?
• Would you describe yourself as perfectionistic?

Would others?
• Have you ever failed to complete a project on time because of your high standards for that project?
• Would you call yourself a workaholic? Would others? If so, do you spend so much time working that you have little time for family, friends, or entertainment?
  • Do you have difficulty taking time off work because you worry about getting behind?
  • How many hours a week do you work?
  • Would you work the same number of hours if you could get the same pay for fewer hours?
• Do you have a strong sense of moral or ethical values? Do you think you are more concerned about ethics or values than other people?
• Do you worry that you have done something immoral or unethical?
• Do you find it difficult to throw things away even if they are old and worn out?
• Has anyone ever complained about all the things you save?
• Do you do jobs yourself because no one else will do them to your satisfaction?
• Do you take over other people's responsibilities to make sure things are done properly?
• How is it for you to spend money on yourself? On others?
• Do people describe you as stubborn?
• Do you save as much as you can for future problems?

For those who worry about whether they are depressed, as this often goes along with OCPD, I have borrowed a useful and easy-to-fill-in questionnaire. Consent was sought, but no reply was received. As with the checklists I’ve included earlier in this chapter, it’s important to recognise this is not a diagnosis. Only a medical professional can do this, as with OCPD, where the opinion of a clinical psychologist or a psychiatrist is essential if the condition is causing serious problems that treatment or therapy could help with. Or where relationships in the family are suffering too much.

However, if the list helps to prompt the reader to seek help, this might be extremely important. There is solid evidence, explained in Chapter 11, that OCPD can go along with quite severe episodes of depression, involving suicide and sometimes – rarely, fortunately – such a sense of devastating failure that all seems lost.

Men in particular have been known to shoot themselves, their partners and their children, or if threatened with losing their homes and children, to take their own lives and those of their children.
DEPRESSION TEST

You will need pencil and paper to calculate your score. Choose an answer for each question, note down the score, then total them. You will be able to interpret the total from the observations at the end. This is not a substitute for a proper diagnosis.

1. Over the past two weeks how often have you had feelings of hopelessness about the future?
   A. not at all (0 points)
   B. some of the time (1 point)
   C. most of the time (2 points)
   D. all of the time (3 points)

2. Over the past two weeks, how often have you been feeling low in energy or slowed down?
   A. not at all (0 points)
   B. some of the time (1 point)
   C. most of the time (2 points)
   D. all of the time (3 points)

3. Over the past two weeks how often have you been blaming yourself for things?
   A. not at all (0 points)
   B. some of the time (1 point)
   C. most of the time (2 points)
   D. all of the time (3 points)

4. Over the past two weeks how often have you been feeling "blue"?
   A. not at all (0 points)
   B. some of the time (1 point)
   C. most of the time (2 points)
   D. all of the time (3 points)
5. Over the past two weeks how often have you had a feeling of worthlessness?

   A. not at all (0 points)
   B. some of the time (1 point)
   C. most of the time (2 points)
   D. all of the time (3 points)

6. Over the past two weeks how often have you had a poor or overindulgent appetite?

   A. not at all (0 points)
   B. some of the time (1 point)
   C. most of the time (2 points)
   D. all of the time (3 points)

7. Over the past two weeks how often have you had difficulty falling asleep or staying asleep?

   A. not at all (0 points)
   B. some of the time (1 point)
   C. most of the time (2 points)
   D. all of the time (3 points)

8. Over the past two weeks how often have you had no interest in things you once enjoyed?

   A. not at all (0 points)
   B. some of the time (1 point)
   C. most of the time (2 points)
   D. all of the time (3 points)

9. Over the past two weeks how often have you had difficulty concentrating or making decisions?

   A. not at all (0 points)
   B. some of the time (1 point)
   C. most of the time (2 points)
10. Over the past two weeks how often have you thought about committing suicide?
   A. not at all (0 points)
   B. some of the time (1 point)
   C. most of the time (2 points)
   D. all of the time (3 points)

**DEPRESSION TEST RESULTS**

As noted, this test is NOT intended to give a diagnosis for clinical depression. It might help in identifying depressive symptoms, and assist in your decision about whether to seek professional help.

Total Scores of 0-10. Your results are not consistent with clinical depression. We all have "blue" periods in our lives, but if they don’t go away, see your doctor.

Total Scores of 10-20. You seem to have some of the symptoms of depression. If you continue to feel like this, or have thoughts of suicide, see your doctor.

Total Scores of 20-25. You are probably at high risk of clinical depression. You should go to your doctor with these test results and ask for a proper evaluation.

Total Scores of 25-30. You may be suffering from clinical depression and at risk of harming yourself. Get help immediately through your doctor.
WHAT IS THE EVIDENCE 
OCPD IS A PROBLEM?

People have known about Tightrope Walking for a very long time. Freud wrote about it. He called it anal-retentive personality and linked it to potty training during childhood. More recently, since the 1980s, there’s been quite a push to work out just how common it is. It’s thought to be the second most common kind of ‘personality disorder’. Some of the others you’ve probably heard about – narcissistic, paranoid, histrionic, borderline, schizoid, schizotypal, antisocial, avoidant, dependent and passive-aggressive. To check how many people in the ‘general’ population have OCPD, the problem is to find a bunch of people who are representative. Most TR Walkers don’t even know they’ve got OCPD. Often being stubborn, they’d probably refuse to have anything to do with an interviewer with a clipboard waylaying them in the street! Or knocking at the door.

So the usual trick is to swoop on people who’re already in the system: people referred to clinics or hospital for treatment for something else such as depression, anxiety or angry outbursts. In these cases – as you might expect you’re going to get figures up to more than 5%. Yet some researchers think that if you could get to ‘the general population’ to check it out, it would probably work out at around 1% to 3%. One study came up with this kind of figure.

So if you work in an office where you have about one hundred colleagues, one of them at least is likely to be a TR Walker. Or up to three. They’re usually men. Often very successful too. Who knows, maybe your boss!
As we have seen in the previous chapters, there is a great deal of circumstantial evidence that there is a genuine and distressing problem, even if it isn’t a major social issue with consequences for society as a whole. The sad thing is that, as far as I know, there hasn’t been any attempt so far to measure just how many relationships crash to earth when there’s a TR Walker around. Whether at work or at home. Or in any organisation.

