Psychiatr. Pol. ONLINE FIRST Nr 395: 1–18
Published ahead of print 17 May 2026
www.psychiatriapolska.pl
ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
DOI: https://doi.org/10.12740/PP/OnlineFirst/214387

Anankastic personality in historical and contemporary perspective: a literature review

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Summary

Obsessive–compulsive personality disorder (OCPD), rooted in Janet's psychasthenia, Freud's "anal character," and Schneider's notion of anankastia, is among the most common yet least frequently diagnosed personality disorders. Contemporary classifications emphasize its dimensional nature. The central features are perfectionism, rigidity, and excessive need for control. Prevalence in the general population is estimated at 6.5%. In clinical populations, rates are higher: 16% among outpatients and up to 30% in inpatients. OCPD most often co-occurs with obsessive–compulsive disorder (OCD) (17–45%), depression (31–76%), bipolar disorder (32.4%), anxiety disorders (17–30%), substance use (25–29%), eating disorders (20–61%), and autism spectrum disorder (19–43%). Comorbidity with OCD is associated with earlier onset, delayed diagnosis, and poorer insight. It is also linked to greater chronicity, elevated suicide risk, and bipolarity. Etiology is multifactorial, including genetic (27–78%), neurobiological, and environmental factors. Reduced quality of life is emphasized, linking the severity of OCPD traits with psychosocial burden. Diagnosis should include psychological testing and collateral information, supported by clinical observation. Psychoeducation and psychotherapy constitute a central component of treatment. The strongest evidence supports cognitive–behavioral therapy targeting perfectionism and rigidity. Psychodynamic methods, schema therapy, and third-wave approaches may also be useful, while pharmacotherapy has a limited role.

Key words: obsessive personality disorder, anankastic personality, comorbidity

1. Evolution of the concept of anankastic personality

Anankastic personality, also referred to as obsessive-compulsive personality disorder (OCPD), represents one of the most prevalent yet least frequently diagnosed variants of personality pathology. Although described in the clinical literature for more

than a century, its core conceptual nucleus has remained remarkably consistent, even though the range of traits incorporated into the construct has been gradually modified over time [1]. Its origins lie in the tradition of describing the "compulsive character" and related personality patterns, which European psychiatry at the turn of the 19th and 20th centuries began to distinguish from obsessive–compulsive neurosis (today: obsessive-compulsive disorder, OCD). As early as 1903, Pierre Janet introduced the concept of psychasthenia – now equated with OCPD – characterized by perfectionism, indecisiveness, pedantry, authoritarianism, and restricted emotional expression [2, 3]. Shortly thereafter, Sigmund Freud elaborated his theory of the "anal character," whose defining traits included orderliness, stinginess, and stubbornness. The need for control was subsequently regarded as the central element of the so-called anal-erotic character, while the shared etiology of OCD and OCPD was linked to regression to the anal stage of child development [4]. In the following decades, Aubrey Lewis postulated the existence of two personality types among individuals with obsessive–compulsive neurosis: the first characterized by negative affect, stubbornness, and irritability, and the second marked primarily by uncertainty [5, 6]. Parallel to this, European psychiatry developed typologies of personality, aimed at systematizing variants of "psychopathic characters." The seminal contributions of Emil Kraepelin and Kurt Schneider were of particular importance. It was Schneider who introduced and popularized the term anankastic (from the Greek *anankē*), describing, among others, "uncertain anankasts" – individuals excessively scrupulous, hypercorrect, and overly cautious, compensating their sense of insufficiency with heightened control. This firmly established the anankastic pattern as a distinct type within the domain of personality pathology [7]. The reference to the etymological root *anankē* carries important interpretative significance. In Greek mythology, Ananke, the sister of Chronos, embodied inexorable compulsion and the inevitability of fate, leading to complete submission to destiny. This metaphor aptly reflects the rigidity and intransigence characteristic of this phenotype [8]. As American classifications evolved, the concept was incorporated into the DSM. In DSM-I (1952) and DSM-II (1968), the term compulsive personality was used, with a brief proposal of anankastic personality in DSM-II to avoid diagnostic confusion with OCD [1, 9, 10]. A turning point came with DSM-III (1980), which for the first time systematized personality disorders on Axis II and introduced the term compulsive personality disorder [11], while DSM-III-R (1987) consolidated the modern designation OCPD within Cluster C [12]. In ICD-8 (1965), OCPD was coded as 301.49, clearly separated from obsessive–compulsive neurosis (300.39) [13]. ICD-9 (1977) retained this classification [14], whereas the term "anankastic personality" entered official WHO nomenclature only with ICD-10 (1992) [15]. The understanding of anankastic personality was also shaped by specific cultural contexts. In the Protestant–Victorian era of work ethic, frugality, and discipline, traits such as perfectionism and meticulousness were regarded as virtues rather than pathology. Travers [16] noted that the ethic of self-improvement promoted by Smiles reinforced the conviction that control and order form the foundation of success. Bureaucratization and standardization further strengthened these patterns, often obscuring their psychological costs. Harari et al. [17] demonstrated that perfectionism, although occasionally adaptive, typically reduces job satisfaction and

