

TIGHTROPE WALKING

ALL YOU NEED TO KNOW ABOUT OCPD AND PERFECTIONISM

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TIGHTROPE WALKERS

We all know one or more.

They're more often than not 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. But they have to be in CONTROL everywhere and all the time, even though that is not possible.

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. 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 in strictest order. 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

mark along the shelves to show where this runs.

Mrs Tightrope Walker will tear into you if you move one of her ornaments. If you do an errand for her and spend 76p when it could have been 48p, she's horrified and wants the difference back from you as a punishment for your stupidity. And yet you know she's got teapots full of money stashed away somewhere.

If you have a drink with Mr Tightrope Walker, 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?

Mrs T R Walker is 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/falling, an error.

What is more, they'd like other people to be 'up there' with them – following their clever example. Not wobbling

the wire. If one does chooses to 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 colleagues. Sensible rules are just the job, as when driving a train along the track.

But whatever the job is, it's going to be a strain. After all, 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, whether they're in control or not.

Being perfect all day is stressful and exhausting. So home is where TR Walker can relax. Everything there will be perfect, surely? This is far from the case in many instances. It's not unheard of for a partner to breath a sigh of relief if and when the TR Walker is out or goes away for a time. When TR Walker returns, there's a scramble to get everything back in order.

If everything's in its place, no challenges, no problems. Unless there's someone around who does things differently. Then it's a case of making things happen properly. This might involve shouting or even a thump to make the point, and tears all round.



Frank Sinatra did it *his way*. TR Walker does too. TR Walkers are happiest 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.



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, known as OCD — a question of excessive anxiety about cleanliness. OCPD is about a personality characteristic for getting things 'just so', according to the preferences of Mr or Mrs T R Walker.

TR Walkers are prone to depression and hard to treat. (1988 Pilkonis et al., 1996 Corruble).

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PREFACE AND INTRODUCTION

1

Who is this book for?

This small work has been specially written for people who are actually concerned with OCPD. The style, including the cartoons, is as light-hearted as possible to make it an easy read. The language too, is informal.

Many people don't know OCPD exists, but will recognise the picture from the introductory pages, or from the sketches on the cover and on the pages inside.

As already noted, OCPD isn't the same as OCD (obsessive-compulsive disorder). OCD has to do with rituals such as hand washing or not stepping on the lines in the pavement. OCPD is a personality disorder with, in some cases similar traits to OCD.

Freud called it anal-retentive. Others call it perfectionist, or anankastic. OCPD occurs in about 1% of the general population. It is seen in 3–10% of psychiatric outpatients. The disorder most often occurs in men.

A TR Walker needs to keep control over her or his life, so is constantly getting bogged down with detail, 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 cheque

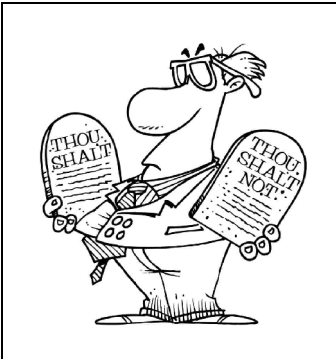


book or credit card with the statement, even every day.

Saving money is a form of hoarding, a favourite TR Walker habit. Being on time. Like the man alongside, who's just to get his four timepieces synchronised..

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.'

The following groups of people might find this handbook useful:

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 affect a parent, a partner, a sibling, a child in unseen ways.

It's also for people who work with someone who shows OCPD characteristics. TR Walker may make allies of superiors, or be hypercritical of the way things are run, and even knowingly break the rules, often on the quiet.

Parents who're worried they have a child who's pernicky, maybe about food might also find it helpful. The child loves organising everything. Maybe even dictates to the grown-ups. If the parents know about OCPD, they might worry about their child developing full-blown OCPD as an adult.

One group who might particularly find it helpful are professionals who might meet OCPD in their work, such as doctors, counsellors, psychotherapists, lawyers, teachers, clergy, managers, civil servants (1991, Oldham et al.).

Lastly, Tighrope Walkers themselves. People who are worried because others 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. TR Walker might lose it and start to feel very angry, or bottle it up, becoming 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 becoming available on the Internet and in bookshops on 'perfectionism'. The trouble is, the 'perfectionist' description, which is often how it's seen, doesn't necessarily indicate OCPD. Plenty of perfectionists do not

display other OCPD traits (2007, Wellen et al.).