TR Walkers are tough to be with, critical and often quite sanctimonious. And they’re not averse to punishing people who don’t measure up. Even with a good thumping. Someone suggested they quite like someone to do something to them so they can nurse a nice long grudge. And work out how to get back at that person!

The message boards on the Internet have many stories of vengeful and even deceitful behaviour over money and possessions during divorce, surprising in the context of TR Walkers’ position over correctness.

The best evidence about how it is to be with a TR Walker, apart from anecdotal evidence of the kind on the message boards that we’ve already considered, comes from counsellors and therapists working with people they’ve identified as suffering from OCPD, or had referred to them by doctors. Inevitably, they don’t reveal what they find in detail, although one has written about the general experience.

Glen O. Gabbard, MD, professor of psychiatry, Baylor College of Medicine wrote an article that appears on the web (© 2000 Lifescape). The following is based on the article. Gabbard points out that OCPD hasn’t been carefully studied across a long period of time. But we do know from a couple of research studies, which I will come to, that it is fairly stable for some years after first being diagnosed. Again, the message boards on the Internet cite many stories of marriages that have survived, despite OCPD, for over twenty years, plenty of time for wives and husbands to observe how consistent the behaviours can be. Gabbard points out how dutiful TR Walkers often are – seldom late, they pay their bills
promptly.

Gabbard writes about treatment, which again I will come to, but he also comments on some of the trickiest OCPD characteristics. He mentions anger. When TR Walkers are angry with someone, rather than expressing it, they may do the opposite: try to ingratiate themselves and flatter. He must be talking here about situations outside the home. Besides, anger is likely to be hidden or not admitted to as shameful. The therapist may have to point out to the TR Walker that his or her defensive reaction to any comment by the therapist may be more to do with the TR Walker being sensitive to faults in him or herself. For this reason, it might be quite a long slog to persuade the TR Walker to drop the guilt and lower his or her high standards.

He mentions too how often TR Walkers have repetitive thought patterns that spring into action automatically. These often incorporate their own arguments to persuade themselves that their beliefs are okay and right. They’re a kind of monologue, a conversation with themselves. Sometimes this is out loud and non-stop.

Professor Gabbard observed how uncomfortable some TR Walkers are with intimacy and ‘emotional connections’. This doesn’t mean to say they don’t love their nearest, or want to feel close. But emotional intimacy – actually opening up – may feel threatening.

The same may be true for TR Walker’s relationship with the therapist. Gabbard comments on how tricky it might be to get a TR Walker to therapy in the first place. The chances are he or she can’t see the need. ‘Why? I’m doing fine? Look at me, I’m at the top of my profession. Look, you’re the sick one. You’re the one who needs therapy.’

Most TR Walkers in therapy are only there because of ‘a lot of family pressure’. So the family might have to tackle TR Walker en masse, pointing out how the family is losing out through the effects on personal relationships that the disorder is causing.

As already suggested, TR Walkers suffer from some difficult personality
handicaps, among the worst rigidity and stubbornness. This is why they may find it hard to take a different view – it’s not in their nature to do so. Appealing to their sense of decency might do the trick. Many have very high morals. But the family needs to recognise that it could take a long time for TR Walker to admit that he or she has a real disorder and that this is what’s behind the difficulties in the family.

Gabbard suggests encouraging TR Walker to do some reading first to help convince him or her that it’s not other people – it’s TR Walker’s own problem.

In Chapter 11, I summarise Raja and Azzoni’s report into research on TR Walkers in hospital after almost lethal suicide attempts. In short, they were their own worst enemies. They not only hid their symptoms of depression but got into disputes that helped depress and frustrate them further.

As noted, much of the evidence that OCPD is a problem comes increasingly from support-forum anecdotes. The consistency of stories is truly surprising, right down to the kind of detail that enrages TR Walkers and leads to conflict. Sadly, as far as I know, this vast source of evidence has yet to be tapped and may never be. The anonymity of message boards is important. Those who live with TR Walkers are often keen to keep secret the fact that they are writing publicly about their difficulties. I have nevertheless drawn on the essence of this material to bring alive the points I’m making. But it’s important to recognise it for what it is – no more or less than ‘chat’ on the Internet. Yet it rings true and suggests a largely hidden social problem. Who knows how many marriages break down, how many children are left in sole parent households? How many suicides are the consequence of OCPD?

10
MORE ABOUT HOW YOU CAN TELL

As I’ve pointed out, a proper diagnosis by a professional such as a clinical psychologist or a psychiatrist, is the only way to be sure about whether you or your TR Walker have OCPD. But it helps to compare notes, to hear what people who have to live with it say about it. So let’s now look at some of the complaints people make about TR Walkers.

The MSN support group from which I have drawn inspiration showed
its first posting on the message board in 2003. It took a while for the forum to get going but it’s now vast with over 2000 members. Monthly postings have steadied out at around 500.

The saddest thing is the sheer scale of the negative reaction from people who have to live on the tightrope with the walker. The pain and anger is huge. And the heartbreak. Some of the stalwarts have learned to cope by a distancing technique. A number have managed to persuade their partners to read the literature, go to counselling, or at least try to respond to suggestions about how not to upset everyone else.

It’s hard to know how successful this is without some proper research, but many TR Walkers shy way from that. There are, though, success stories. However, the TR Walkers’ rules for life at home are beyond the understanding and sometimes tolerance of those who live with them. To this end, I have selected and paraphrased an assortment of odd rules that partners or ‘close others’ think epitomise what they have to live with. They seem funny enough on paper, but it plainly takes more than a sense of humour to tolerate them.

- He’s convinced the sea and river are going to flood our house whereas there’s no evidence it can. But we’re all set and prepared in case. We mustn’t leave our shoes on the floor inside the door in case they float away, so they go on a shelf over the door. We keep a lot of old clothes in the loft because if ours get wet, then we’ve got some dry ones. Everything in our food cupboard has to be in plastic containers, and we keep a string bag behind them so we can tow them when we swim out. I dare not buy anything in tins. Too heavy, and they’ll rust. I did once. He lost his temper and slapped my face.