increases interpersonal conflict. More recently, Kim et al. [18] showed that excessive demands may foster counterproductive behaviors under conditions of job insecurity, partially mitigated by learning competencies.

The historical descriptions outlined above provide the foundation for contemporary classifications of OCPD [19–21].

2. Contemporary classification

In ICD-10, anankastic personality disorder was classified as one of the specific personality disorders (F60.5). Its description emphasized an excessive need for order, scrupulousness, and control, which rigidifies functioning. The criteria included perfectionism, pedantry, excessive caution, and persistent doubts, as well as stubbornness. Obsessive thoughts and impulses were also mentioned, though these are not equivalent to OCD symptoms. ICD-10 criteria assumed an onset in childhood or adolescence, consolidation of traits in adulthood, and their persistence with a negative impact on social and occupational functioning [15]. In DSM-5 (APA, 2013), obsessive–compulsive personality disorder (OCPD; code 301.4) was retained in cluster C ("anxious/fearful") within the traditional categorical model, but Section III also proposed a dimensional framework. This encompasses four core domains of functioning (identity, self-direction, empathy, intimacy) and five pathological personality trait dimensions. Such an approach allows for assessment of the severity of dysfunction and better captures the continuum of personality traits, instead of being limited to a dichotomous evaluation. The definition refers to a pervasive pattern of preoccupation with order, perfectionism, and control – both mental and interpersonal – beginning in early adulthood and present across contexts. In contrast to ICD-10, DSM-5 criteria do not include components of obsessions or impulses [3, 12]. In ICD-11, obsessive–compulsive/anankastic personality no longer functions as a stand-alone diagnostic category. Instead, the concept of anankastia was introduced as one of the personality trait domains, which may vary in severity (mild, moderate, severe). In practice, code 6D10 is applied for general personality disorder, with subcode 6D11.4 indicating a predominance of anankastic traits, while QE50.7 is used for subthreshold difficulties. The description of anankastia emphasizes perfectionism, adherence to rules, scrupulousness, routine, and excessive planning, as well as emotional and behavioral restrictions such as lack of spontaneity, stubbornness, and risk avoidance. The ICD-11 authors did not specify the minimum number of traits required for diagnosis, instead underscoring their early onset and impaired adaptability [8, 20, 21].

A summary of these three classification approaches, together with a comparison of the diagnostic criteria and key diagnostic emphases, is presented in Table 1.

Table 1. **Comparison of diagnostic criteria for obsessive-compulsive (anankastic) personality disorder in ICD-10, DSM-5, and ICD-11**

