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Anancastic power or mediocrity in health: dilemmas of patients with obsessive-compulsive disorder in the process of treatment. Case report.

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Summary: *Basing his observations on two patients suffering from deep obsessive-compulsive disorder, the author discusses the therapeutic difficulties related to their subjectively different concepts of illness and health, the level of therapeutic intervention accepted by them, and tries to explain the term anancastic power' and its relation to the dynamics discussed.*

Key words: obsessive-compulsive disorder, anancastic power, anancastic personality, case study

It is commonly known that anancastic disorders are characterised by early appearance of the first symptoms, a chronic course and significantly late onset of specialised treatment [1, 2, 3, 4]. The symptoms of obsessive-compulsive disorder often have a highly immobilising influence, they are sometimes absurd in their content and ruin patients' and their family's life. They are mostly concealed or even protected by the ill, who are ready to look for professional help only in a critical situation [1, 3, 4]. It is then obvious that the rule: 'late diagnosed – difficult to cure' is applicable. The fact remains - univocally effective methods of treatment of obsessive-compulsive disorder have not been recorded until now and therapists working with patients suffering from the spectrum of obsessive-compulsive disorders know perfectly well how difficult it is to gain the patient's trust and subsequently a complete and permanent remission of symptoms. The other vital problems are: an often years' long period of treatment and a constantly necessary multidirectional form of therapeutic intervention [3, 4, 5]. In particularly difficult cases, the effects of on even very intense therapy are slow and often have no character of spectacular improvement. Sometimes it is difficult to estimate whether the patient is more disappointed about the poor effect of treatment or the therapist more frustrated with resistances met in the endeavours for the patient's health.

In this paper the problems related to various stages of treatment or, first of all, therapy of two patients suffering from obsessive-compulsive disorder will be presented.

Case history 1.

Mr. Józef, a 51-year old male, decided to start the treatment of his obsessive-compulsive disorder at the age of 50. He did not suffer from any serious somatic illnesses as yet and he used to avoid contact with all doctors. The history of anancastic symptoms dates back 30 years and the symptoms were increasing linearly. Mr. Józef had not established his own family and had not made many friends. All his adult life he worked as a civil servant. He always fulfilled his job duties in an extremely perfectionist manner and in his own opinion he was recognised as a role model for others. He lived similarly: strictly, stiffly, and faultlessly – he also demanded this from others. When he started being avoided by people, Mr. Józef found that nobody could equal him. In course of time anancastic symptoms assumed more and more bizarre forms: Mr. Józef used to creep around in his flat, full of fear that a gust of wind which he could cause may blow carefully arranged sheets of paper out of the desk. He would suddenly run out on the staircase anxious that his doormat was stolen (but then he couldn't shut the door – with the same fear of the sudden gust of wind). When he went outside he walked in a special manner – every now and then he used to return to check whether what he had noticed on the street was a coin or just a stone. As he initially used to return rarely, after some time he started to do it every few minutes, lengthen the distance more and more until several hundred meter stretches turned into many kilometres' loops. He could even jump out of a train from Katowice to Bielsko to make sure that he locked the door to his flat. However the most destructive ritual was an evening recapitulation. If Mr. Józef had not recaptured every important event of the day, he could not enter the elevator in his building. When two years ago he lost his job, he stayed in a front of the lift for 6–8 hours and sometimes for the whole night. The only way of counteracting of the rituals (and applied by the other patients having obsessive-compulsive disorder) was avoiding the rituals called 'obsessive slowness' [Hand 1996]. It is difficult to imagine he hadn't washed his hair for a few years, although he used to make hairdressers trim it all the time. If one forgot about his unpleasant smell, Mr. Józef kept a proper appearance. He was brought to my office by his parish-priest, the only authority he could acknowledge. Since the beginning of treatment Mr. Józef clearly defined the rules of this therapy: he decided that the drugs, and changes in fundamental rituals aren't possibly realisable, there's no place for any behavioural exercises (it's rubbish), and no medical tests would be useful. When I asked about possible hospitalisation he became offended, and when I described his hopeless general situation and necessity to obtain disability pension he told me that I completely didn't understand what he suffered from and how to deal with it effectively, and afterwards he left the office angry. He came back. In the course of therapy he allowed drugs into treatment and started to talk about the illness. After about a year he accepted help in a fatally tardy pension case. At the same time he ate nothing but bread, keeping the house modestly with the rest of his savings.

