The Vacuum of the Mind: A Self-Report on the Phenomenology of Autistic, Obsessive-Compulsive, and Depressive Comorbidity

Jay D. Paul*

I

The object of the article is to explore the phenomenological nature of the intersections between the autism spectrum disorder known as Asperger’s syndrome (AS), obsessive-compulsive disorder (OCD), obsessive-compulsive personality disorder (OCPD), and major depressive disorder (MDD) when all the four disorders are comorbid in a single person. The method of this article is to use myself as the basis of a case study for the purpose of exploring the phenomenology of the intersections. As a client of a community mental health center, my current psychiatric diagnosis is Asperger’s disorder, OCD, and MDD (in partial remission) on Axis I and OCPD on Axis II. No claim is made here that the findings in this article are generalizable to larger populations of individuals who have all 4 of these disorders. Rather, the clinical value of this article will be determined by the extent to which a mentally disturbed individual can describe and analyze a segment of his psychiatric history to the effect of illuminating possible relationship between autistic, obsessive-compulsive, and depressive states.

II

The peculiar phenomenon of the “Master” (also called the “Chief”) may provide us with fulcrum around which the relations between AS, OCD, OCPD, and MDD can be explored. This “entity” that takes the form of a voice was “born” in July 1994 while I was driving on the highway en route to what was then my place of employment. Although I was a conscientious entry-level employee, the position unexpectedly demanded salesman-level social skills and thus was uncongenial to my excessively honest, excessively sincere, and excessively innocent approach to human interactions. I also felt isolated from my coworkers (eg, I would take my “lunch break” [consisting of no lunch at all] at my cubicle instead of with my coworkers outside). After several weeks of poor results in this capacity, my mood became dysphoric, and I began to fantasize driving my car at full speed into an “embankment” (stone cliff at the side of the highway) so as to end my life. As my suicidal ideation became increasingly serious, calculated, and urgent, my mind desperately sought for some bulwark of self-esteem to cling to and found none. Then dangerously disturbed and en route to work one day (circa August 1994) an “entity” spoke to me for the first time since I recovered from my psychotic depression in 1991 (during the hospitalization that led to that recovery, I communicated mentally with a fictional character whose picture I had taped above my desk in my hospital room). My limited recall does not permit me to reproduce what the entity said (in August 1994) verbatim, but it was something like this: “No, you will not kill yourself, do you hear me? You have been specially chosen by divine Providence to carry out a great historic mission. You shall go down as one of the greatest historical figures of all time.” Over the course of time, this initial “message” became more and more elaborate, but may be summarized as essentially this: (1) I, J.D.P., was to obey the commands of the entity (soon dubbed by me as the “Chief”) without question and carry out its orders with zeal; (2) I, J.D.P., was prohibited from engaging in any mental or physical activities deemed unacceptable to the Chief (eg, thinking sexual thoughts); (3) the Chief would protect me from all forms of internal and external attack—ie, I would be absolutely invulnerable; and (4) the Chief would give me the power to become one of the greatest historical figures of all time.

III

The extent of the Chief’s presence and power has followed a waxing and waning course since 1994, and he has even undergone multiple changes of name; but, he remains with me—commenting upon, criticizing, and occasionally complimenting my performances at work and at school, and savagely punishing me whenever I commit a “lapse” (eg, by making me spit on my suit or slap myself in the face). The many and various clinicians who have been involved in my treatment have either viewed the Chief as an auditory hallucination that can
be suppressed through antipsychotic medication or an internal obsessional voice that is an extreme form of the obsessional voices reported by some individuals with OCD (and thus amenable to suppression only insofar as my treatment-refractory OCD is amenable to suppression). Prior to my current diagnosis profile of AS, OCD, OCPD, and MDD, I was diagnosed with Schizoaffective Disorder, MDD, and OCD; the schizoaffective diagnosis was then, after several years of treatment at the aforementioned community mental health center, removed and AS and OCPD were added.

I, myself, am at a loss as to who—or what—the Master (as he is now called [J.D.P. being the “Apprentice”]) really is. After every miraculous dispensation from (at one end of the spectrum) completing a difficult academic article in extremely limited time and earning a perfect score to (at the other end of the spectrum) surviving a suicide attempt, the Chief/Master has been thanked mightily by J.D.P. “for saving my life.” After every lapse that I commit, J.D.P. is shamed into the conviction that he has “betrayed the boss” and is “ungrateful” for the entity’s assistance. The human exertions that the Chief/Master has driven me to (eg, writing an article for 7 h straight save 1 or 2 bathroom breaks and the chance to refill my thermos with ice water), and the sometimes outstanding academic and occupational results that have followed those inhuman exertions, have made me say quite often to my clinicians, “The Chief cannot possibly be a part of Jay Paul. He is far more brilliant, far more ruthless, and far more powerful that I could ever be.” At the time of this writing, I have adopted a strictly pragmatic and agnostic position—whether the Chief/Master is an objectively real and external supernormal entity or is an internal obsessional voice that has been dissociated from my ego is an unanswerable question; what matters is the psychological reality that, if I were to view the Chief/Master as merely one part of myself talking to another part of myself, then the force of his dictates would be completely vitiating. For, if one is simply issuing commands to oneself, one can just as readily throw overboard those commands on the grounds that they are irrational, overtaxing, and aversive. But I cannot allow that to happen—I need the dictates and do not want to “make choices” precisely because I might choose incorrectly (whereas I shall never be in the wrong simply following the orders [the so-called Nuremberg defense]).