- If I put my coffee mug on the little table by the sofa and it’s not exactly in the middle, he’ll get up and move it. And rant at me. It’s got to be in the middle because, he says, it might tip the little table over.

- The kids’ coats are all hung in the cupboard in the hall. I used to have their own pegs for them, like they do at school, with little labels I found
in a shop with their names on. She’s reorganised the cupboard. The coat pegs are graduated sizes, as are the coats. My kids are 5, 8 and 12. The pegs go left to right, the smallest first, up in size. The coats must be hung backs to the hall so no one can see inside the linings. You have to button them up first so the collars sit nice and not creased.

• I use washing powder for the laundry. He used to go on about it not dissolving but won’t let me buy liquid detergent. He reckons it’s too expensive. We make our own. He says you can never exactly measure how much shop liquid to put in. So it’s got to be powder. He got me some letter scales to weigh it. He’s made a chart. It’s on the wall.

I have to weigh the washing on a spring balance in a shopping bag, then refer to the chart for the amount of powder. That also depends on what the fabric is. I have to weigh out the powder, then mix it in a medicine mixer with warm water. He’s hung a thermometer up so I can get the temperature right. Then I have to put the lid on the mixer and shake it until the powder is dissolved. I have to time that. And so on. I get so fed up. If I didn’t do it that way, he says he won’t let me near the washing machine again. If I do it while he’s out, he gets livid with me.

• She takes two days a week, all day, she says, balancing the books. That’s paying the bills, checking the stubs on the cheque books against the statements, checking up on our investments. She goes on the web and looks up the interest rates, what’s going on in the stock markets, doing comparisons all over the world. She siphons off every penny she can find to put away. Someone said that’s normal for OCPD. Like hoarding money. And she’s dead mean. She stands over the kids while they’re spending their pocket money in case she’s given them more than they really need. She cancelled Brett’s football club subscription because she said it was a waste of money as he didn’t go to all the practices. She makes Sophie eat the stale crusts on the bread, but she does a nice thing with them. Soaks them in the last of the milk in the carton, wipes them round the sugar bowl where the sugar has stuck on the inside, then fries it in the fat she’s cut off the bacon. It smells good, I must say, but Sophie hates it. And if she doesn’t eat it, my
wife won’t let her have tea.

- When you go into Waitrose (never use Tesco or Sainsbury), after you get through the door, go left, clockwise round the outside, then go down each aisle in order, clockwise from the left. Up one side, down the other. Then cross to the next, up one side down the other side. Never cross an aisle when you’re viewing them. If there’s a cheap offer advertised in the paper, be on the doorstep at 8 am and do nothing else. You might find something you can keep for emergencies. When you leave, move the car up near the main road in case someone hits it when you’re too far away to see it happen. Then go down into town for any shopping you have. You mustn’t cross the road through the underpass as it might fall in. When you’re in town, never buy anything at the full price. Everything has to be a bargain. Perish the thought we don’t take the lists. One for ‘dry goods’. Another for perishable things like meat, fish, fruit, vegetables, eggs, milk, bread, and such like. When you pack the food in the bags, you’ve got to put dairy in one, meat in another, flour things in another, and so on. Shopping’s a chore, a misery. I hate it, but she says she needs me there. If I don’t go, she says it’s proof I don’t love her.

Some people manage to cope with this, but many don’t. The message boards on the worldwide web are full of stories of marital and relationship breakdown, and of aggression from the TR Walker where there is any attempt to resist her or his demands. Resistance works both ways. Some TR Walkers themselves react to a demand or request from a partner (or child) with ‘demand resistance’. Someone pointed out it’s like a game of cards. The other person’s demand is like them using a trump, so TR Walker objects. Giving in over the ‘trump’ would be like TR Walker conceding a game. It’s against their nature. Demand resistance can get nasty. This is often when violence enters. Or at least sulking.

And yet, as we know, many TR Walkers go out of their way to help people, and are loving and giving. So it’s important, if you’re living with
one, to look at the ‘good’ side and bear that in mind. More about coping later. Here’s another checklist compiled by studying what critical relatives say about TR Walkers. If you tick more than four or five, there may be a problem:

- Can’t understand why other people get cross with her/him even when people point it out. Seems to be prepared to toe the line at work, goes along with it, but boils with resentment. Is afraid of blowing up one day and doing something silly. Tells people it’s okay, and is perfectly happy there. People keep saying it doesn’t look like it.
- Has a good old sort out to decide what’s important to keep then there’s a big issue over what to chuck out. It doesn’t make sense to others, but TR Walkers says it’s because it’s the only way to keep the place tidy. The trouble is, it takes ages deciding what to chuck out.
- TR Walker insists he understands other people better than they understand themselves. Tells them what they think and believe. When they deny it, TR Walker accuses them of lying.
- Keeps feelings locked down, but often shows a caring helpful side.
- Hates to see people indulge their emotions, but he’s kind of fascinated by it. Maybe he’d like to do the same, but can’t let himself.
- When the feelings are let out, they’re the kind of feelings that just can’t be kept down, like tears or anger.
- Writes lists of what to do or where things are, or how to do things. Posts lists up in the kitchen or where everyone can see them.
- Wraps up the garbage in neat parcels. Cleans out the dustbin after use.
- Keeps a list of everything in the freezer with dates against each item.
• Keeps the heating in the car down to a fixed temperature. Turns it off in the bathroom.
• Saves money and tucks it away in secret accounts and in boxes he hides from me.
• Thinks she is ‘responsible’, so she says she’s got to be in charge and make other people accept that.
• He thinks other people are irresponsible or sloppy or too casual, or too unpredictable. Or irrational.
• Isn’t aware just how upset other people are at what he or she is doing, or trying to force on them.
• ‘House devil, street angel.’ Domineering at home, polite and deferential in public.
• Has a special place for each thing in the fridge, exactly to the last inch.
• Very competitive.
• ‘Driven’. Always on the go, can’t relax.
• A tendency to ‘rant’ over trivial things.
• A rule he or she has made up is important.
• Once his or her mind is made up, just won’t change, no matter how many logical arguments are put forward as to why he or she might have got something wrong.
• Works out carefully what is the best way of doing anything, spends a lot of time checking it out, then imposes that as the ‘right way’ to do it on everyone around.
• Has little rules that make no sense, such as only green ink to be used to write entries on the calendar on Sundays, black ink during the week and red on Saturdays.
• Has a caustic sense of humour, satirical and scathing.
• Has sudden unpredictable outbursts of temper over something that hasn’t gone right, usually because of someone else’s stupidity.
• Parents or uncles and aunts, or grandparents have the same problems, even if undiagnosed.
• Gets into power struggles at work.
• People say he or she is a ‘control freak’.
• Obsessed by the possibility of future danger, not always logical. Has a picky attitude to food, almost like an eating disorder such as bulimia or anorexia.