Mr. Józef always talked about his rituals very proudly and with great dignity. He builds very long, vivid, complex sentences and he can talk continuously for several minutes. He considers himself as a master of perfection and assumes that if anancastic

symptoms went missing he would have no aims or plans any more. Every year he ritually goes on pilgrimages to holy places and permanently has hygienic problems he neglects and knows that if he wanted, he would cope with them (however he cannot wash himself during a pilgrimage as well). He claims that nobody else could even imagine how thorough he can be and he doesn't think that anancastic disorders may refer to other people. He accounts himself as unique (in fact, it's hard to disagree with him). In therapy, he would like to gain selective improvement: keep a few of the rituals and suppress the others. But when he really gained some improvement as an effect of the prescribed Clomipramine, after a few weeks he noted that it's a helpless drug because after taking it he got more free thoughts and nothing good results from this kind of thoughts. Although having very good intellectual abilities, he is not able to consider the possibility of recovery. It seems that he cannot even imagine this possibility. The institutions that could help him categorically direct their aid to those more in need.

As yet, after a one year acquaintance with Mr. Józef, the biggest success in the therapy is a fact that the patient continues regular contact with the psychiatrist which lets him have a critical approach the problem and mobilises him to some psychomotor activity, other than that implied by the obsessive-compulsive disorder.

Case history 2.

Mr. Robert is a 21 year-old male. He lives with his parents who since the beginning of his illness were consequently submitted to incredible rituals he forced upon them and with time he dominated and controlled almost the whole flat. He finally left his own room a few years before the beginning of treatment, forbidding entrance not only to himself but also the household. He motivated this by saying that 'everything there is arranged perfectly'.

Indeed, there were the jars filled with ideal (according to patient's reasoning) amount of sand and unexpectedly evenly arranged books in the room divider. Between them there was a telescope which was placed precisely and in one constant place. On the walls he stuck a few favourite posters in which he perfectly folded the corners. As every passage through this territory could disturb the balance created there, the only solution, consistent with the ritual of illness, was to leave the room completely and to occupy the living room.

A symbiotic relationship with his mother enabled him a several weeks of irrational compulsions due to which Mr. Robert wasn't able to do even the simplest activities necessary for an independent existence. He could stand without moving for several hours, would not eat for many days, and not leave the toilet for the whole night. He used to keep himself from urinating and defecating to the borders of endurance, however sometimes it happened that the rituals were prolonged and the patient got dirty. Decidedly he eliminated all activities not connected with his home, considering them as not necessary. In contrast to Mr. Józef, he always consented to treatment, although during the first years when his illness was diagnosed as simple schizophrenia, he secretly considered it as an absurd. Indeed, the patient had not experienced any psychotic symptoms as yet, and in opposition to the diagnosis of simple schizophrenia

and in a sense of perfection and repetition, he manifested extraordinary activity. Long, exhausting rituals consisted of obsessive arrangement, counting, and compulsive dressing (or getting ready to bathe). If he made even a slightest mistake he used to punish himself consequently and strictly by specific multiplication of the rituals, provoking in this way a further prolongation of the already extremely lengthy, relatively simple activities. Finally, when he fell into obsessive slowness, he succeeded in reducing the anancastic intensity. Considering the fact that in the clinical picture axial symptoms of obsessive-compulsive disorder unquestionably dominated, we changed the previous diagnosis. Just then Mr. Robert decided that he can trust us and agreed to the offer of multi-layered treatment based on pharmacotherapy (every attainable SSRI and clomipramine), behavioural therapy and family systemic therapy. In pharmacotherapy, the most effective drugs were: paroxetine in a dose 60 mg/day and fluvoxamine in a dose 200 mg/day with parallel application of small doses of pindolol.

