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Short communication

Prevalence of childhood obsessive–compulsive personality traits in adults with obsessive compulsive disorder versus obsessive compulsive personality disorder

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ABSTRACT

Identifying risk factors of psychopathology has been an important research challenge. Prior studies examining the impact of childhood temperament on adult disorder have largely focused on under-controlled and inhibited presentations, with little study of overcontrolled traits such as obsessive–compulsive personality traits (OCPTs). We compared rates of childhood OCPTs in adults with OCD (without OCPD) ($n=28$) to adults with OCPD (without OCD) ($n=27$), adults with both OCD and OCPD ($n=28$), and healthy controls (HC) ($n=28$), using the childhood retrospective perfectionism questionnaire, a validated measure of perfectionism, inflexibility, and drive for order. Adults with OCPD (both with and without comorbid OCD) reported higher rates of all three childhood OCPTs relative to HC. Individuals with OCD (without OCPD) reported higher rates of inflexibility and drive for order relative to HC, suggesting that these traits may presage the development of OCD, independent of OCPD. Childhood OCPTs were associated with particular OCD symptom dimensions in adulthood (contamination/cleaning, doubt/checking, and symmetry/ordering), independent of OCD onset age and OCPD diagnosis. Longitudinal prospective studies evaluating OCPTs in children are needed to better understand the progression of these traits from childhood to adulthood and their ability to predict future psychopathology.

1. Introduction

Identifying risk factors of psychopathology has been an important challenge for researchers since it can provide a window for early detection and treatment, which would reduce the morbidity, disability and mortality associated with mental illness. Research suggests that early appearing temperamental differences have a pervasive influence on life-course development and are predictive of adult personality structure, interpersonal relations, and psychopathology. For example, Caspi (2000) reported that undercontrolled 3-year-olds grew up to be impulsive, unreliable, and antisocial, and had more conflict with members of their social networks and in their work, whereas inhibited 3-year-olds were more likely to be unassertive and depressed and had fewer sources of social support. In another study (Caspi, Moffitt, Newman, & Silva, 1996), undercontrolled 3-year-olds were more likely at 21 years to meet diagnostic criteria for antisocial personality disorder and to be involved in crime, whereas inhibited 3-year-olds were more likely at 21 years to meet diagnostic criteria for depression. Further about one-third of children born with a temperamental bias that predisposes them to be highly reactive to unfamiliar stimulation as infants and to be fearful or avoidant of unfamiliar events and people as young children show signs of serious social anxiety by adolescence (Kagan & Snidman, 1999). Preliminary data on a brief parent education program for the reduction of inhibited temperament in preschool children show promise that it may be possible to modify early risk for anxiety disorders (Rapee, 2002). Based on this literature, measures of childhood temperament may prove valuable in investigating chains of influence on adult disorder.

The focus on undercontrolled and inhibited temperaments in prior studies raises the question of what impact overcontrolled traits in childhood, such as perfectionism, inflexibility, and drive for order, would have on later psychopathology. To date research on the impact of these childhood obsessive compulsive personality traits (OCPTs) has largely focused on eating disorders, where they have been identified as key risk factors (Jacobi, Hayward, de Zwaan, Kraemer, & Agras,

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2004). For example, Anderluh, Tchanturia, Rabe-Hesketh, and Treasure (2003) collected retrospective accounts of childhood OCPTs in an eating disorders sample using the EATATE semi-structured interview. Patients with eating disorders were much more likely to endorse childhood OCPTs compared to healthy controls (HC), and these traits were highly predictive of the development of eating disorders. In fact, the odds of developing an eating disorder increased nearly sevenfold with every additional trait reported, suggesting a strong dose–response relationship. In addition, patients with eating disorders who endorsed childhood OCPTs were more likely to develop adult OCPD, indicating that OCPTs may persist from childhood to adulthood.

Childhood OCPTs may also be a risk factor for developing OCD. In an adult OCD sample ($n=18$), Coles, Hart, and Schofield (2012) retrospectively studied the symptom phase, defined as the period characterized by the presence of obsessions and compulsions without significant interference or distress. They reported that, among other factors, perfectionism and preoccupation with details/order frequently emerged after initial obsessions and compulsions but before (on average, 2–3 years before) full-criteria for OCD were met. However, this study was limited by sample size, not controlling for the presence of OCPD in the OCD sample, given the high comorbidity between these conditions (Albert, Maina, Forner, & Bogetto, 2004; Garyfallos et al., 2010; Lochner et al. 2011; Pinto, Mancebo, Eisen, Pagano, & Rasmussen, 2006; Samuels et al. 2000), and the absence of a validated measure of childhood OCPTs.

To date, no study has specifically examined rates of childhood OCPTs in those who develop OCD as adults versus those who develop OCPD as adults. To address this gap in the literature, we compared rates of childhood OCPTs in adults with OCD (without OCPD) to adults with OCPD (without OCD), adults with both OCD and OCPD, and healthy controls (HC), using the Childhood Retrospective Perfectionism Questionnaire (CHIRP), a validated brief self report measure (Southgate, Tchanturia, Collier, & Treasure, 2008). We hypothesized that adults with OCPD would have the highest rates of childhood OCPTs among these groups and that childhood OCPTs would occur more frequently in adults with OCD than in healthy controls. Further we explored the impact of such traits on OCD symptomatology in adulthood.

2. Method

2.1. Overview of study design

This study was conducted at the Anxiety Disorders Clinic at the New York State Psychiatric Institute, Columbia University, and approved by the Institutional Review Board. Participants provided written consent prior to study participation. Fifty-six adult outpatients with a principal diagnosis of OCD (28 with comorbid OCPD and 28 without comorbid OCPD), 27 outpatients with a principal diagnosis of OCPD, and 28 HC completed the CHIRP. Independent evaluators assessed OCD symptom content and severity.