Moreover, the 'official' definition (as in the DSM, Diagnostic and Statistical Manual), suggests a rather meek and conforming type of person. This may be the case for some, but to judge from the observations of unhappy partners, they can be bombastic and domineering individuals whose underlying perfectionism isn't too obvious to others. This is because the rules are in the heads of TR Walkers, made up by themselves, their own idea of what's right and wrong. Not always do they make it obvious that they are living according to their own rules.

An example of rule-following, is systematic ordering, such as lining up books on a bookcase as on the shelves of in a library.

To help demonstrate how easily people with OCPD might go undetected, here are two examples.

I was once told about a young 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.

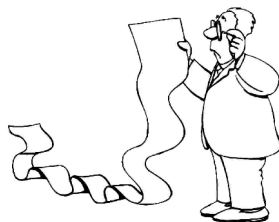
She hoards DVDs of photos of them, all kept in neat piles in her bedroom, with detailed lists of what she's got the neatest tiny writing to make space for more. She keeps

these lists 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. 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 demonstrate this on paper, they're so important. Maybe in the form of lists. Lists and lists, sometimes hidden from other people.

The wife of a TR Walker once wrote that her husband had left his diary and list in a hotel. He was out of his mind until she reminded him that maybe it would be a good idea to start a new one from what he could remember, rather than fret about it. He did so, and was somewhat less frantic about losing his list.



WHY AM I WRITING THIS?

I'm keen to give a higher profile to the dilemma of people who suffer from OCPD. They can be a social problem, but as they do not have a major impact on society, the resources are not there either for much research (except where it can be folded in with other investigations), nor for treatment options through national service.

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.

Whether this is a fair observation or not, I've been given to understand that some doctors don't know much about OCPD. For a start, it's often confused, as I have noted, with OCD and seen as a personal but irritating disorder.

This is almost inevitable, since someone decided to give it a similar name. This doesn't help at all. The trouble is that because OCPD is often hidden or secret, it could be seriously under-diagnosed (2007 Fineberg et al.).

Assuming it's recognised, given that it's defined as a Personality Disorder, it's usually seen as 'incurable', along with all other personality disorders. In a way it is, because it's often a constant and life-long battle to fight the urges to stick with the detail, arrange things in a particular way and not let anyone else take over.

What certainly is a cause for concern is that there's only sparse public recognition of OCPD, as noted, nor of its effect on the sufferer. Despite my best efforts, I have been unable to trace any research into the question of how well recognised OCPD is among the general public.

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 even suicide (2007, Raja et al.).

Miserable because no one understands them. People know something's wrong but think TR Walkers are just 'difficult' or perverse, or eccentric, and often say so.

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. The list to follow is a catalogue of worst-case scenarios for the consequences of untreated 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, towards those who don't conform.
5. Alcoholism as a retreat from stress.
6. Disruption at work with frequent job changes.
7. Over-reaction to failure, leading to self and/or other harm, including in the street, and where relevant in hospitals, when advice and treatment are rejected.

MY QUALIFICATIONS FOR WRITING THIS

BSc (Hons.), PhD in Psychology, Postgraduate Diploma in Counselling and Guidance.

Fifteen years working as a counsellor and therapist in three general practices, along with OCPD patients in the voluntary sector, and in my private practice

THE PROBLEM TIGHTROPE WALKING [OCPD]

Why the term 'Tightrope Walkers' (TR Walkers)? As noted, I've used the idea of walking a tightrope because for the

OCPD sufferer this personality disorder is like walking a tightrope.

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 to show it goes further than this. As suggested already, 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 alcoholism (1996 Stein). If anger isn't the style of TR Walker, frustration can spill out in other ways. TR Walkers have been known to go to great lengths to make a point — public demonstrations, posters, banners, letters to the newspapers. They can't see how this might look to, and upset, people close to them.

As some TR Walkers cannot understand how other people think or feel, this can cause considerable anguish to the other person. To this extent, OCPD shares this trait with Asperger Syndrome, a high-functioning form of Autism.

Tightrope Walkers have little space for anything other than things being 'square', in order, 'just so', as they see it, regardless of what other people think or how they feel.