If you’ve ever watched Sesame Street, Bert has OCPD. Many TR Walkers aren’t anything like this, but it’s the kind of picture that comes out of the message boards and also what professionals write about TR Walkers. This is sad, because these are almost always very decent, honest people, with all the best intentions in the world. And a sense of guilt, with strong consciences. Work comes first. For some TR Walkers, wife, kids, partner, friends, going out and having fun, don’t come into it. This is because at some level, they believe they’re the only person who can do their job properly. Or they feel it’s their duty to fulfil their commitment to their employer. And this is all-consuming. Utterly. TR Walkers sometimes can’t see the wood for the trees. They can’t raise their heads above the detail to see the whole picture. They get terribly bogged down with the ‘leaves on the trees’. It’ll take them twice as long or more to do something another person might dash off quickly. But it would never be to the same standard, in the eyes of TR Walker, as if she or he had done it themselves. Outside work, TR Walkers can be lovely fun, but they’re often isolated because they make it very clear to everyone around that only they know things or can do things. They can be smiley and smug, irritatingly self-righteous and self-certain.


Again, it’s all negative. They can’t win. It’s sad for them personally. They’re doing their level best, all the time, so why the name calling? No wonder so many get depressed.

Backed into a corner, they trust no one and can become quite difficult to
deal with, so people see them as ‘pigheaded’. The reason for this seems to be that TR Walkers are terrified of things slipping about and changing. But they don’t realise this is their own problem and not the fault of others.

To get a perspective on this negative catalogue of perceived faults, we need to remind ourselves some of them aren’t necessarily faults. They’re qualities that are best used in the right place as long as TR Walker doesn’t go over the top. Let’s face it, we need people like TR Walkers to see to the nitpicking detail – writing, legislation, planning what should go into a spacecraft.

If not writing books, copy editing them! Their preoccupation with attention to detail means they have all kinds of fears about not being ‘prepared’ for the future. As we’ve seen, it shows up in the way they anticipate imagined disasters. Or they’re almost phobic about things getting broken or harmed.

Perhaps this links with a tendency to rarely discard useless objects if they can possibly see a way of using them in the future, a future that’s full of scary possibilities, anything changing being one of them.

So they won’t want to switch the furniture around. Or tolerate untidiness. They’ll go on at the kids about their rooms or clothes. Nor do they like to relocate. Or deviate from the familiar route to work, allow a bit of slack in an itinerary, or do anything for fun on the spur of the moment. It all confuses them. It makes everything too unpredictable.

If you have TR Walker as a subordinate, and you can’t agree, there’s trouble. You might get defied if you try to make TR Walker do things he or she doesn’t think are right. You may even be forced to sack them or push them out. Often that’s not the right tack. They probably have some good ideas, so listen, and then make up your mind! They’re mostly best off working for themselves, then they can be top dog. They make good soldiers, pilots, policemen, doctors, lawyers, and politicians.

You’ll come across them a lot in finance, engineering and computing, in teaching and in universities. In fact, anywhere their undoubted qualities come in handy.

If they hit failure, though, this is when they’re at their most vulnerable. There are documented examples of people (men, usually), killing themselves
and their families. This is because the worst thing would be to lose home and family. That’s where they’re kings or queens. Home is where they can impose their own rules right down to the last detail. After all, they’re experts at this. In theory, everything at home should be straightforward and utterly predictable. So TR Walkers may fight to the last inch rather than leave their homes and everything that’s familiar, including their children. They have been known to lie in court so as to make sure their spouse is the one to leave, while the children and home – along with all the certainty and routine TR Walker knows and prefers – remain under his or her control. The Internet message boards show many stories about crooked thinking and behaviour over money, possessions, and what is to happen to children. TR Walker, as we need to remind ourselves, has to be right, and can be nothing else.

Whatever he or she chooses to do is nothing but right. TR Walkers are not particularly slow to offer the evidence to a shrewd observer that they suffer from this disorder. They ‘tell’ it, all the time, to those around them prepared to listen and watch what they say and do. A simple test is all you need to be sure.

Four things, research shows, stand out and don’t vary much between sufferers, or across time:

1. Nitpicking preoccupation with details, arranging things and keeping them in order.
2. Rigidity and stubbornness.
3. Reluctance to let other people do things or to delegate in case others get it wrong.
4. Problems with social relationships. That is OCPD in a nutshell, whether in children or adults.

**CHAPTER 11**

**WHAT ACADEMIC RESEARCH SAYS**

In this chapter, because we’re dealing with ‘formal’ material, I’ll drop the term TR Walker in favour of OCPD sufferer. If you’re bored by formal academic stuff, skip this chapter, but having said that, I’m only going to summarise what’s been found. The full references are in the last pages.

There are many books and academic articles about OCPD, but not a lot
that reflect exhaustive research into the inner world of OCPD sufferers. This chapter points to some research reports that might help the reader see what it’s all about. Most of this is fairly recent.