ICD-10 (Anankastic Personality Disorder, F60.5)	DSM-5 (Obsessive-Compulsive Personality Disorder, 301.4)	ICD-11 (Anankastia, 6D11.4)
Number of features required: ≥3	Number of features required: ≥4	No specific number of features descriptive domain, applied only with personality disorder (mild, moderate, severe) or "personality difficulty"
1. Excessive doubts and caution 2. Preoccupation with details, rules, order, and organization 3. Perfectionism interfering with task completion 4. Excessive conscientiousness and scrupulousness leading to neglect of pleasure and relationships 5. Excessive pedantry and rigid adherence to social norms 6. Rigidity and stubbornness 7. Demand for subordination + unwillingness to delegate tasks 8. Intrusive thoughts or impulses (not equivalent to OCD)	1. Preoccupation with details, rules, order, organization, schedules 2. Perfectionism interfering with task completion 3. Excessive devotion to work at the expense of relationships and recreation 4. Extreme conscientiousness, scrupulousness, and inflexibility regarding morality/ethics 5. Hoarding/difficulty discarding objects (finalization problem) 6. Reluctance to delegate tasks unless others follow exact standards 7. Miserliness toward self and others 8. Rigidity and stubbornness	Perfectionism: concern with rules and right/wrong, meticulous attention to details, rigid daily routines, excessive planning and scheduling, emphasis on order and neatness, correcting others' work, strong beliefs about perfection and imperfection, interpersonal difficulties due to inflexibility. Emotional/behavioral constraint: rigid emotional control, lack of spontaneity, stubbornness and inflexibility, disapproval of emotional displays, risk-avoidance (real or imagined), repetitive behaviors, difficulty stopping tasks until 'perfect,' over-deliberation and decision-making difficulties.
Onset in adolescence or early adulthood; traits stable, causing impairment; exclusion of other mental disorders.	Symptoms present since early adulthood, across contexts; egosyntonic; cause distress/ impairment; not due to other disorders/substances.	Traits stable over time; must cause functional impairment (personal, social, occupational); anankastia is not a stand-alone diagnosis.
Key differences		
Includes intrusive thoughts/ impulses as a feature.	Includes miserliness and hoarding/ finalization problem.	Emphasis on emotional and behavioral limitations

3. Epidemiology and curse

Obsessive–compulsive personality is among the most common personality disorders, both in the general population and in psychiatric samples. Population-based studies estimate its prevalence to range between 2% and 7% [3, 22–24]. Broader analyses indicate that, on average, about 10–12% of adults meet criteria for any personality disorder, with this subtype being the most frequently diagnosed, reaching

approximately 4% in Western countries [25]. A global synthesis of studies including more than 89,000 individuals reported a prevalence of 6.5%, with results remaining relatively stable over time and across regions [26]. Demographic associations are inconclusive, although most studies suggest a higher prevalence among men [27]. While many studies suggest lower rates among younger adults, pointing to a possible increase of anankastic traits with age [28–30], a meta-analysis by Clemente et al. [26] indicated a decline in prevalence in older cohorts.

In clinical populations, prevalence is markedly higher than in the general population. Estimates range from around 16% in outpatient samples to nearly 30% among hospitalized patients, with rates of 18–20% in prison and student populations [26]. Findings from smaller samples confirm this tendency – for instance, in one outpatient cohort, the disorder was diagnosed in 8.7% of patients, ranking just behind avoidant and depressive personality disorders, with nearly half of the sample meeting criteria for more than one personality disorder [31]. The most frequent comorbidities were paranoid and schizoid personalities, suggesting that this condition does not always fit neatly within the classic Cluster C profile [32]. Despite its high prevalence, it remains underrecognized and relatively rarely addressed in clinical research [3, 24].

The stability of anankastic personality remains a matter of debate. Samuels et al. [33] found that after one year of follow-up, only 42% of patients continued to meet diagnostic criteria. In adolescent populations, this rate was even lower – just 32% – suggesting that in some cases the phenomenology of this disorder may be developmental and transient [4, 34, 35]. In contrast, Grilo et al. [36] reported that after two years of follow-up, approximately 60% of individuals still met criteria. Analyses of individual criteria point to considerable heterogeneity: perfectionism, reluctance to delegate tasks, and rigidity of attitude appear to be the most stable features, whereas miserliness is more often influenced by situational factors and shows less constitutional stability [35, 37–39].

4. Comorbidity

The data summarized below indicate that the phenomenon of obsessive–compulsive personality is transdiagnostic, appearing in both internalizing and externalizing disorders [4].