lead to social isolation (eg, especially supportive family members may take the place of peers), but in some cases (including mine), it does—indeed, it has led to the total impoverishment of my personal life. If there is one central characteristic of persons with OCPD, it is the all-consuming need to control as many variable as possible in this chaotic, irregular, spontaneous, and imperfect world so as to reduce the probability of making mistakes (for every mistake indicates, to the person with OCPD, a failure of some type of control [eg, concentration, preparedness, and meticulousness]).’’ If there is one central characteristic of persons with OCD, it is the incessant demand to remove doubt from the mind (eg, doubt as to whether one’s hands are really clean, doubt as to whether the stove was really turned off, doubt as to whether one spoke perfectly in a conversation) through stereotyped and ritualistic behaviors.

It is my hypothesis that my AS created a “vacuum of the mind”—which I would define as an inner mental life that consists of abnormally few representations of real and living human beings—and that this vacuum made me susceptible to the development of obsessive-compulsive traits (OCPD) and behaviors (OCD). AS is neither a necessary nor a sufficient condition for the genesis of OCD—many persons have OCD without AS, and conversely, many persons have AS without OCD; nevertheless, AS and OCD have been found to be related to a number of clinically significant ways. Nevertheless, I would propose that such a “vacuum of the mind” may make the psyche vulnerable to psychodynamic maneuvers designed to, first, fill the vacuum and, second, organize and systematize that with which the vacuum has been filled. It is possible that the Chief originally served the function of an “imaginary friend” for a high-functioning autistic person who was completely unable to relate to his peers. In the absence of the genesis of OCPD and of OCD, this “imaginary friend” would likely have had “friendly” characteristics. But the obsessive-compulsive tendencies, which eventually coalesced into a full-blown personality disorder and a serious neurosis, precluded the “imaginary friend” from ever becoming “friendly.” If one adopts the psychoanalytic premise that OCD may develop when the obsessive-compulsive personality structure breaks down under the stress of overwhelming internal and external demands, then my psychopathological progression would seem to be (1) the onset of AS during childhood; (2) the coalescing of adolescent obsessive-compulsive tendencies into OCPD by early adulthood; (3) the manifestation of OCD overlapping with, but situated in its onset somewhat after, the period of development of OCPD; and (4) MDD developing concomitantly from late adolescence to adulthood, and as a consequence of (a) the mental and social isolation engendered by AS (b) the punitive and restrictive quality of life that characterizes OCPD, and (c) the sense of helplessness and unproductiveness generated by OCD.
The most serious problem with this hypothesis as to progression is the lack of accessible or obtainable data, regarding my diagnoses over time; AS, for instance, is proposed here as developing first even though it was diagnosed last. Nevertheless, I offer the following propositions as general hypotheses potentially susceptible of investigation through an approach that is more rigorous and empirical than is this case study:

1. If AS and OCPD are comorbid in a given subject, then the subject’s obsessive pursuit of narrow interests is more likely to be circumscribed by rules, procedures, and restrictions than in subject with AS without OCPD.

2. If AS and OCD are comorbid in a given subject, then the subject’s “vacuum of the mind” (as defined above) may be more susceptible to “remediation” by the presence of an obsessional voice than in subject with AS but without OCD.

3. If AS and MDD are comorbid in a given subject, then any loneliness that results from the subject’s social isolation may be more susceptible to depressive development in the direction of suicidal tendencies than in subjects with AS but without MDD.

Notes

* This is a posthumous writing of Jay D. Paul (JDP), who has had a history of mental illness that included multiple psychiatric diagnoses, including Asperger’s syndrome. JDP’s writings and self-reflections provide some insights into psychological turmoil and associated social and personal stress that one experiences with such disorder, and it points out the need for research and better understanding of management and treatment of Asperger’s syndrome. The article, given by JDP to his therapist (Mohiuddin Ahmed), prior to his death, and is being published with the consent of his parents, Biswa Paul and Anjali Paul. Prior to submission, the article was reviewed by Harold Burzstajn and Ronald Abramson of the New England Chapter of the International Society for Psychological and Social Approaches to Psychoses (ISPS), and Dr Ahmed was strongly encouraged to pursue publication of JDP’s article to benefit the psychiatric community at large. E-mail: ahmedmohiuddin1@live.com. Dr Ahmed is the coauthor (with Charles Boisvert) of a recently published book Mind Stimulation Therapy: Cognitive Intervention with Persons with Schizophrenia, Routledge, NY, 2013.