Children can also suffer OCPD-like symptoms. They may seem unusually careful and 'driven'. They will already show a penchant for arranging things, such as their toys, or even their choice of toys. Lego sets are just the right toy for a

child who likes to arrange things with a ‘just so’ outcome. They might also be ultra clean and tidy their own rooms and insist on their own way of doing things.

Lists too, as soon as they can write — things they’ve just got to do. They may never be able to finish their homework fully — it must be utterly perfect. They may also have ‘tics’ or make odd noises, but usually grow out of this. These traits could be a form of Tourette Syndrome.

As shown later, research suggests there is a chance that such children will turn out to have an eating disorder when they grow up, or suffer OCPD (2008 Maina et al.).

Being a TR Walker isn’t all negative. Some of their qualities are admirable, and a great asset in particular jobs.

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 not usually the case for people with Obsessive-Compulsive Disorder (OCD), who hate their life-dominating 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 (including foul swearing), especially when under stress. These are distinctive traits of Tourette’s

As with their other habits, they may be unaware of this. There is research into this little-known aspect of some TR Walkers’ lives (2009, Hollander et al.). Another could be Intermittent Explosive Disorder, with violent and sudden outbursts of rage (2004, Villemarette-Pittman et al.).

Being a TR Walker is a difficult thing to have to cope with, especially when quiet and hard working. Even then, TR Walker is constantly on the look out, on guard, very vigilant. However, while being overly buried in detail, the world may pass 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 most TR Walkers blend in with other people while their private life, their inner life, is one of tragic torment.

If you're a TR Walker, you'll know what I mean. You can't imagine how it must feel to wake up every morning not worried about what you have to do that day. Or 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.

TIGHTROPE WALKERS SPEAK

The only source of information available to me directly, with the consent of the forum managers, was on Support Forum web sites. As the authors, understandable, wish to be anonymous, I've picked my way through the material, taken the spirit of it and concocted what follows here.

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 and feel:

"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 with nothing to do. If I lose my lists, my plan for the day, it's hell, 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."

"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.”

“My ex-wife got in touch and asked me why I used to hit her. I told her I wasn’t used to anyone questioning my word.”



“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, or to eat out, or for a drive out into 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.”

“My boyfriend loves getting out and away from the house with me. It’s what we want to do together. It’s 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 boyfriend doesn't do something soon, I'll go back into my shell and lock him out. I'll never let anybody in again. He wants me to open up, but he'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 boyfriend doesn't understand my problem. He 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 I 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 heads-down over the weeds in the garden.

If TR Walkers 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 was able to sample 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'. That's a step too far.

So unless you know 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 don't approve of.

Here are examples of the kind of verbal attack some TR Walkers make on 'close' others, based on material from the same Internet Support Forum.:

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. 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 doctoral research (1996 Daniel) 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.

In particular, they have trouble reading what lies behind facial expressions. They refuse to look for help. 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 and an unproven theory.

As the evidence above suggests, some 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, so rather than 'flee', 'fight'.

Their frustration and confusion feeds into depression. The trouble is 'weakness' is something they won't admit to. They're not keen on the very idea 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 reveals the welcome qualities of OCPD husbands, wives and partners.

So before I return to the tougher side of TR Walkers, I'll give some space to the 'nice' side.

The table to follow shows the results of a short analysis carried out on 27 May 2008.

The material was from a 'positives' thread on the MSN message board. The thread started on 16 August 2005. Between then and 2008, ninety-six messages had been posted. The text was sorted, yielding 451 phrases, adjectives and verbs to describe a TR Walker.

The number of respondents and their proportion in the total for each category are shown in the table. For example, 60 people made observations that their TR Walker was attentive and considerate. Their observations formed 15.3% of all.

Erring on the side of caution, some of these comments might have been provoked by seeing what other people had written, so they might not be a credible picture.

**SURVEY SUMMARY: PERCEIVED OCPD POSITIVE
ATTRIBUTES with number of observations and their
percentage of all observations**

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 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%
Good provider 5	1.1%
Companionable 4	0.9%

Note that these aren't necessarily 'facts' about TR Walkers, rather opinions from who knew at least one.

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 as seen by contributors. *Highly moral and perfectionist.*

A 56% rating for reliable and dependable, has positive values obvious to those around, along with 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

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? The survey was of 'positive' attributes, but had 'negative' attributes had been sought, the other side of TR Walkers' observable attitudes and behaviour would be those frequently referred to in this book.