4.1. OCPD and OCD

Although the best-documented comorbid relationship is that between this personality pattern and OCD, the pathogenesis of obsessions should not be understood as a direct continuation of anankastic traits [40–42]. The frequency of co-occurrence is estimated at 17–45% [24, 43–50], and the presence of anankastic features is associated with earlier onset of illness, greater diagnostic delay and longer treatment latency (13.2 years versus 7.2 years in those without the personality disorder), higher symptom severity, poorer insight, stronger manifestations of aggression and impulsivity, and greater rates of depressive and anxiety comorbidity [30, 45, 47, 49–51]. These findings are

consistent with observations by Eisen et al. [42], who demonstrated that patients with the dual diagnosis experienced more than twice the number of OCD relapses within a five-year period. This comorbidity is also accompanied by significantly reduced quality of life, higher unemployment rates, older patient age, and greater functional burden, including impaired sexual functioning and a diminished capacity to regain full psychosocial functioning [29, 30, 49, 50]. Clinically, such patients more often present with hoarding, checking, doubting, symmetry, and ordering symptoms [45, 47, 50, 51], as well as taboo obsessions and obsessive slowness [30], suggesting the existence of distinct OCD endophenotypes influenced by anankasticity [29].

4.2. OCPD and affective disorders

The prevalence of anankastic personality among patients with depression (MDD) is estimated at 31–76%, occurring more frequently in men and proving more common than other personality disorders [52–55]. Particularly significant are traits of perfectionism and rigid moral standards, which increase the risk of relapse, exacerbate depressive symptomatology, and elevate suicidal risk [53, 56, 57]. It has also been noted that the presence of this personality pattern increases vulnerability to postpartum depression [58]. Similar associations apply to the occurrence of MDD in the course of OCPD, which emerges as one of its most frequent complications (up to 76%) [4]. The relationship with bipolar disorder (BD) has been less extensively studied. Limited reports indicate that this personality disorder has been diagnosed in 32.4% of patients with BD [55, 59]. Comorbidity with OCD presenting bipolar features has been estimated at 11–35% [60, 61]. Importantly, the presence of this personality disorder in patients with OCD has been associated with greater severity of both depressive and manic symptoms [30, 59, 60, 62], which has been interpreted as a leading marker of bipolar features contributing to an unfavorable prognosis [30]. Supporting evidence indicates that cyclothymic affective temperament, as common as comorbid BD in patients with OCD, may be further intensified by the presence of anankasticity [63, 64].

4.3. OCPD and selected disorders from the compulsive spectrum

Anankastic traits frequently co-occur with other compulsive spectrum disorders [65], including body dysmorphic disorder, where the prevalence of OCPD reaches 14–28% [4, 66], and hoarding (considered both as a symptom dimension of OCD and as a separate diagnosis). OCPD is regarded as a common factor that contributes to the overlap of these phenomena, reinforces cognitive rigidity, and increases treatment resistance [4, 67]. In eating disorders, OCPD is reported in 20–61% of cases, most frequently in restrictive anorexia and binge-eating disorder, where it represents the most prevalent personality pathology [4].

4.4. OCPD and anxiety disorders, addictions, and personality disorders

Long-term studies indicate that OCPD is the most frequent personality disorder comorbid with generalized anxiety disorder (up to 30%) and is present in 17% of patients with panic disorder [4, 68]. In populations with alcohol and substance use, prevalence rates reach 29.4% and 25.7%, respectively [4, 24, 68]. Comorbidity also extends to other personality disorders: Fineberg et al. [4], citing Hummelen et al. [69], reported that 77% of OCPD patients met criteria for additional diagnoses, most commonly paranoid personality (23%), whereas McGlashan et al. [70] found avoidant (27.5%), borderline (9.2%), paranoid (7.9%), and narcissistic (7.2%) personalities to be most frequent.