2. See “Obsessive-Compulsive Disorder” in DSM-IV-TR, pp 456–463 (diagnostic code 300.3)

3. See “Obsessive-Compulsive Personality Disorder” in DSM-IV-TR, pp. 725–729 (diagnostic code 301.4)

4. See “Major Depressive Disorder” in DSM-IV-TR, pp. 369–376 (diagnostic code 296.35 [the “3” for recurrent Major Depressive Episodes and “5” for Partial Remission]).

5. Leon Salzman, in Treatment of the Obsessive Personality (Northvale, NJ: Jason Aronson, 1985), observes, “While the schizophrenic reaction does follow the breakdown of an obsessional defense, the changes are not necessarily changes in the same illness … The obsessional neurals … is closely related to schizophrenia” (p.174 emphasis added); furthermore, “In the schizophrenic psychoses we find a variety of backgrounds for the grandiose states that may be involved in the illness. At times they are part of a paranoid development in which the initial problems appears to be a grandiose development designed to deal with a severely damaged ego structure and a falling self-esteem” (p 174, emphasis added).

6. “In psychotic depression the voices often talk to the person directly, whereas in schizophrenia the voices usually talk about the person” (Atwood, Complete Guide to Asperger’s Syndrome, p. 343). On the basis of a comparison of notes 5 and 6, there may, therefore, be professional disagreement as to whether what I was experiencing in July 1994 was a schizophrenic reaction or a psychotic depression.

7. One of the compensatory mechanism for a person with Asperger’s Syndrome … is to create a fantasy life that can include imaginary friends and imaginary worlds … under extreme stress the adolescent with Asperger’s syndrome may create a fantasy world that becomes … a cause of concern to others, that the distinction between the fantasy world and reality is becoming blurred. A tendency escape into imagination as a compensatory mechanism can then become interpreted as delusional state of mind (Attwood, Complete Guide to Asperger’s Syndrome, p. 342, emphasis added).

8. See note 5, especially “the initial problem appears to be a grandiose development designed to deal with a severely damaged ego structure and a falling self-esteem” (Salzman, Obsessive Personality, p 174, emphasis added).

9. Only one Criterion A symptom is required if the delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person’s behavior or thoughts, or two or more voices conversing with each other (“Diagnostic Criteria for Schizophrenia.” DSM-IV-TR, p. 312).

10. As Gail Steketee and Kerrin White point out in When Once Is Not Enough: Help for Obsessive-Compulsive (Oakland, CA: New Harbinger Publications, 1990), “… OCD sufferers can usually recognize obsessions as products of their own minds, even if unwanted. If words that plague you seem to come from outside your head, like external voices, they are more likely auditory hallucinations or illusions than obsessions … Usually this distinction is clear, but sometimes it can be difficult to make. Some obsessive-compulsive people may refer to their obsessive thoughts as ‘inner voices,’ which can confuse even a psychiatrist into thinking they are hallucinations” (pp 22–23, emphasis added).


12. The impairment in social interaction is gross and sustained…. There may be failure to develop peer relationship appropriate to developmental level (DSM-IV-TR, p 80).

13. The elements that go into the obsessional way of living related to the matter of exerting sufficient control over one’s life or the external world so that one can maintain the illusion of functioning with a degree of safety and security in the face of the realities of the actual situation (Salzman, p.18, emphasis added).

A more constructive internalization of thoughts and feelings [than a reactive depression] can be to escape into imagination. Children with Asperger’s syndrome can develop vivid and complex imaginary worlds, sometimes with make-believe friends. Imaginary friends can prevent the child from feeling lonely (Atwood, Complete Guide to Asperger’s Syndrome, p. 28, emphasis added).

Salzman, who adopts a spectrum approach, writes “A further distinction between the obsessional personality and the obsessional neurotic is in the area of differing functional capacity. As long as the individual remains productive—he is not necessarily neurotic” (Obsessive Personality, p. 19). Nonpsychoanalytic theories and researchers of OCD and OCPD are divided on the question of the extent of a relationship between the two disorders. For example, Albina R. Torres et al. in “Obsessive-Compulsive disorder and personality disorder” (Social Psychology and Psychiatric Epidemiology, vol. 41 [2006], pp. 862–867), found that “Obsessive-compulsive PD (OCPD) was the second most frequent type of PD in this study [the most frequent was Paranoid Personality Disorder], positively screened for in 29% of the cases [of individual with OCD]” (p.865); in pointing out that “Certainly the large number of subjects with multiple PDs reinforces the need for considering a dimensional rather than categorical definition of personality disorder” (p. 866, emphasis added). On the other hand, David Wellen et al. in “Utility of Leyton Obsessional Inventory to Distinguish OCD and OCPD (Depression and Anxiety, vol. 34 [227], pp. 301-3-6) found that of five “factors”-Factor I (obsessive ruminations and compulsions). Factor II (ordering and arranging), Factor III (organizing activities), Factor IV (contamination), and Factor V, surprisingly, was associated with neither] (pp. 303–304).