

**INTERNATIONAL JOURNAL OF  
EDUCATION, PSYCHOLOGY  
AND COUNSELLING  
(IJEPC)**  
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**“I CAN STRIVE FOR EXCELLENCE AND STILL BE KIND TO  
MYSELF”: A CASE REPORT ON MULTIFACETED  
INTERVENTION FOR A YOUNG WOMAN WITH DEPRESSION  
AND OBSESSIVE-COMPULSIVE PERSONALITY TRAITS**

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**Article Info:**

**Article history:**

Received date: 05.09.2023

Revised date: 11.10.2023

Accepted date: 02.11.2023

Published date: 12.12.2023

**To cite this document:**

Lee, S. H., Saw, J. A., & Ramlee, F. (2023). “I Can Strive For Excellence And Still Be Kind To Myself”: A Case Report On Multifaceted Intervention For A Young Woman With Depression And Obsessive Compulsive Personality Traits. *International Journal of Education, Psychology and Counseling*, 8 (52), 56-68.

**DOI:** 10.35631/IJEPC.852005

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**Abstract:**

Limited literature exists on the management of depression with comorbid Obsessive-Compulsive Personality Disorder (OCPD). This case report presents the psychological intervention provided for a young woman with clinical depression, anxiety, and traits of OCPD. Additionally, she exhibits distinctive maladaptive coping mechanisms, having created vivid characters in her mind since a young age to ensure flawless behaviors. The treatment approach was based on the framework of cognitive behavioral therapy and incorporated elements of compassion training and dialectical skills training. The intervention aimed to address the complex interplay between depression, anxiety, OCPD traits, and the unique coping strategies observed in the patient. As a result of the treatment, her BDI score reduced from severe to mild, and she demonstrated an increase in healthy coping skills. This case report documents the treatment approach used to address the multidimensional challenges presented by individuals with comorbid conditions involving OCPD traits. Furthermore, recommendations are provided on how to manage similar cases.

**Keywords:**

Case Report, Depression, Self-Compassion, Obsessive-Compulsive Personality, Cognitive Behavioral Therapy

## Introduction

Individuals who suffer from clinical depression often experience a heightened sense of excessive guilt (Tilghman-Osborne et al., 2012). This guilt tends to worsen when they also have a comorbid obsessive-compulsive personality disorder (OCPD), a type of Cluster C personality disorder. In a qualitative study, 60% of participants with OCPD described experiencing a high level of guilt related to morality and religious rules (Shariati et al., 2018). This is alarming since guilt increases the risk of suicidality, especially when compounded by a sense of shame (Kealy et al., 2021). Individuals with OCPD exhibit a pervasive preoccupation with excessive perfectionism, orderliness, and attention to detail, along with a strong desire for mental and interpersonal control, often at the expense of flexibility and efficiency (APA, 2022). This pattern typically emerges in early adulthood and manifests in various contexts (APA, 2022). Despite being one of the most prevalent personality disorders, affecting approximately 2-8% of the population (APA, 2022), there is limited literature on its management.

A meta-analysis study found that cognitive behavioral therapy (CBT) could be effective for individuals with depression and comorbid of personality disorder, especially when longer treatment duration is involved (Banyard et al., 2021). However, a review conducted by Finch and colleagues (2021) suggests that the treatment approach for individuals with OCPD should employ multimodal treatment strategies, including conservative pharmacological intervention, management of comorbid conditions such as depression and anxiety, and regular assessment of suicide risk. The psychological treatment should focus on addressing the perfectionism and rigidity that lead to functional impairment, as well as reducing the over-reliance on control in one's life. It is also important to incorporate corrective emotional experiences to promote more flexible thinking and encourage personal growth beyond the scope of treatment.