4.5. OCPD and neurodevelopmental disorders

The relationship between this personality pattern and neurodevelopmental disorders – particularly autism spectrum disorder (ASD) – is clinically intriguing yet insufficiently explored. OCPD emerges as one of the most frequently diagnosed personality disorders in this context, with reported prevalence rates of 19% [71], 32% [72], and 42.6% [73]. In the study by Strunz et al. [74], the prevalence reached 29.6% among individuals with ASD, and 17% in the subgroup with co-occurring ASD and ADHD. These findings were consolidated by the systematic review of Rinaldi et al. [75], which confirmed that OCPD is among the most common personality disorders in patients with ASD.

5. Quality of life and suicide risk

The impact of anankastic traits on well-being remains underestimated in the literature, although available data indicate that OCPD significantly reduces quality of functioning. Typical features include harsh self-criticism, chronic feelings of insufficiency, and cognitive rigidity, which hinder adaptation and create a sense of being trapped in repetitive patterns. Excessive need for control causes even minor shortcomings to be perceived as serious failures, while leisure time is often viewed as wasted, contributing to overload and isolation. In interpersonal relationships, limited emotional flexibility, low tolerance of uncertainty, and rigid standards foster conflict, destabilize bonds and professional life, and in contemporary cultural contexts lead to the perception of individuals with OCPD as demanding and inaccessible. The key mechanism is dysfunctional perfectionism, closely linked to excessive control and rigidity [8]. Pinto et al. [76] identified two dominant styles of functioning: the controlling style – characterized by emotional coldness, imposition of norms, and micromanagement – and the anxious style – marked by procrastination, entrapment in details, and exaggerated fear of making mistakes. Both patterns result in similar outcomes: reduced life satisfaction and impaired occupational and family functioning, generating substantial costs for both the individual and their environment. The degree of functional impairment exceeds that observed in OCD, and individuals with OCPD seek psychological help more frequently than patients with depression [3, 38].

In this context, the association of OCPD with vulnerability to suicidal behavior assumes particular importance. When rigid standards are deeply internalized and simultaneously experienced as external pressure, psychological burden increases, leading to feelings of helplessness and loss of purpose [76]. Diaconu and Turecki [56] showed that patients with OCPD during the course of MDD more frequently experience suicidal thoughts and attempts than those without this diagnosis. They are also characterized by fewer declared reasons for living and a lower level of fear of death – both regarded as key predictors of suicide risk. These observations indicate that perfectionism, which in some contexts may serve an adaptive function, becomes a serious risk factor in the setting of depression [77]. Therefore, the assessment of patients with OCPD should include not only evaluation of psychosocial functioning but also systematic measurement of suicide risk [30, 76].

6. Etiology

The etiology of OCPD is complex, encompassing biological, psychological, and environmental factors [8, 24]. Genetic determinants appear to play a central role: family and twin studies indicate a high heritability (27–78%), although molecular findings remain inconsistent. The 5-HTTLPR polymorphism has been linked to anxiety traits typical of cluster C personality disorders [3, 78], while DRD4 and DRD3 variants have been associated with both avoidant and obsessive–compulsive traits [79]. It is also possible that conditions damaging the central nervous system – such as traumatic brain injury, vascular disease, tumors, epilepsy, Huntington's disease, multiple sclerosis, endocrinopathies, or heavy metal intoxication – may contribute to the development of personality disorders, including OCPD [3, 79]. One hypothesis proposed that in OCPD the particularly dense network of neuronal connections within limbic structures might facilitate the consolidation of rigid behavioral patterns. However, the only morphometric study addressing this question did not confirm such an assumption: Reetz et al. ([29]; cited in Diedrich and Voderholzer [80]) reported reduced gray matter volume in the cingulate gyrus compared with healthy controls. The concept proposed by Riddle et al. [81] distinguishes two major dimensions of OCPD: order/control, associated with reduced insight, and hoarding/indecisiveness, more strongly linked to executive dysfunctions and showing clear familial and genetic determinants. Aycicegi-Dinn et al. [82] proposed that OCPD traits may serve as a compensatory mechanism for primary cognitive deficits. Mollinger [83], in turn, suggested a disturbed balance between two information-processing systems: diminished empathic mechanisms alongside heightened systematizing mechanisms. These findings should be interpreted cautiously, as they neglect both the heritability of anankastic traits and a broader evolutionary perspective [29, 84].