WHAT ABOUT THE CHILDREN?

The evidence appears to be that children with obsessive-compulsive characteristics stand a chance of developing full-blown OCPD in adulthood, or in girls of having eating disorders (2005 Halmi et al.).

What does this mean in practical terms for parents? How can you tell if a child is likely to develop into an adult with the symptoms of OCPD? The answer is to watch for behaviour that seems unusual for a 'normal' child.

Here is a selection, paraphrased, of characteristics 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.
- Inflexible, insists other children do what he wants.
- 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 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 own 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 such as these is to start keeping a diary. If the behaviour continues for more than, say, a year, it would be a good idea to ask for a referral to a specialist.

It is especially important for parents and others involved, such as grandparents and child minders, to be alert to how they personally behave when with the child.

Such as insisting too heavily on perfection or getting things right. This is likely to underscore the traits the child may already show, so the task is one of teaching flexibility.

Offering affection and showing a close interest in what the child is doing may help to break down the invisible emotional barriers that such children appear to place between themselves and others when preoccupied with how things ought to 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 of a 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 has to involve him/her acknowledging he/she has a problem at all.

The next step, if that can be achieved, is to discuss (preferably in the presence of a therapist) how to deal with the issue as a family.

If the TR Walker won't go to therapy, then there is a dilemma.

On the Internet, for a time, there was 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, gently and affectionately, 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 at his daughter for leaving her shoes in the hallway when they ought to be (in his view) up in her bedroom, it could be helpful to comment to both parties along these lines. "Julie, someone might trip over them. Can you take them up when you go to bed or put them somewhere safe down here?"

Next: "Dad, I really wouldn't worry about it too much. After all, we all leave things around sometimes, surely? And 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. Maybe it would help if you ask her quietly to move her shoes? Then give her a hug."

These days, 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 special reason. As I have suggested, there is some evidence OCPD 'runs in families' (2007 Reichborn-Kjennerud et al.). This is not 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 seen as perfectly normal in one family, but in others.

But it is also possible these styles of behaviour may trigger a genetic tendency, kicking it into action so that it is expressed in full (2007 Reichborn-Kjennerud et al.).

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 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, is going to be vital.

What are these influences? Some people think that faulty upbringing is the *cause* of OCPD. This helps explain why some children sometimes show some of the symptoms, OCPD shows up in late adolescence or early adulthood.

Although this can hardly be levelled at parents as a failing, some TR Walkers say one or both parents were emotionally unavailable. This meant they felt they weren't valued or even loved.

Now that we know OCPD may run 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 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 so as to teach good manners, safe ways of doing things, and so forth?

If this over-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 OCD, but there 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, a child prone to anxiety and depression, if in a family where there is OCPD-like behaviour around, then that's what the child may learn and express when older.

This does not, of course, mean that there isn't a 'gene' in any event 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 behaviours 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.

HOW CAN YOU BE SURE?

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 has been revised for the new DSM V. According to the DSM 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 disposing of things that others might keep (Jefferys and Moore, 2008). TR Walker will obsess about what to keep and what not to keep. What to hoard or dispose of is the main problem.

This is a good example of TR Walkers' indecisiveness. Omitted from the DSM summary list are the tendency to depression (sometimes suicidal), sometimes violent flare-ups of temper, the research that suggest OCPD is thought to run in families, and the likelihood of descent into alcoholism.

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.

QUESTIONNAIRES

Two questionnaires exist that people find useful in helping to decide on whether to have a formal diagnosis of OCPD.

The first, and most commonly used 'self' test, is the 'Cammer Test', Developed by Leonard Cammer M.D..

The second questionnaire is less well known.

Neither is a diagnosis, so if the tests provoke unease it is as well to check with your doctor to see whether you can have a professional diagnosis.

SELF TEST (CAMMER TEST)

Rate each statement below on a scale of 1 to 4 as follows:

None or a little of the time - 1
Some of the time - 2
Good part of the time - 3
Most or all of the time - 4

Questions:

- I prefer things to be done my way.
- I am critical of people who don't live up to my standards or expectations.
- I stick to my principles, no matter what.
- I am upset by changes in the environment or the behavior of people.
- I am meticulous and fussy about my possessions.
- I get upset if I don't finish a task.
- I insist on full value for everything I purchase.
- I like everything I do to be perfect.
- I follow an exact routine for everyday tasks.
- I do things precisely to the last detail.
- I get tense when my day's schedule is upset.
- I plan my time so that I won't be late.
- It bothers me when my surroundings are not clean and tidy.
- I make lists for my activities.