Even though OCPD is a distinct personality disorder rather than a disorder of ‘obsessions’, eg hand washing or avoiding the cracks in the pavement, there can be an overlap with OCD. Some OCD patients have OCPD features, as well as ‘tics’, as in Tourette’s syndrome. But this doesn’t mean to say they’d get a full OCPD ‘label’. Most people, after all, show some of the OCPD characteristics, even if not enough for a full diagnosis.

I’ve already mentioned the best-known inventory for checking whether OCPD is a meaningful diagnosis – the DSM-IV details are in the Bibliography. The DSM is updated periodically, but it looks as if, given new research, that OCPD might have to be shifted to another Axis or Cluster for a better fit. Apart from the DSM-IV and the other checklists I’ve given in Chapter 8, there is another ‘formal’ way of checking. This is the Leyton Obsessional Inventory (LOI). It’s a self-report questionnaire that assesses obsessional symptoms. A study in 2007 had a look at this to see whether it could pick up differences between the ‘hand washing’ OC disorder and OCPD.

The researchers found that the distinguishing feature of OCPD is the habit of ordering and arranging things.

But they came up with nothing on ‘parsimony’ (stinginess), but they were, after all, looking at ‘self reporting’, which is inevitably flawed. One pretty clear link, obviously not 100%, is between OCPD and eating disorders. A study in 2005 looked at the link between ‘perfectionism’, OCPD and OCD among a group of patients suffering from eating disorders. Unsurprisingly, they came up with the finding that perfectionism was more linked with OCPD than OCD. This, the researchers suggested, might be why OCPD sufferers are more likely to suffer from eating disorders than people with OCD, the ‘hand washers’. Some go as far as anorexia or bulimia, so eating fads ought perhaps to be on the official checklists. In another study into eating disorders in 2003 by Anderluh (et al), childhood OCPD traits could have been used to predict eating disorders in adulthood. For every extra trait on the DSM-IV list, the chances of there being an eating disorder
in adulthood increased by a factor of 6.9. People with eating disorders who reported perfectionism and rigidity in childhood had significantly higher rates of obsessive-compulsive personality disorder (sometimes also with OCD) alongside their eating disorder, compared with eating disorder subjects who did not report those traits. If a child shows four or more of the characteristics on the DSMIV list, then there’s a good chance of an eating disorder in adulthood, and along with this of growing up to be a OCPD sufferer.

What does this mean? OCPD and eating disorders might be closely linked. So this is something for parents with perfectionist children to be alert to. And that’s not all. Children who have OCD symptoms in childhood, even if they grow out of these, are also likely to grow up with OCPD.

So what about adults with OCPD? Frances et al. (1995, p. 378), in what I recognise instantly more readily than the DSM catalogue, described individuals with OCPD as ‘perfectionistic, constricted, and excessively disciplined; behaviourally rigid, lacking empathy, intellectualized, and detailed; aggressive, competitive, and impatient; driven with a chronic sense of time pressure and an inability to relax; controlling of themselves, others, and situations; indirect in their expression of anger although an apparent undercurrent of hostility is often present; some strongly inclined to hoard money and other possessions; preoccupied with orderliness, neatness, and cleanliness; inflexible and stubborn in relationships.’

The ‘indirect’ expression of anger can be through sarcasm, ‘sending up’, or making fun of someone, humorous mocking. If in writing, satire would be a typical outlet. According to Millon and Davis (1996, p. 505) OCPD is a ‘conflicted personality style’. Individuals with OCPD possess traits that are in conflict with one another.

Their interpersonal style and intrapsychic structures can never be fully focused nor coherent due to internal schisms that can neither be escaped nor resolved. Millon and Davis say the essential conflict is between obedience and defiance. On the face of it, OCPD sufferers behave in a normally compliant fashion. Inside, though, all they really want to do is assert themselves and defy any rules imposed upon them.

Basically, individuals with OCPD consciously behave like the dependent PD – appearing to do as they are told while unconsciously they ‘feel like’ a person with antisocial personality disorder (Millon, 1981, p. 218) – and in my own experience get round to it from time to time.
As in Dependent Personality Disorder, people with OCPD incorporate the values of others and submerge their own individuality. But they don’t really do this fully because inwardly they are defiant. The more they adapt, the more they feel anger and resentment (Millon & Davis, 1996, p. 505). This makes them uncomfortable people to have as subordinates, or even as bosses, suggesting they will feel unsettled in any organisation that wants them to conform.

Richards (1993, p. 255) also suggests OCPD shares qualities with the antisocial (aggressive) and the dependent (submissive) styles. This could explain individuals who choose to work in structured organisations but find themselves wanting to change or break the rules.

Individuals with OCPD see themselves as responsible or ‘in charge’, so they often attract the ‘bossy’ and ‘interfering’ labels. They believe that they must be self-reliant. They might feel overwhelmed if they do not have systematic rules and regulations to follow (Beck & Freeman, 1990, pp. 46-47).

These individuals are as harsh in their judgment of themselves as they are of others (Millon, 1981, p.226) so can be deeply unpopular. They value control over most other virtues. They emphasise discipline, order, reliability, loyalty, integrity, and perseverance (McWilliams, 1994, p. 298). If they fail to live up to their own ideals they can go through periods of self doubt and guilt. Yet they don’t recognise their own ambivalence about achieving aspirations and meeting expectations (Millon, 1981, p. 226).

As has also been seen through Internet support groups, individuals with OCPD see others as too casual, irresponsible, self-indulgent, and incompetent (Beck & Freeman, 1990, p. 46). They are contemptuous about people whom they see as ‘frivolous and impulsive’. They consider emotionally driven behaviour immature and irresponsible.

They don’t usually recognise that the rules they use for judging other people are rules they unconsciously detest themselves (Millon, 1981, p. 226), suggesting that perhaps that’s just how they would love to behave, but won’t allow themselves to. Perhaps Sutcliffe, the ‘Yorkshire Ripper’, was an example – he claimed to disapprove of prostitutes yet visited them.