Only a few case reports for patients with OCPD have been published in recent years. Schema therapy, for instance, addresses individuals' unconscious motivations and addresses the irrationality of thoughts stemming from excessive conscientiousness, moralism, and perfectionism (Fu et al., 2021). One case study utilizing schema therapy demonstrated effectiveness in reducing dominant schemas in patients with OCPD through cognitive, experiential, and therapeutic relationship interventions (Bakhshipour & Mahmoud, 2022). Similarly, interpersonal therapy has been employed in a case study to identify maladaptive interpersonal schemas, utilizing behavioral experiments to reconstruct perfectionistic behaviors and using experiential techniques such as rescripting to establish a connection with healthier aspects of the self (Cheli et al., 2020). A case study by Bhukhari et al. (2018) found that implementation of cognitive restructuring and relaxation techniques under the CBT modality was effective in reducing symptoms and improve functioning of a female with OCPD. Furthermore, compassion-focused therapy was applied in a case study involving a woman with major depressive disorder exhibiting strong elements of perfectionism and self-criticism (Matos & Steindl, 2020). This approach involved compassion mind training and skill development. Besides that, Radically Open Dialectical Behavior Therapy was used in a case study of a male with excessive perfectionism, eating disorder and mood disorders by improving the patient's flexibility and openness (Little & Codd, 2020).

In light of the limited literature available on the management of individuals with OCPD, the purpose of this case report is to document the treatment approach employed for a young woman presenting with clinical depression, anxiety, and traits of OCPD, and to discuss the clinical implications and challenges of managing this case. This patient frequently experiences

overwhelming guilt and shame. She also exhibits distinctive maladaptive coping mechanisms, having created vivid characters in her mind since a young age to ensure flawless behavior. Based on the currently available evidence, the treatment approach for this patient incorporated elements of compassion training and dialectical skills training within the framework of cognitive-behavioral therapy. The intervention aimed to address the complex interplay between depression, anxiety, OCPD traits, and the unique coping strategies observed in the patient.

### Case Background

B, a 22-year-old single female who is studying her final year of architecture, was referred for psychological intervention. She was first seen in the inpatient psychiatric ward due to a suicide attempt, where she presented with multiple cuts on her left arm and neck. After being discharged, she continued to receive follow-up care as an outpatient at the Psychology clinic.

B reported experiencing depressive symptoms, including a persistent low mood, extended episodes of crying, anhedonia, fatigue, poor concentration, poor appetite, excessive guilt, feelings of worthlessness, and suicidal thoughts. She also experiences symptoms of anxiety, including worries, tremors, palpitations, insomnia, and occasional panic attacks. B copes with her anxiety by engaging in self-harm through cutting, as a way to numb her anxiety and punish herself. Additionally, she occasionally takes an excessive amount of paracetamol to aid sleep. These behaviors began during the pandemic in 2020, when B felt stressed about working online with her group members. As a result, her CGPA significantly dropped, leading her to retake a semester.

B often obsesses over exceedingly high standards for herself, which can at times be unattainable. When she feels incapable of meeting these self-imposed targets, she tends to abandon her efforts entirely and prefers to start anew. For instance, if she cannot achieve an A grade on an exam, she would rather receive an F and retake the course. B's preoccupation with meticulously planned schedules leaves her feeling guilty for taking any breaks. The strictness of her standards often hinders her ability to complete tasks, resulting in procrastination and academic failures. Additionally, B exhibits rigidity and stubbornness in her behaviors. In social situations, if B believes she has said something inappropriate, she tends to apologize excessively and distance herself from the individual involved, perceiving the friendship as no longer perfect and unworthy of maintaining. She frequently reviews social scenarios and scrutinizes her actions for any perceived mistakes. B's strictness and rigidity are primarily directed towards herself rather than exerting control over others or her finances. In the past, B embraced this "all or nothing" approach to life, believing it helped her achieve straight A grades during her schooling years. However, she has recently realized that her expectations have become excessively challenging, leading to heightened anxiety. Frustrated by her perceived failures, B has developed symptoms of depression and has experienced suicidal thoughts. After a psychiatric evaluation at the ward, she has been diagnosed with Major Depressive Disorder with anxious distress in crisis, along with co-morbid traits of Obsessive-Compulsive Personality Disorder (OCPD).