- I think that I worry about minor aches and pains.
- I like to be prepared for any emergency.
- I am strict about fulfilling every one of my obligations.
- I think that I expect worthy moral standards in others.
- I am badly shaken when someone takes advantage of me.
- I get upset when people do not replace things exactly as I left them.
- I keep used or old things because they might still be useful.
- I think that I am sexually inhibited.
- I find myself working rather than relaxing.
- I prefer being a private person.
- I like to budget myself carefully and live on a cash and carry basis.

Final Scoring:

25-45. Not compulsive or uptight.

46-55. Mildly O-C. Your compulsiveness is working for you, and you are successfully adaptive.

56-70. Moderately O-C. You are adaptive but uptightness has crept into your personality function, and you experience uncomfortable days of high tension.

71-100. Severely O-C. You are adaptive but quite uptight, insecure and driving hard. The closer you are to the rating of 100, the nearer you come to playing brinkmanship at the ragged edge that borders on exhaustion of your adaptive reserve and a slump into depression.

It may be painful to accommodate to the final score, but it

can be a journey toward a happier, more relaxed and fulfilling life.

I have so far seen no evidence that either of these scales has been validated against the DSM criteria. Yet they give the flavour of issues that might be a problem for TR Walker.

Naturally, TR Walkers are as varied and as individual as any other members of the population. It's obvious from looking at the websites, and the way people complain about or praise them.

There is an argument that says — as Mallinger (1992) suggests — OCPD is only a problem if TR Walker's behaviour is causing a problem in his or her own life. Self-report is also not necessarily reliable either (1988 Pfohl et al..

If you suffer from OCPD, you may have to listen to other people's opinions. This could be difficult. The tricky bit comes in deciding how close a TR Walker is to suffering from a real 'personality disorder', rather than just eccentric or bossy.

This is when it's a good idea to go back to the DSM definition. As I show in later in a section on research into OCPD, this is the gold standard for sorting out subjects for research. The Manual itself has several pages of detailed information about how OCPD presents, and how to distinguish it from other personality disorders, and indeed from OCD, the 'hand washing', ritual-driven, disorder, even though there can be some overlap.

Sadly 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 highly likely to be resisted.

One more checklist.

Zimmerman (1994) suggests posing the following questions in the assessment of individuals with OCPD. This checklist focusses on 'perfectionist' and 'passive-aggressive' qualities, omitting some of those described here.

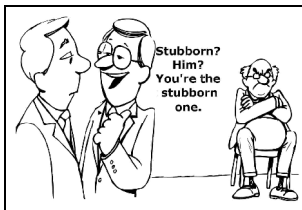
Let's not forget where the original research was probably conducted — in someone's office/consulting room! TR Walkers were out of their own kingdom, away from their home patch and comfort zone, and on their best behaviour.

An Internet OCPD Support Forum told a different story — of people who are, however nice and sweet and thoughtful, regularly tyrannical and awkward at home.

The self-test to follow illustrates a summary key characteristics of OCPD. Ticking more than four or five of these traits suggests there may signal a problem.

- 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 of work because you worry about getting behind?
- How many hours a week do you work? ò 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?



- On others? Do people describe you as stubborn? Do you save as much as you can for future problems?
- 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 right?
- How is it for you to spend money on yourself?

For those who worry about whether they are depressed, given that this often goes along with OCPD, I have borrowed a useful and easy-to-fill-in questionnaire, set out later. Consent was sought from the body concerned, but no reply was received.

As with the checklists earlier in this section, it's important to recognise this is not a diagnosis. Only a medical professional can do this. 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 later, 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, perhaps after a business failure 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.

**SUICIDE AND MENTAL HEALTH ASSOCIATION
INTERNATIONAL**

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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) D. all of the time (3 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)

How to interpret this follows.

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 OCPD 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 enough 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 approach is to coopt people who are already in the system — people referred to clinics or hospital for treatment for something else such as



depression, anxiety or angry outbursts (1991 Oldham et al.).