Unfortunately, OCPD insistence on doing things according to rules – which they can always support with logical arguments – upsets other people. Some individuals with OCPD do become aware of their impact on other people but don’t understand it at all. They’re inclined to think that other people have no right to react to them in that way (Turkat, 1990, p.85).
Research in 2000 found a link with paranoid and schizoid personality disorders. We all know what paranoid means. Schizoid refers to lack of interest in social relationships with a tendency towards a solitary lifestyle, secretiveness, and emotional coldness. This may be why the formal definition of OCPD mentions this batten down of emotions. But it’s not the entire picture for all OCPD sufferers – many are not like this at all, even though they may present several other features and therefore qualify for the OCPD label.

It’s as well to be aware of the paranoid streak in OCPD sufferers. This is how they get into arguments. They may react very negatively to being challenged. It’s seen as a criticism. People with paranoid natures can’t take that. It feels like a dangerous attack on them. This feature explains the angry and resentful nature of some OCPD sufferers, or at least explains their tantrums at home if they’re crossed.

There has been a huge amount of research into links between OCD and OCPD (see Wellen et al, 2007). Again and again, the proof is returned that these two are not closely related. This doesn’t mean that hand washers don’t show OCPD symptoms. But the important difference remains: hand washers know something is wrong, whereas OCPD sufferers don’t until they have it pointed out to them and begin to accept it. Even then, some can’t ever believe it and continue to think there’s nothing wrong with them that isn’t the fault of someone else.

The other big difference between OCD and OCPD is that OCPD sufferers need to control.

How common is OCPD? A study in 2004 by Albert and associates, using a ‘normal’ sample recruited from doctors’ practices so as to compare with people suffering from anxiety disorders, found the OCPD rate among ‘normal’ people was 3%. Other studies have come up with lower percentages, so it’s likely to be somewhere between the two, so 1-3%.

Some recent research into the suicide risk of patients with ‘mood’ disorders – depression and ‘bipolar’ (manic depression) – was completed in 2007 by Raja and Azzoni in Italy. They studied 1699 psychiatric patients admitted to a clinic and in particular 109 cases where patients were admitted for intensive care after suicide attempts. When OCPD was present, they found that both relatives and hospital staff tended to think patients were just being awkward – manipulative or provocative.

The authors concluded that symptoms of OCPD were a distraction from the underlying mood disorder. This was thanks to a tendency to denial,
whether about the seriousness of their almost lethal suicide attempts, their true feelings, or the potential usefulness of medication or hospital treatment. Basically, what the researchers were saying is that it’s harder to work out just what is going on in the minds of OCPD patients because of their stilted and cool, off-hand maybe, manner in public. They thought that OCPD actually made the depression worse and suicide more likely. This was because once patients realised they’d lost control of aspects of their lives (finances or personal relationships) they were likely to act angrily and impulsively then pretend they hadn’t.

Compared with other patients, those with OCPD were the most likely to have made seriously lethal suicide attempts – 70% among those studied as against 27% among the other patients.

The authors presented seven case studies. They commented on how the ‘controlling’ nature of OCPD patients enabled them to pretend they were better although they were still showing underlying symptoms. Among these were insomnia or hypersomnia, weight loss or gain, as well as unusual, even risky behaviour, along with non-typical levels of activity.

The researchers also checked on previous ‘mood’ episodes to see whether patients were behaving in a similar or different manner. Based on their case studies, Raja and Azzoni made a number of important observations. OCPD patients believed that spending had to be tightly controlled to provide for future catastrophes. What differentiated ‘persons with OCPD from others’ was less their own reaction to financial misfortune than the attitudes of relatives and significant others to their problems. They felt their relatives were inadequate and irresponsible. This led to resentment and quarreling.

The researchers were struck by just how contradictory it was for patients with OCPD, who displayed such a penchant for control, to find it so hard to deal with marital problems. Their OCPD patients’ methods of interpersonal control vacillated between despotic over-involvement and angry rejection. Presumably, their suicide attempts were the result of not being able to control their relatives’ attitudes to saving money.

What causes OCPD? Is it genetic or down to nurture or environment? Is it ‘in the genes’? Or down to what’s happened along the way? A study in 2007 (Reichborn-Kjenneru et al.) looked at the extent to which genetics play a part
in three personality disorders, including OCPD. The researchers used identical twins and a comparison group. They also studied environmental factors. They looked at one feature of personality that all three groups shared. Among the OCPD group it turned out to be the least heritable and also the least influenced by environment.

The researchers argue on the basis of this that OCPD is distinct from the other personality disorders in this ‘cluster’, as defined in the DSM. All this really says is that OCPD does not fit in that cluster. It says nothing about whether it’s genetic or not.

Research into eating disorders strongly suggests ‘familial transmission’ of OCPD along with anxiety neurosis (Lilenfeld et al, 1998). This makes sense. OCPD must involve feeling anxious about getting things right. Other researchers have identified a specific genetic link. In 2003, a team in New Zealand took DNA samples from 145 depressed patients – not a bad place to find OCPD sufferers, as we know. They looked at three polymorphisms of the DRD4 and DRD3 genes so see if having these had anything to do with obsessive-compulsive and ‘avoidant’ personality disorders rather than with risk-taking behaviours. Polymorphisms are expressions of different genotypes.

The research found a link with all three phenotypes. Further, the research team found that the 2-repeat allele of the DRD4 exon III polymorphism, the Gly9,Gly9 genotype of the DRD3 (Ser9Gly 72 polymorphism), also the T,T genotype of the DRD4 -521 C>T polymorphism, were all linked with a greater chance of patients scoring on an assessment scale for either ‘avoidant’ or obsessive-compulsive personality disorder, but not with risk-taking. This again makes sense. After all, OCPD sufferers, we know, like things to stay the same, so tend to caution.