B is the second of five siblings. Her mother is a worrier. Her parents have high expectations for her, considering her to be the most well-behaved child compared to her siblings. Her elder sister has been rebellious towards their parents and has been verbally harsh towards B. Her family members are not receptive to mental health treatment, and her elder sister has made

comments suggesting that B's mental illness brings distress to the family. Fortunately, her youngest sister was supportive towards her.

Socially, B has many friends but hesitates to confide in them due to her fear of burdening others. However, she always prioritizes helping her friends when they need assistance. B has rejected advances from males due to her fear that she may not meet the standards of being a good wife. Throughout her primary and secondary school years, B consistently achieved straight As and actively participated in competitive sports activities. Her studies were going well until the onset of the pandemic and subsequent lockdown, which coincided with the development of her depressive mood.

Despite being born with a carefree and mischievous personality, her parents consistently motivated her to strive for achievement like others. To cope with these expectations, B created vivid imaginative characters in her mind, representing teams that argue for the best decisions for her. Reflecting on their origin, she realized that she created these characters based on certain beliefs or statements (e.g., "no pain, no gain") or as reminders after making any mistakes. The first character she created was associated with the belief that she must uphold her family's name and avoid bringing shame upon them, which connects to her overarching theme of "I am not good enough."

## Methods

This is a secondary analysis of medical file of the patient via case study method. Clinical records of the session notes related to patient's background history, psychological assessment and treatment notes were extracted and to be analyzed for the case report. Patient's identifying information (e.g., name or name of university) was excluded and pseudonym was given to maintain anonymity and confidentiality. The outcomes and complications of the patient's management were then discussed in the context of existing literature and reported in the case report. Upon the decision to include the study as a case report, written consent was obtained from the patient.

## Results

### *Psychological Assessment Before Treatment*

The Beck Depression Inventory, Second Edition (BDI-II; Beck et al., 1996) was utilized to assess the severity of B's depressive symptoms. The inventory consists of 21 items that patient rated on a 4-point Likert scale, measuring both affective and somatic symptoms associated with depression. The total score is then interpreted based on the following ranges: 0–13 indicates minimal symptoms, 14–19 indicates mild symptoms, 20–28 indicates moderate symptoms, and 29–63 indicates severe symptoms. Prior to the treatment, B obtained a score of 43 on the BDI-II, which falls within the severe range of depression with strong suicidal ideation.

Seretis and colleagues (2022) suggest a strong association between OCPD and maladaptive coping strategies, such as rigid perfectionism, self-blame, and compulsive planning. They further propose that considering an individual's coping repertoire is essential when formulating a treatment plan for OCPD. In light of this, the Coping Scale for Adults (Fredenbert & Lewis, 2000) was administered to assess B's coping skills. The Coping Scale for Adults consists of 60 items that measure 20 different coping strategies, including worry, self-blame, and humor. Based on B's profile, it was observed that she employs a combination of both helpful and

unhelpful coping mechanisms. B tends to engage in a significant amount of self-blame, keeping her thoughts and feelings to herself, not actively coping, and relying on worry to manage difficulties. On the other hand, she frequently utilizes coping strategies such as focusing on problem-solving, working hard, taking social action, and protecting herself.

The Personality Assessment Inventory (PAI; Morey, 1991) was also utilized to assess B's personality and psychopathology. The PAI is a comprehensive questionnaire consisting of 344 items, and patients rate their responses on a scale ranging from "false, not at all true" to "very true." B's PAI clinical scales indicate significant difficulties in thinking and concentration, accompanied by prominent distress and dysphoria. She tends to exhibit withdrawal and isolation, feeling disconnected from those around her. B's PAI profile suggests significant depressive experiences, including feelings of sadness, anhedonia, worthlessness, and hopelessness. She experienced disturbances in sleep patterns, reduced energy levels, and changes in appetite and/or weight. Her self-concept appears to be poorly established, and her attitude toward herself tends to fluctuate. She expressed a pessimistic outlook and a lack of hope for significant improvement, which, combined with potential impaired judgment, increases her risk for self-harm. Additionally, B experiences a distressing level of anxiety and tension, primarily expressed through physiological or somatic symptoms such as sweaty palms, trembling hands, irregular heartbeats, and shortness of breath. Moreover, B's thought processes exhibit marked peculiarities, characterized by confusion, distractibility, and difficulties in concentration. B's interest in and motivation for treatment align with typical individuals seeking therapeutic help. Her responses indicate an awareness of significant problems and a perceived need for assistance in addressing these issues. She demonstrates a positive attitude toward the potential for personal change, the value of therapy, and the importance of personal responsibility.