Psychological factors in the etiology of anankastic personality include both classical psychoanalytic concepts and contemporary cognitive approaches. Freud associated stubbornness, stinginess, and excessive conscientiousness with fixation at the anal stage of development. Other models highlight the role of immature defense mechanisms, such as affect isolation or reaction formation. Alternative hypotheses

point to the role of cognitive deficits, including limited empathy and difficulties in understanding social norms. A different perspective is offered by the temperamental approach, according to which OCPD traits represent relatively stable, partly genetically determined personality characteristics that shape an individual's responses to environmental stimuli. In Cloninger's model, particular importance is assigned to heightened harm avoidance and excessive persistence [3, 85]. Overcontrolling parenting styles, low parental care, and early traumatic experiences – such as neglect or abuse – are also significant contributors. In combination with the child's innate temperamental traits, especially a tendency toward rigidity and systematization, these factors create a synergistic effect that fosters the consolidation of obsessive–compulsive patterns of behavior [84].

7. Diagnosis

The diagnosis of obsessive–compulsive personality remains challenging due to the lack of clear operational criteria and the wide variability of assessment methods. A comparative study by Samuel and Widiger [86] demonstrated that the most commonly used self-report scales for this disorder display only moderate convergent validity, with inconsistent alignment to individual DSM criteria. These discrepancies are particularly evident in relation to the Five-Factor Model (FFM): some scales emphasize excessive conscientiousness, while others highlight neuroticism or deficits in agreeableness.

An overview of the most frequently used diagnostic methods is presented in Table 3.

Table 2. **Diagnostic methods for anankastic personality – comparison of selected tools (based on: [35, 86]**

Tool	Advantages	Limitations
SCID-II / SCID-5-PD (clinical interview)	"Gold standard"; systematic assessment of each DSM criterion; high clinical validity	Time-consuming; requires training; burdensome for patient
SCID-II-PQ (screening version)	Quick screening; good coverage of OCPD criteria	Overly sensitive; requires confirmation in clinical interview
PDQ-4 (Hyler)	Popular, covers all DSM criteria; easy to use	Tendency to overestimate diagnoses
OMNI Personality Inventory (Loranger)	Full coverage of DSM criteria; broad symptom spectrum	Less common in clinical practice
WISPI-IV, SNAP	Good alignment with DSM criteria; valuable in research	Less known in routine diagnostics
NEO PI-R (FFM)	Maps OCPD traits onto personality dimensions (e.g., excessive conscientiousness, low openness)	Not a diagnostic tool; used for research and profiling

table continued on the next page

MCMI-III, MMPI-2	Frequently used in practice; broad clinical application	Limited concordance with DSM criteria (e.g., no assessment of perfectionism, miserly spending); low validity for OCPD
Compulsive Personality Assessment Scale (CPAS)	Brief, easy to apply; directly assesses 8 core OCPD traits (e.g., perfectionism, workaholism, need for control, rigidity); allows severity rating (0–4)	Relatively new tool; requires further validation and standardization; limited use outside clinical research

SCID-II – Structured Clinical Interview for DSM-IV Axis II Personality Disorders; SCID-5-PD – Structured Clinical Interview for DSM-5 Personality Disorders; SCID-II-PQ – SCID-II Personality Questionnaire; PDQ-4 – Personality Diagnostic Questionnaire, Fourth Edition; OMNI – OMNI Personality Inventory; WISPI-IV – Wisconsin Personality Inventory, Fourth Edition; SNAP – Schedule for Nonadaptive and Adaptive Personality; NEO PI-R – Revised NEO Personality Inventory; FFM – Five-Factor Model of Personality; MCMI-III – Millon Clinical Multiaxial Inventory, Third Edition; MMPI-2 – Minnesota Multiphasic Personality Inventory, Second Edition; CPAS – Compulsive Personality Assessment Scale.