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 suffer from OCPD. Or up to three. They're usually men. Often very successful too.

As we have seen in the previous sections, there is a great deal of circumstantial evidence that there is indeed 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 a great deal of interest in finding a way to discover just how many relationships, at home or at work, crash to earth when there's a TR Walker around.

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 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, often during divorce. This is surprising in the context of TR Walkers' position over moral 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, professionals 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 (copyright 2000 *Lifescape*). The following is based on this article. Gabbard points out that OCPD hasn't been carefully studied for some time.

But we know from a couple of research studies, some more recent than 2000, which I will come to, that OCPD 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, giving plenty of time for wives and husbands to observe the consistency of behaviour.

Gabbard points out how dutiful TR Walkers 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.



As anger is likely to be hidden or not admitted to, as a shameful way to behave, 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 a long slog to persuade the TR Walker to drop the guilt and lower his or her high standards.

Gabbard notes 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 not internal, but 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.'

Research into people who are troubled but refuse therapy, showed (Daniel, 2006) that this group of people sheared away from the intimacy of all relations save those with their spouses and children.

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 much the family is

losing 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.

As noted, much of the evidence that OCPD is a problem comes increasingly from Internet 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 that the observations are nothing but 'chat' on the Internet and cannot be evaluated without tightly controlled research.

Yet this 'chat' 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?

MORE ABOUT HOW YOU CAN TELL

As 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 presumably it helps to compare notes, and to hear what people who have to live with a TR Walker have to say about it.

So let's now look at some of the complaints people make about TR Walkers. The 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 in the end it had over 2000 members. Monthly postings 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 so is 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 research, but many TR Walkers shy away 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 sound 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 of graduated sizes, as are the coats. Our 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, so 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."

"Doing the shopping. 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. 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 on you. When you're in town, never buy anything at the full price. Everything has to be a bargain. Then go back to Waitrose to finish. 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 show 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, but they have their limits where it comes to pressure on them.

So it's important, if you're living with an OCPD sufferer, to look at the 'good' side and bear that in mind. More about coping later.

Here's another catalogue compiled by studying what critical relatives say about sufferers from OCPD.

"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."

"Hoards. Money, facts, information, physical things, like old clothes. Strange things, like old paint pots, even when dried up. For years. Just in case. Bottles of urine by the bed. Old newspapers. 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."

"He stands in front of me saying he understands me, he knows how I feel, and I don't know who I am, or believe. He says I'm too stupid ever to understand anything. When I complain he just grins and walks off. I think he's keeping his feelings locked down. He just 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 he does let his feelings 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 rubbish into neat parcels. Scrubs the recycling bins out. Keeps a list of everything we keep 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. Keeps a list in the car of how much gas he's bought and how many miles he's got out of it."

"Saves money and tucks it away in secret accounts and in boxes she 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."

"Very competitive. 'Driven'. Always on the go, can't relax. A tendency to 'rant' over trivial things."

The list is endless. Here are more:

- Always has a reason why a rule he or she has made up and is imposing 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 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 some 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.

Interestingly, and not unsurprisingly, 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, and not being there means things are going to fall to pieces.

They feel it's their duty to fulfil their commitment to their employer. And this is all-consuming. Utterly.

It's a not unusual observation on message boards that TR Walkers can't see the wood for the trees. They can't

raise their heads above the detail to see the whole picture. They get 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, apparently TR Walkers can be 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. You'll hear people gasp at the things some TR Walkers say. Some of them upset other people so much they attract negative labels: snide, sarcastic, over-conscientious, over-scrupulous, blind, conceited, lacking in empathy, tyrannical, barrack-room lawyer. Impossible to have a relationship with, like trying to climb up the face of the Eiger. Rigid.

Again, it's all negative. They can't win.

It's sad. 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, auditing accounts, driving buses, flying aircraft, designing rockets.

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 discard useless objects as rarely as possible, especially if they can 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. Sometimes that's not the best tack. He or she may

have some good ideas. So listen, then make up your mind!

TR Walkers are mostly happier 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 (2006 List et al.), (1991) Benford et al.). 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.

If there's a threat to the familiar, orderly way of life, and depression sets in too deeply, anger is first directed at family, then after that the only way out beyond that is suicide.