### ***Case Conceptualization***

The 4Ps conceptualization was used to formulate and understand B's presenting problems. Several predisposing factors contributed to B's current presentation. These factors included a genetic predisposition to worrying tendencies or social modeling of her mother's worrying behaviors, as well as the high parental expectations placed upon her as the "obedient child" within her family. B had experienced pressure to conform to an achievement-oriented persona, which contradicted her carefree nature. This pressure resulted in the development of perfectionism and high self-expectations from a young age. Notably, B had developed a coping mechanism involving the creation of vivid imaginary characters in her mind, who served to keep her on guard and ensure that she met these high standards.

The pandemic and the transition to online learning acted as precipitating factors in B's case. The context of the Covid-19 pandemic required psychological flexibility, but her rigidity increased the challenges for her to adapt to a new working style with her university mates. It was likely that the high level of academic stress and a decline in her grades due to her all-or-nothing behaviors had contributed to further guilt and harsh self-criticism, and eventually the development of depressive and anxiety symptoms.

Numerous perpetuating factors sustained B's difficulties. The lack of understanding from her family members, combined with her tendency to avoid taking breaks or seeking help, contributed to her ongoing struggles. Unhealthy coping mechanisms, including dissociation, self-blame, and self-harm, further perpetuated her challenges.



B did possess protective factors that could support her treatment. She shared a close bond with her younger sister and demonstrated an openness to seeking help. B's skills in visualization could be used as resources during her treatment. Additionally, her supportive nature, consistent academic success with straight A grades, conscientiousness, and motivation for treatment provided a foundation for a positive prognosis.

### ***Treatment and Progress***

While B also receives pharmacological treatment, the following section focuses on the psychotherapy sessions conducted with B. Session 1 to 4 was conducted when she was in the inpatient ward, with the gap between sessions being 1 to 2 days. Session 5 to 14 was conducted in the outpatient psychology clinic, with the gap between sessions being 1 to 4 weeks. A follow up session was conducted 3 months after session 14. Each of the session lasted for an hour. Table 1 summarizes the treatment for B.

**Table 1: Treatment Summary for B**

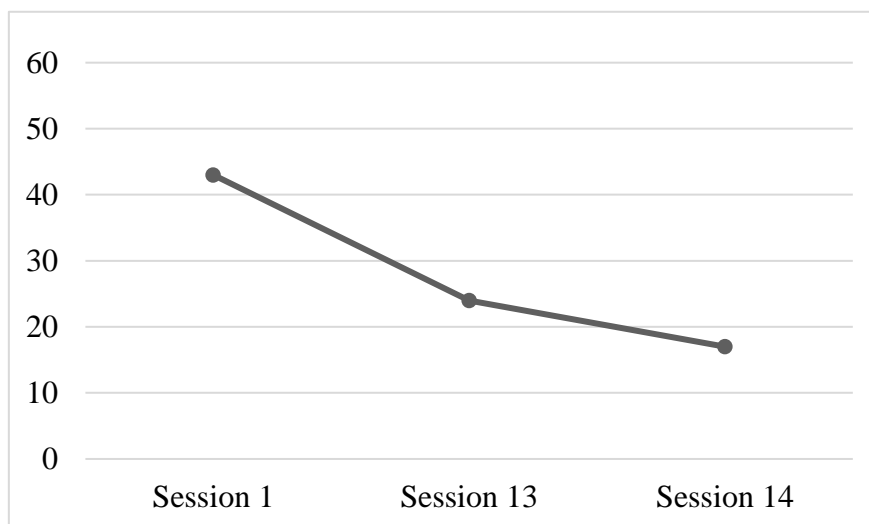
<b>Session</b>	<b>Treatment provided</b>	<b>Progress</b>
1	- Psychoeducation on depressive symptoms and all-or-nothing thinking pattern - Introduction to self-prioritization	-Accepting own diagnosis and increase awareness of unhealthy coping skills and cognitive distortions
2	- Psychoeducation on treatment plan - Address pros and cons of self-harm as coping strategies - Facilitate self-validation techniques, including validating own emotions	-Increasing awareness that she has been dismissing her feelings -Learning to acknowledge own emotions
3	-Facilitate awareness that characters in her mind were all part of her and provided psychoeducation about the importance of integrating these dissociated parts as part of her journey to recovery	-Graining insights that the characters in her mind were created by her and were her own thoughts.
4	-Prepare for discharge from psychiatric ward -Facilitate reflection on origins of character in her mind and the positive impact of genuine friendship	- No suicidal intention or self-harm urges -Experience more positive dreams and sense of peace
5	-Facilitate openness to social support and communication skills with lecturers and classmates -Facilitate mindful grounding technique	-Opening up to close ones and university lecturer -Actively reading up about depression
6	- Discuss alternative coping strategies - Facilitate loving-kindness meditation	-Reducing self-blame tendencies