In 2006, another study into a D3 receptor gene confirmed that there is a high chance, if you have a particular type of the gene ‘DRD3’, that you may develop OCPD, especially if you’re male. Males with this genotype of the DRD3 gene were to a highly significant degree (p=0.001) most at risk. The researchers noted that the D3-dopamine receptor gene, DRD3, is also suspected to be behind several disorders where the dopaminergic system might be involved. What does this mean? Dopamine is produced in a very old part of the brain and is linked with cognitive and emotional functions, and sometimes with repetitive behaviours.
This is only suggestive research at this point, but it may well turn out that OCPD has a definite genetic basis. This possibility has been explored. In 2000, Nestadt et al, in a carefully controlled community study, found OCPD in around 32% of OCD subjects, compared with 6% of ‘controls’. OCPD appeared in 12% of OCD case relatives, compared to 6% among ‘control’ relatives. Of personality disorders, only OCPD occurred significantly more often than expected in the case relatives, suggesting shared heritability linking the two disorders, OCD and OCPD. Measures of neuroticism were found to be significantly higher in relatives too, involving anxiety, vulnerability to stress and self-consciousness. The authors suggested the existence of a common inherited temperament that goes along with OCD and OCPD in families. In a second study in 2000, Nestadt et al. found that OCPD was over represented in never-married high school (University) graduates, while OCD is known to have high celibacy rates. However, OCD is not a prerequisite for OCPD.

Indeed, as Irle et al. (1998) suggested, after following up patients who had had brain surgery in 1970, OCD and OCPD might involve different neural pathways. Fineberg et al. (2007), in a review of research into the ‘boundaries’ between OCD and other disorders, suggested that OCD is characterised by ‘harm avoidance’, while OCPD goes along with wanting ‘completeness’, in other words ‘closure’ – the feeling that things are ‘just right’, or perfect.

In 2005 Skodal et al. showed that OCPD patients, checked for ‘functional impairment’, in 2003 then again in 2005, showed no improvement overall. The most severely affected aspect was ‘social functioning’. Their social functioning was no better at all. This is not a happy conclusion – it means that OCPD sufferers cannot expect to just ‘get better’, or get on better with other people, without doing something active about it.

While this research was going on, Grilo et al. were having a look at OCPD patients in 2002, then again in 2004, checking them against the DSM-IV criteria. The aspects of the disorder most likely to be still there in 2004 – at about the same levels as in 2002 – were still ‘preoccupied with details’, ‘rigid and stubborn’, and ‘reluctant to delegate’.

Another aspect of OCPD that often attracts comment on the message boards is a tendency to unreasonable outbursts of anger. What has puzzled the professionals is why OCPD sufferers, known for their controlling nature,
are prone to angry outbursts.

In 2004 Villemarette-Pittman et al. came across ‘an unexpectedly large number of OCPD diagnoses among patients clinic referred and self-referred for aggression problems’. So the anecdotal evidence checks out. After all, OCPD sufferers respond to antidepressant medication, and angry outbursts and irritability are often features of depression. After all, Freud called depression repressed anger. In summary, there is growing evidence that OCPD runs in families. Although symptoms can be brought under control, where OCPD goes with serious depression, it may be misdiagnosed and the backdrop to suicide. The persistent symptoms are rigidity, reluctance to delegate, preoccupation with details and difficulty with social relationships.

CHAPTER 12
GETTING OFF THE TIGHTROPE

The first step is for TR Walker to accept something is wrong. This isn’t always easy, as the reaction is likely to be defensive and angry. However, if it’s made clear how the happiness of other people could depend on treatment or counselling, slowly TR Walker might come to accept the need to go for help.

Normally, treatment for OCPD involves self-help and psychotherapy. There are quite a lot of options available in the UK, including the support of specialists.

Sometimes support groups are a sensible first step – meeting others with the same background to share experiences and gain encouragement. Your local mental health organisation will know what is available. You can ask through your doctor. Indeed, the general practitioner might be first place to ask. Although medication isn’t normally offered, SSRI type antidepressants can be helpful. This is because there’s often underlying depression in any event, regardless of all the other symptoms that might be causing problems for TR Walker. SSRIs can also help damp down the sense of frustration and resentment. Anxiety and feelings of dread can also be helped by anti-anxiety medication. This can help cut down dependence on alcohol. Attention Deficit
Disorder. Medication has been found by some people to improve mental focus. This helps with getting jobs finished where this is a problem. The objective of any medication, of course, is to quieten down the turmoil in the mind of TR Walker, improve the sense of well-being.

This can ‘kick start’ recovery. Cutting down on caffeine – in coffee or Coca Cola – is a good idea too!

ACAT. Association for Cognitive Analytic Therapy, PO Box 6793, Dorchester, DT1 9DL, United Kingdom. Monday to Thursday 9am to 5pm. Tel: 0844 800 94 96 [local call rate]. Website: http://www.acat.me.uk

Cognitive-behavioural therapy is a powerful technique that works with some people, but it might take a long time. Some TR Walkers don’t want to do this – they need to trust and respect the therapist, and that might come hard. Cognitive-behavioural therapy is based on the idea that the patient can develop skills through self awareness that allow her or him to monitor what is going on, both in their own minds and in what they’re doing. Once awareness and self-monitoring is ongoing, changes begin to happen.

COGNITIVE-ANALYTIC THERAPY

(CAT) (Ryle, 1995 and 2003), which research shows can help, falls under this heading. This would be an example of how CAT works. Let’s say TR Walker has just got upset because his wife has put the vacuum cleaner back in the wrong place in the under-stairs cupboard, a cartoon displaying his reaction to his wife’s decision has been shown in an earlier cartoon. Rather than launch into an inquisition, he’d be expected to question himself about what precisely has upset him. Then go into a process of talking to himself about the feelings this has generated in him.

And how reasonable they are – or otherwise. Often it involves keeping a diary and hatching out a plan with the therapist. The idea is to replace negative strands of thought with more positive ones. TR Walker is upset because he feels his advice about where best to put the vacuum cleaner is being ignored. Therapy will suggest that he adopt the notion that one person’s advice is as good as any other’s. The aim is to teach him a more flexible way of thinking.

It’s true that personality disorders can be difficult to treat. They involve
such deep-rooted patterns of thinking, feeling and ways of relating. But many
people do in fact change the way they think and behave, learn to control their emotions
and eventually lead more fulfilling lives. The key to success depends on:

- monitoring thoughts, feelings and behaviour
- being honest about one’s own imperfections
- accepting responsibility for solving problems
- rather than blaming someone else
- being open to change
- staying motivated

The usual talking therapies aren’t always as helpful to people with a personality disorder as they are to others.