In a different scenario, TR Walkers have been known to lie in court, to ensure 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 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 for much of their lives offer up the evidence they have a problem to any shrewd observer. The observer may not know what is wrong, but can provide descriptions that stack up against both the DSM, and research into OCPD.

They 'tell' it, all the time, to those around them prepared to listen and watch what they say and do.

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 in adults.

WHAT THE RESEARCH SAYS

If you're bored by formal academic stuff, skip this section, but having said that, I'm only going to summarise what's been found.

The full references are at the back of the book. There are many books and academic articles about OCPD, but

not a lot reflecting exhaustive research into the inner world of OCPD sufferers.

This section 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 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 syndrome. (2009, Hollander et al.).

But this doesn't mean to say they'd get a full OCPD 'label'. Many 'normal' 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. Details are in the Bibliography. The DSM is updated periodically. Apart from the DSM, the Leyton Obsessional Inventory (LOI) (2007 Wellen et al.) can be useful. It's a self-report questionnaire that assesses obsessional symptoms.

A study by Wellen et al., (2007) had a look at this to see whether differences between the 'hand washing' OCD disorder and OCPD could be adequately defined. The researchers found that the distinguishing feature of OCPD is the habit of ordering and arranging things. They came up with nothing on 'parsimony' (stinginess), but they were, after all, looking at 'self reporting', which is inevitably only part of the story.

One reasonably clear link, but not 100%, is between OCPD and eating disorders. Halmi Ka et al., (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 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 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 DSM list, then there's a good chance of an eating disorder in adulthood, and along with this, of growing up to be an OCPD sufferer.

What does this mean? OCPD and eating disorders might be closely linked. (2005, Halmi Ka, et al..)

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),, described individuals with OCPD as follows:

‘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; often inclined to hoard money and other possessions (2008. JEFFERYS et al.,). They are preoccupied with orderliness, neatness, and cleanliness even when hoarding.

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 also 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.

It seems that individuals with OCPD behave as if they

have the dependent personality disorder — appearing to do as they are told while unconsciously they ‘feel like’ a person with antisocial personality disorder (Millon, 1981, p. 218).

In my own experience a TR Walker may get round to behaving as if they do have Dependent Personality Disorder (DPD) from time to time.

As in DPD, people with OCPD incorporate the values of others, but submerge their own individuality, often a defiant streak. 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 suggested OCPD shares qualities with the antisocial (aggressive) and the dependent (submissive) styles.

This could explain how individuals who choose to work in structured organisations may find themselves wanting to change or break the rules. This is because Individuals with OCPD see themselves as responsible or ‘in charge’, so they often attract the ‘bossy’ and ‘interfering’ labels.

They believe they must be self-reliant. Yet, they might feel overwhelmed if they do not have systematic rules and regulations to follow (Beck & Freeman, 1990, pp. 46-47), even if they internally disagree with them.

TR Walkers, are sometimes as harsh in their judgment of themselves as they are of others (Millon, 1981, p. 226).

They are often 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, confirm this.

TR Walkers can be very 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 (Millon, 1981, p.226), suggesting that perhaps that's just how they would love to behave, but won't allow themselves to.

There have been examples in the criminal courts. Men who are known to disapprove of prostitutes yet visit them, then threaten their lives.

Naturally 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 really 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 battening 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 much research into links between OCD and OCPD (2007 Wellen et al.). 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 depressive) — was completed in 2007 by Raja and Azzoni in Italy. They studied 1,699 psychiatric patients admitted to a clinic and in particular 109 cases where patients were admitted for intensive care after suicide attempts.

Where 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, offhand maybe, manner in public. They thought that suffering 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, one of which showed up in a different form on an Internet forum.

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 quarrelling.

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 about the need to save money.

What causes OCPD? Is it genetic or down to nurture/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 of the three, 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 (1988 Lilienfeld et al.). This makes sense. OCPD must involve feeling anxious about getting things right.

However, other researchers have identified a specific genetic link. In 2003, a team in New Zealand took DNA samples from 145 depressed patients (2003 Joyce et al.). 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 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 prefer things not to change, and tend to caution. In 2006, another study (Light et al.) into a D3 receptor gene confirmed that there is a high chance, if an individual has a particular type of the gene 'DRD3', OCPD may develop, especially among males. 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 linked with cognitive and emotional functions, and sometimes with repetitive behaviours. This is only suggestive research at this point, but it may be that OCPD has a definite genetic basis.