- |    |  |  |
|----|--|--|
| 7  | -Facilitate progressive muscle relaxation to manage anxiety<br>-Facilitate behavioral activation   | -Learning to validate and accept own emotions (allowing herself to cry)<br>-Increasing productivity in daily life  |
| 8  | -Reinforce self-care after overdose incident triggered by self-hate<br>-Cognitive restructuring to separate mistakes from self-worth<br>-Facilitate assertiveness skills | -Acknowledge own needs and rights  |
| 9  | -Re-psychoeducation on depression in view of increased depressive symptoms<br>-Reinforce self-compassion<br>-Facilitate behavioral activation                            | - Separate depressive symptoms from own self-competency<br>- Learning to be kind to self during low mood   |
| 10 | -Facilitate time management skills to prioritize urgent and important things for herself   | -Increased motivation and engagement in exercises and pleasurable activities   |
| 11 | -Facilitate coping with changes in family dynamic after father's recent death<br>-Facilitate assertiveness skills and self-care  | -Starting to advocate for own needs  |
| 12 | -Affirmed B's positive progress<br>-Facilitate self-compassion exercises   | -Improved mood, have stable eating and sleeping patterns<br>-Able to prioritize rest and self-care, has more realistic expectation on own progress<br>-Started a romantic relationship with a stable boyfriend<br>-Reconciled with her elder sister<br>-Absent of characters in mind and self-harm coping for 2 months |
| 13 | -Reinforced assertiveness skills   | -Discontinued medication with psychiatrist's approval<br>-Able to establish healthy boundaries with friends and mother   |

14	-Review progress and summarizes coping skills learned -Discuss relapse prevention	-Able to generalize skills learned during various situations
3 months follow up	-Review progress	-Able to maintain positive progress and engage in daily practice of compassion meditation

**Psychological Assessment After Treatment**

B underwent administration of the BDI-II and Coping Scale for Adults to review her progress during session 13 and 14. From an initial score of 43 before treatment, there was a drop in her score to 24, indicating a moderate level of depressive symptoms during session 13. During the termination session, her BDI-II score reduced to 17, indicating a mild level of depressive symptoms. Figure 1 illustrates her BDI-II scores. In terms of coping skills, B continued to rely on Problem-Focused coping. She demonstrated increased utilization of social support, improved relationships, spiritual support, relaxing diversions, and physical recreation. B had reduced the use of worry, self-blame, and avoiding the problem.