Group therapy can do the trick. Groups usually have practical aims, and an emphasis on social skills and assertiveness training. Assertiveness doesn’t mean being bossy. It’s about being skilful in dealing with others, and not finishing up feeling guilty or put down, as TR Walkers often do.

Groups can be good fun too and offer the chance to practise new skills and try out different ways of doing things. It might feel strange to people who prefer ‘special’, one-to-one relationships, but they allow TR Walkers to try out different relationships and form fresh attachments. It can be illuminating to find that other people care too and that it’s not necessary to have someone close and comforting
to gain support and endorsement.

Attending a therapeutic community for a number of months can be helpful. The NHS runs some, but these are usually for the most severe personality disorders. The emphasis is on working together so that staff and patients share responsibility for tasks and decisions. People are encouraged to express their feelings about one another’s behaviour in group discussions. This means facing up to the impact your attitudes and behaviour have on others. As not everyone there will have OCPD, this can be very illuminating.
One of the problems, as will readily have been seen here, is that there is a tendency to see only the worst in TR Walkers. This book has many pages of negative observations, some of them key to the definition of the disorder. This is just as true of the online support groups, which tend to be full of the pain of people who see themselves (often rightly) as the ‘victims’ of TR Walker abuse.

So if you’re a relative, remember to give weight to and praise for the good things. As we have seen, TR Walkers are often loving and decent people who need to make the best of their strengths and abilities. They all need the encouragement of friends, family and professionals to change their behaviour. This means everyone being on their own best behaviour! No negativity, no name-calling or judgmental statements.

ADVICE FOR SUPPORTERS: Try to identify situations that bring out the best or worst in your TR Walker. For example, even if intimacy is an issue and he or she is uncomfortable with other people, it can help if TR Walker is encouraged to get lost in, say, discussing a subject that really interests him/her deeply. So if your TR Walker is a home body, try to encourage him or her to join things outside the house. Not only is this a distraction, but a way of getting in touch with like-minded people. A society, club or further education class might do.

As we have already noted, some TR Walkers are ‘big’ in any event in being involved outside the home as naturally helpful people. They often have intelligence, drive and skills that are useful in the community. While treatment is going on, it’s important to keep this good work going – it’s an excellent foundation for restoring TR Walker’s sense of self worth.

There are many success stories. Getting outside help is only half the story though. The family is the rest. Here are helpful ideas for ‘significant others’:
• Recognise that when TR Walker is upset it’s not your fault but TR Walker’s fear and anxiety speaking.
• Draw an invisible boundary to mark your own emotional area. Withdraw behind it. Stay calm.
• Imagine you’re observing something happening to someone else. This helps with ‘distancing’.
• Put your own support system in place. Find a counsellor to whom you can regularly offload. Or a good friend might help, someone who’s seen what you’re going through.

The more you react negatively to TR Walker, the more difficult it is for both.

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COPING WITH VIOLENCE

As family members in OCPD households sometimes reveal to friends and relatives, or to their doctors, or in support groups, violence is a not uncommon feature of the lives of some couples or children where there’s a TR Walker in the family.

The reason for this appears to be that TR Walker’s need to control everything and everyone around leads to a huge build-up of frustration and anger if this goes awry. Any opposition is going to be experienced as a kind of attack on what TR Walker sees as right.

In some cases, the anger can build up to the point where it spills over. This is called ‘disinhibition’ by psychologists, but it is nothing other than loss of control, something TR Walker will rapidly feel guilty about as perfect control is important. But being always right means TR Walker won’t easily admit to this. It will still be the ‘fault’ of the other person. ‘You shouldn’t have provoked me or questioned my word,’ is a common rejoinder if asked for an explanation, making the victim WRONG and the perpetrator RIGHT.

Violence is never acceptable or right. There is only one appropriate response from a victim – to ‘not engage with the rage’, as is said, to distance oneself and immediately seek help, whether from the police (as domestic
violence is illegal in Britain and many other countries) or from your doctor, preferably both.

As the research of Villemarette-Pittman and others shows, people referred for treatment for violent and aggressive outbursts have a surprising number of OCPD sufferers among them. It’s part of the TR Walker OCPD story. In the UK, there is an organisation dedicated to the support of victims, research and the dissemination of information about domestic violence. In particular for women. Here are the details:

Women's Aid, PO Box Bristol 391, BS99 7WS Tel: 0117 944 4411 Fax: 0117 924 1703 Email: info@womensaid.org.uk

Helpline: helpline@womensaid.org.uk
Their excellent website is here: http://www.womensaid.org.uk/

If you are a TR Walker yourself and know you are vulnerable to this problem, and feel you can’t control it, seek help from your doctor. Anger management training is commonly available locally, or perhaps through private counsellors and therapists who sometimes advertise in newspapers and Yellow Pages.

**APPENDIX 1
USEFUL READING**

EKLEBERRY, Sharon Cl. (2000, March). Dual Diagnosis and the Obsessive-Compulsive Personality Disorder. The Dual Diagnosis Pages: "From Our Desk", online.
FARROW, Tom F. D. Et al. (2007). Empathy in Mental Illness. Cambridge University Press.
Jensen’s ‘Gradiva’ and Other Works, 167-176.


PHILIPPSON, Steven. PhD. The RIGHT Stuff: Obsessive Compulsive Personality Disorder: A Defect of Philosophy, not Anxiety. Online.

PHILLIPSON, Steven, PhD. When the going gets tough... the Perfectionist takes control. Organized Chaos. Volume 6. Center for Cognitive Behavioral Psychotherapy, New York.


SCHOLTEN, Amy. MPH. Obsessive-compulsive disorder and obsessive-compulsive personality disorder: they’re not the same. Online.


APPENDIX 2
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2007. WELLEN D, SAMUELS J, BIENVENU OJ, GRADOS M, CULLEN B, RIDDLE M, LIANG KY, NESTADT G. Depress Anxiety. 24(5): Utility of the Leyton Obsessional Inventory to distinguish OCD and OCPD.


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