2.2. Participants

Participants were 111 adults (> 18 years of age). Fifty-six patients met DSM-IV OCD criteria as their principal diagnosis for at least one year and had at least moderate symptoms (Yale-Brown Obsessive Compulsive Scale (YBOCS) total score $\geq$ 16). This group was subdivided into those with comorbid OCPD and those with no history of OCPD. Twenty-seven patients met DSM-IV/5 OCPD criteria as their principal diagnosis and had no history of OCD. Patients were excluded for other psychiatric problems needing immediate treatment (e.g., mania, psychosis, suicidality) or an unstable medical condition. Other comorbid conditions were permitted only if OCD (or OCPD) was the most severe and impairing condition. The HC group consisted of 28 individuals with no history of OCD, OCPD, or other psychiatric diagnoses and no history of psychotropic medication use. Psychiatric diagnoses were determined by a senior clinician (MD or PhD) and confirmed by an independent rater using the Structured Clinical Interview for DSM-IV (First, Spitzer, Gibbon, & Williams, 1996). OCPD was assessed using the OCPD module of the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II) (First, Gibbon, Spitzer, Williams, & Benjamin, 1997).

2.3. Measures

2.3.1. Childhood retrospective perfectionism questionnaire (CHIRP)

The CHIRP is a 20-item self-report questionnaire (with yes-no format) designed to assess the presence of childhood (up to age 12) behaviors, across various domains (e.g., schoolwork, hobbies), that are indicative of the following OCPTs: perfectionism, inflexibility, and drive for order (Southgate et al., 2008). Following scoring procedures in Southgate et al. (2008), perfectionism was deemed present if at least one behavior was endorsed in any two of the following areas of the child's life: schoolwork, self-care (i.e., appearance), looking after his/her room, and recreational activities. Inflexibility was deemed present if at least one behavior was endorsed in each of the following domains: rigid behaviors (e.g., finding periods of transition difficult) and rule-bound behaviors (i.e., excessive obedience to rules). Drive for order was deemed present if relevant behaviors were endorsed in both of the following domains: appearance (i.e., clothes or hair) and looking after his/her room. "Childhood" is operationalized as up to 12 years of age to ensure that the behaviors assessed were present during a time preceding the onset of OCD for the vast majority of the clinical population (Ruscio, Stein, Chiu, & Kessler, 2010). In the present study, the CHIRP was scored both categorically (presence/absence of each OCPT) and dimensionally [number of OCPTs (0–3) and number of OCPT-related behaviors (0–20)]. In our sample, the CHIRP demonstrated excellent internal consistency reliability (Cronbach's alpha = .91).

The behavioral indicators on the CHIRP were all derived from the EATATE semi-structured interview, which also assesses childhood OCPTs. These behavioral examples were developed for the EATATE based on a process that included a panel of experts with extensive clinical and research experience, literature reviews of personality traits, and a patient focus group (Anderluh et al., 2003). Southgate et al. (2008) reported substantial agreement between self-report ratings on the CHIRP and interviewer-collected data on the EATATE, as well as with the reports of informants, individuals who had good knowledge of the proband in childhood and could report on behavioral indicators of childhood OCPTs. In their study, patients with eating disorders endorsed more childhood OCPTs on the CHIRP than HC; more childhood OCPTs were associated with greater eating disorder severity in adulthood.

2.3.2. Yale-Brown obsessive compulsive scale (YBOCS)

The YBOCS is a 10-item semi-structured interview of current OCD severity, based on domains of time, distress, interference, resistance, and control, yielding a total score ranging from 0 to 40 (Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann, et al., 1989). The YBOCS symptom checklist (YBOCS-SC) was administered to gather information on specific current obsessions and compulsions. The YBOCS-SC was used to generate scores for each OCD patient along five different symptom dimensions (taboo thoughts [aggressive, sexual, religious obsessions], contamination/cleaning, doubt/checking [includes obsessions about overresponsibility for harm], hoarding, and symmetry/ordering) using previously published procedures (Pinto et al., 2007, 2008; Pinto, Greenberg, Murphy, Nestadt, & Rasmussen, 2009). The YBOCS was only administered to participants with OCD.

2.4. Data analysis

Demographic variables and rates of childhood OCPTs for OCPD, OCD + OCPD, OCD − OCPD, and HC were compared using ANOVA for continuous variables and χ^2 for categorical variables. Significant effects of group were explored further using protected least significant difference (LSD) tests or χ^2, as appropriate. Non-parametric tests (Kruskall Wallis H tests) were used to compare the three groups on ordinal (number of childhood OCPTs) and non-normal (CHIRP total score) variables, followed by pairwise Mann–Whitney U tests. Univariate linear regression models were used to test number of childhood OCPTs as a predictor of the five OCD symptom factors, controlling for OCD onset age and OCPD diagnosis. We controlled for OCD onset age in these analyses because of an association between age of onset and symptom content in prior OCD studies (Maina, Albert, Salvi, Pessina, & Bogetto, 2008; Pinto et al., 2006; Tukel et al., 2005). All statistical tests were conducted at two-sided level of significance, $\alpha = .05$.

3. Results

3.1. Description of sample

OCPD, OCD + OCPD, OCD − OCPD, and HC did not differ on gender, age, race, years of education, employment status, or current use of psychiatric medication (see Table 1). The OCD + OCPD and OCD − OCPD groups did not differ in the number of participants with OCD as the only current axis I disorder, in OCD severity on the YBOCS, and in age of OCD onset. In these two groups, OCD severity was in the markedly ill range and average OCD onset was in late