**Figure 1: B's BDI-II Scores During Session 1, 7 and 14**

**Discussion and Implications**

The aim of this case report is to document the treatment for a young woman who presents with clinical depression, anxiety, and traits of OCPD. The treatment approach for this patient incorporated elements of compassion training and dialectical skills training within the framework of cognitive behavioral therapy, which is in line with the recommended by Finch and colleagues (2021). Cognitive behavioral therapy (CBT) was effective in managing this case with a primary diagnosis of major depressive disorder with anxious distress and comorbid OCPD traits. This is consistent with the recent reviews suggesting that CBT is effective for cluster C personality disorders (Banyard et al., 2021; Ergin & Alkar, 2022). The therapist introduced psychoeducation about depressive symptoms and cognitive patterns or schemas, with a specific focus on B's all-or-nothing thinking pattern. Behavioral skills training such as assertiveness and time management skills were also facilitated. Over time, B gradually became



more open to the possibility of adopting more adaptive thinking styles and developed an awareness of her unrealistic expectations and low self-worth. This approach helped B challenge her negative thinking and develop healthier cognitive patterns.

The treatment also placed a strong emphasis on reducing maladaptive coping strategies and promoting healthier coping skills, in line with the recommendation by Seretis and colleagues (2022) to address maladaptive coping strategies such as rigid perfectionism, self-blame, and compulsive planning for patients with OCPD. Initially, B relied on self-harm as a coping strategy, but the therapist provided psychoeducation on the pros and cons of self-harm, helping B recognize its negative long-term consequences. B acknowledged the need for depression treatment instead of self-harm and self-blame and learned self-validation and self-compassion techniques to effectively cope with her rigidity and excessive guilt. B also learned alternative coping strategies, such as engaging in physical activities, utilizing social support, and practicing meditation. Self-compassion technique was also a component addressed in the case study by Matos and Steindl (2020).

Another unique component of the treatment was the integration of dissociated parts. This intervention is similar to structural integration via narrative technique to manage dissociative symptoms in patients with borderline personality disorder (Sole, 2014). B experienced vivid characters in her mind, and the therapist facilitated B's awareness of these characters and provided psychoeducation on integrating these dissociated parts as part of her recovery journey. B gained insights into the origin of these characters and their connection to her own thoughts, leading to increased self-awareness. The therapist acknowledged the benefits associated with obsessive-compulsive traits in certain contexts and cultural frameworks. It was important for B to recognize that self-compassion would not result in the loss of these positive traits and to address her fear of embracing self-compassion. Gradually, she developed self-worth and trust in her own judgment.

During the management of this case, several complicating factors emerged that had to be taken into consideration. Firstly, it was observed that B experienced worsened depressive symptoms during the process of treatment, as she began to punish herself for not recovering fast enough to function at her previous level. However, her condition gradually improved with the adoption of a better attributional style and understanding of her depression. Nonetheless, it is important to note that the chances of relapse for B remain higher due to her diagnosis of obsessive-compulsive personality disorder. A systematic review conducted by Altawell et al. (2023) supports this, indicating that individuals with this personality disorder are at a greater risk of experiencing relapse or recurrence of major depressive disorder. Consequently, it is crucial to implement relapse prevention interventions specifically tailored to patients with personality disorders.

Another factor that complicated the management of the case was the need to acknowledge and understand the benefits associated with obsessive-compulsive traits, particularly in certain contexts and within a culturally appropriate framework. For instance, self-control, diligence, and determination are highly valued within capitalistic societies and are considered as desirable work ethics. Moreover, individuals with a high level of conscientiousness often exhibit traits such as stress tolerance, emotional stability, and a strong sense of self-worth (Villemarette-Pittman et al., 2004). It is important to recognize that one of the barriers for B in developing self-compassion was the fear that being kind to herself would result in the loss of these positive

traits. Similar findings were discovered in a study by Naismith and colleagues (2019) that examined the barriers to practice compassion-focused imagery among individuals with personality disorders. The participants expressed fear that embracing self-compassion would lead to a loss of self-criticism and identity.

External circumstances, such as the passing of B's father, also added to the complexity of the case. Grief became an additional concern that had to be addressed, although B managed it well within the context of her treatment. Lastly, B presented with an unusual manifestation of an illusion of independent agency or dissociation, where she experienced vivid characters in her mind that ensured she exhibited her best behaviors. Besides, the spontaneous engagement with fictional characters instead of real-life individuals during the loving-kindness meditation was unusual and could be considered borderline delusional. However, it is worth noting that B demonstrated a good level of insight, and fortunately, she was receptive to guidance and able to shift her mindset and behaviors accordingly.