This possibility has been explored several times. 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.

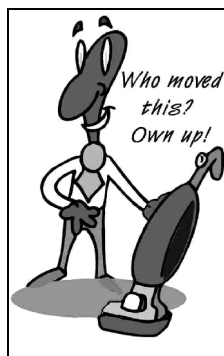
Measures of neuroticism were found to be significantly higher in relatives too, involving anxiety, vulnerability to stress and self-consciousness. The authors suggested the existence of a common inherited temperament that goes along with OCD and OCPD in families. In a second study (2000, Nestadt et al.) found that OCPD was over represented in never-married high school graduates, while OCD is known to have high celibacy rates.

However, OCD is not a prerequisite for OCPD. Indeed, as (1998) Irlé et al. 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'. 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. (2000) were having a look at OCPD patients, then again in 2004, checking them against DSM criteria. The most likely aspects of the disorder that were 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 forum 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. 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 assumed to be the backdrop to suicide rather than a personality disorder. Persistent traits are rigidity, reluctance to delegate, preoccupation with details and difficulty with social relationships.

GETTING OFF THE TIGHTROPE

The first step is for TR Walker to accept that 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.



Sometimes support groups are a sensible first step — meeting others with the same background to share experiences and gain encouragement.

Local mental health organisations will know what is available. Your doctor may have options to offer. 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 may 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 too.

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 and provide visible success. This can 'kick start' recovery.

Cutting down on stimulants such as caffeine, in coffee, tea or Coca Cola, may help too.

Cognitive-behavioural therapy (CAT) 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.

Using CAT, once awareness and self-monitoring is ongoing, changes begin to happen (Ryle, 1995). Information on CAT and possible therapists in the UK can be found on this website: <http://www.acat.me.uk>

This would be an example of how CAT works: let's say TR Walker is upset because his boss has changed the timetable for a project they are both involved with, rather than launch into an inquisition or seethe with anger, 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.

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 can and do 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 may do the trick. Groups usually have practical aims, and an emphasis on social skills and assertiveness training. (1998 Lilenfield et al.).

Groups can 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. They also allow TR Walkers to try 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 some months can be helpful. Here is a website about therapeutic communities: <http://www.therapeuticcommunities.org/>

The emphasis is on working together.

Where groups are set up within the medical system, 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 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 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, naturally, those who surround them being on their own best behaviour, with no negativity, 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/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 noted earlier, some OCPD sufferers are 'big' in any event outside the home. They like to be seen as capable and naturally helpful people. They often have intelligence, drive and skills that are useful in the community.

While treatment is going on, it's a good idea to keep this good work going as it is a sound basis for restoring an OCPD sufferer'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 an OCPD sufferer is upset it's not your fault, but an OCPD sufferer fears uncertain situations and anxiety is 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 or a truly good friend so that you can regularly offload. Support is important — the more you react negatively, the more difficult it is.

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 not uncommon in families where there's an OCPD sufferer who is an adult.

The reason for this appears to be that an OCPD sufferer needs to control everything and everyone around, but cannot achieve this, so it leads to a huge build-up of frustration and anger.

Any opposition is going to be experienced as a kind of attack on what an OCPD sufferer 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 an OCPD sufferer will rapidly feel guilty about as perfect control is important.

But being always right means the OCPD sufferer won't easily admit to this. It will still be the 'fault' of the other person. '*You shouldn't have provoked me,*' 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 (2004) and others shows, people referred for treatment for violent and aggressive outbursts have a surprising number of OCPD sufferers among them, so you should not think this is a one-off. It's part of the OCPD story.

In the UK, there is an organisation dedicated to the support of victims, to research and to the dissemination of information about domestic violence.

<http://www.womensaid.org.uk/>

If you are an OCPD sufferer yourself and know your temper is a problem, and feel you can't control it or may not be able to some day, seek help from your doctor. Anger management training may be available locally, or perhaps through private counsellors and therapists who advertise in newspapers and Yellow Pages, as well as through voluntary organisations.

USEFUL READING

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, provides a common language and standard criteria for the classification of mental disorders. It is used, or relied upon, by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies, the legal system, and policy makers. The current version, published on May 18, 2013, is the DSM-5 (fifth edition). (Courtesy *Wikipedia*.)

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