The analysis of psychological test results should be complemented by information obtained from the patient's close relatives as well as careful clinical observation. Only such a comprehensive approach allows for a reliable assessment of the personality profile and increases the accuracy of diagnosing OCPD [8]. The authors recommend that evaluation should also routinely include structured measures of quality of life and functioning (work/education, relationships, leisure), as apparent "efficiency" may mask substantial psychological and social costs. Equally important is the assessment of comorbidities [76].

8. Treatment

Evidence for the effectiveness of different therapeutic approaches in treating this disorder remains limited, and the lack of direct comparative studies means that the choice of intervention should be tailored to the individual needs of the patient and the available therapeutic options [3].

8.1. Psychoeducation

A fundamental challenge lies in initiating treatment itself, as patients with this personality pattern are often unable to cooperate under conditions other than their own, which necessitates long-term and consistently delivered psychoeducation. This serves not only as an introductory stage but also as an integral component of therapy, involving the gradual provision of information about the diagnosis, anankastic mechanisms, and available forms of help. The therapeutic relationship must be collaborative, and in the initial stage is often dominated by the patient, requiring acceptance of their convictions regarding order, control, and moral values [8, 84, 87]. Equally important

is work with the patient's environment – family or co-workers – since without modifying environmental "reinforcers" of perfectionism, therapeutic effects are difficult to sustain [3, 8, 76].

8.2. Cognitive–behavioral therapy (CBT)

CBT remains the best-documented method of treatment [38], but its effectiveness depends on adapting procedures to the clinical phenotype. The greatest benefits are achieved with approaches targeting perfectionism and rigidity, complemented by training in emotion regulation and development of relational flexibility [51, 88]. In clinical practice, the following techniques are commonly employed:

- behavioral experiments – e.g., provoking mistakes or leaving tasks "unfinished," which teaches tolerance of imperfection and reduces anxiety about loss of control [29, 76, 89],
- training to accept "good enough" standards – scaling effort and abandoning the pursuit of absolute perfection [90, 91],
- cognitive restructuring – addressing metabeliefs (e.g., catastrophic thinking, consequences of errors, dichotomous "all-or-nothing" schemas) [76].

Even short-term CBT has been shown to significantly reduce the severity of traits and improve functioning, with the greatest benefits observed in patients with less severe depressive and anxiety symptoms [76, 92].

8.3. Psychodynamic and alternative therapies

Traditional psychodynamic therapies focus on addressing emotional conflicts and the need for control. Research indicates that short-term psychodynamic interventions may improve functioning in patients with Cluster C personality disorders, although specific data for this condition remain limited [93, 94]. Emotional modulation – understood as strengthening the capacity for accurate identification and expression of emotions – has proven helpful in reducing rigidity in interpersonal relationships [76]. In more severe cases, schema therapy has shown effectiveness, combining cognitive and experiential techniques to address deeply rooted personality patterns. Increasing attention has also been given to "third-wave" behavioral approaches, such as Acceptance and Commitment Therapy (ACT) and Radically Open Dialectical Behavior Therapy (RO-DBT). ACT, in particular, has been shown to reduce clinical perfectionism and enhance overall well-being [76, 92, 95].

8.4. Pharmacotherapy

Pharmacotherapy for this personality disorder is nonspecific, as no medication has yet been approved by the FDA for this indication [76]. Selective serotonin reuptake inhibitors (SSRIs) are most commonly prescribed, primarily targeting co-occurring anxiety, depressive symptoms, and obsessive thoughts, while their impact on anankastic

traits remains limited [96–99]. Consequently, pharmacotherapy serves mainly as an adjunct to psychotherapy [3, 8, 30, 76]. Among the available data, only fluvoxamine has been evaluated in a randomized controlled trial (50–100 mg/day for 12 weeks), which demonstrated a significant reduction in trait severity compared with placebo [100]. Additional reports describe beneficial effects of fluoxetine and citalopram, the latter proving more effective than sertraline in depressed patients with comorbid personality disorders [99]. Comparative studies have also shown the superiority of clomipramine over imipramine in reducing trait severity in patients with OCD [101]. Sparse evidence exists regarding the use of antipsychotics and mood stabilizers, but their effectiveness in the treatment of this disorder remains inconclusive [76].

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