B's fortunate situation of studying in a university with easy access to a hospital without fees played a crucial role in her ability to seek help easily. However, despite this advantage, there were still significant barriers to receiving adequate care. One such barrier was the lack of understanding and support from her family, coupled with the prevailing stigma surrounding mental illness. These factors made it difficult for her to not only seek help but also contributed to her desire to be discharged as soon as possible, to avoid being "a burden" to her family. Furthermore, the high patient load in the hospital added to the challenges faced by B during the treatment. The appointment gap in the outpatient clinic could be as long as one month, which presented a substantial delay in receiving continuous and timely care.

Despite of the challenges, one of the reasons for B's positive progress could be attributed to increased social support and the corrective emotional experiences she received with significant others. This is similar to the treatment approach in the case study by Cheli and colleagues (2020), where the therapist addressed the patient's interpersonal schemas and conduct behavioral experiments to test these schemas. In this case study, B gradually opened up to her family, friends, lecturers, and the support system formed in the ward. Additionally, she reconciled with her elder sister. She also received good emotional support from her new boyfriend. Sharing her struggles with others and receiving support and understanding likely contributed to her progress.

Overall, the therapist's role in managing patients with mood disruption and maladaptive personality may involve providing guidance, facilitating insight, challenging patients in their interpersonal and cognitive patterns, and tailoring interventions to meet their specific needs throughout the treatment journey. Clinicians who encounter similar cases may consider the importance of psychoeducation, cognitive restructuring, social support, coping skills, and relapse prevention. Specifically, clinicians may consider:

- Incorporating psychoeducation about depressive symptoms and cognitive patterns into therapy sessions.
- Focusing on identifying and challenging negative thinking patterns, such as all-or-nothing thinking.
- Reducing maladaptive coping strategies and promoting healthier coping skills.

- Teaching self-validation and self-compassion techniques to effectively cope with rigid thinking patterns, excessive guilt, and low self-worth.
- Acknowledging the benefits associated with obsessive-compulsiveness in specific contexts and cultural frameworks. Addressing patients' fear of embracing self-compassion and helping them understand that it does not result in the loss of these positive traits.
- Recognizing the importance of social support and communication in patients' progress.
- Facilitating discussions and providing guidance to promote understanding, emotional support, forgiveness, and the rebuilding of trust with significant others.
- Providing assertiveness skills training to help patients effectively communicate their needs and set boundaries with family members.

The case study serves as a preliminary step in the process of developing evidence-based treatments tailored for individuals with major depressive disorder, anxious distress, and comorbid personality traits, including OCPD. Given its higher prevalence compared to other personality disorders, it is feasible for future studies to develop a treatment protocol and conduct randomized controlled trials (RCTs) to further investigate the effectiveness of Cognitive Behavioral Therapy (CBT) for this population. This can help establish stronger evidence for the efficacy and application of CBT for patients with mood disruption and personality disorders.

Additionally, it is recommended to investigate the mechanisms of change underlying the effectiveness of CBT in this population. In this case study, the effect of pharmacological medication and external factors could not be controlled and isolated. Examining specific interpersonal, cognitive, and behavioral processes that contribute to symptom reduction and improved functioning can enhance our understanding of how CBT works and potentially guide the development of more targeted interventions.

Furthermore, exploring the integration of other therapeutic modalities or approaches with CBT is recommended. Investigating whether combining CBT with other evidence-based treatments, such as dialectical behavior therapy (DBT) or compassion-based interventions, yields enhanced outcomes for individuals with major depressive disorder, anxious distress, and comorbid OCPD traits would be beneficial.

Lastly, it is important to examine the generalizability of these findings to diverse populations, considering factors such as cultural backgrounds, age groups, and socioeconomic statuses. This will provide valuable insights into the applicability and effectiveness of CBT in a broader range of individuals.

### **Acknowledgements**

The authors would like to express our gratitude to the patient for participation in this case report. We would also like to acknowledge healthcare colleagues who are involved in the patient's care.

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