This was five years ago. Further details referring to diagnostics and the first stage of treatment were published in the second supplement of 'Postępy Psychiatrii i Neurologii' in 1998 [3]. In this paper the topic of interest is the last 12 months when Mr. Robert gained substantial improvement of his health condition. Along with fading of the most destructive obsessions-compulsions and significant progress in family therapy carried out by another therapist, the patient evidently managed to change the main rituals – something previously considered as fortifications impossible to capture. First of all he returned to his room where he was gradually able to overcome previously inviolable order. Because Mr. Robert always showed extraordinary strength, even anancastic power, he started to make up outstanding matters. He called at a library where he borrowed a few books about 14 years ago and to amazement of the employees, returned them blaming his mother as the guilty party. Next, he went to the cable TV operator claiming that his parents used an additional and illegal connection, something he considered as a scandalous violation of rules. When they tried to ignore the issue, more and more fretful Mr. Robert intervened until the illegal connection was removed. He also demanded severe punishment for the household. At the same time he started to invest saved money and bought a mobile phone which he considered to be close to his own perfection. He decided also to improve local litter salvage, and in his expectation of success, brought particular parts of litter to the neighbouring city of Katowice in a masterly sensation of keeping ecological principles. Finally he managed his weight and hygiene, and left the living room to his parents' disposal. He started to practice his verbal communication diligently (previously he used to speak in a ritual way, no more than 3 to 5 words in a sentence with long pauses between words). He decided also to express and inflect the affect (previously he considered an android from the famous movie 'Terminator' as a model for his functioning).

Because he lost a symbiotic relationship with his mother, he especially strongly concentrated on me. At first he acknowledged that we are identical and for his own needs prepared my psychological portrait and obsessively started guessing my thoughts or interpret completely insignificant words or events. As Mr. Robert has an excellent

memory, he recalls conversations from past years, adapting them for his own needs, which repeatedly makes me feel embarrassed. When I asked him how it is, if a man returns to normal activities after so many years when he was seized with obsessions and compulsions, Mr. Robert said: 'It's like landing on another planet. I feel such a different person that a normal ride in a bus makes me amazed. People make mistakes, they are chaotic and don't understand what the real order means.' Mr. Robert confirmed that in his view he feels to be much better than others. He points at his unique skills, being perfect – he justifies this by a very special cynical sense of humour. Persistently he claimed that earlier on he didn't want to recover because he considered being healthy as boring and that this is what he is currently confirming.

In fact it is difficult to account for the patient's motivation; maybe years of multi-levelled therapy, and first of all trust which he gained and respect manifested to the patient, enabled him currently to follow my ideas that let him lead an independent existence and express his own activities. What is especially positive is that Mr. Robert not only gained separation from a symbiotic relationship with his previously helpless mother but also, in the last months, he consequently started to confront himself with me. It confirms the patient's growing aspiration to self-identification and a wish to be independent, although there is a lack (or immaturity) of his own conceptions of a realistic and fair existence.

Comment

1. The presented case histories of two male patients at different ages, suffering from obsessive-compulsive disorder confirm that for the ill, the anancastic symptoms can provide a more natural functioning environment than what is generally understood as health. It reminds us of some patients' problems - suffering from schizophrenia and at the same time obsessive-compulsive disorder takes the latter away from the neurotic disorders' group. Both patients, although being at different ages and having a dissimilarity of manifested symptoms or some personality characteristics, are extraordinary similar in the area of understanding terms such as territory, perfection, uniqueness, excellence, affect, ritual, control, needs and power.

Both of them unusually keep accepted rules and do not accept lies, although at many times they departed from the truth in talking about their symptoms. Undoubtedly, both Mr. Robert and Mr. Józef hold themselves to be extraordinary and better people but this refers only to their pathological phase. None of them accept the possibility that the obsessive-compulsive disorder is an illness referring to other people as well. Differences in the age of patients determine various decisions on when to start treatment. Mr. Robert, 30 years younger than Mr. Józef, consequently showed amazing improvement, and now attempts to find himself in reality using defence mechanisms similar to magical thinking, grandiose self esteem, and as a consequence he can still find himself to be a unique person. This stage of the treatment, although he has a permanent appearance of various eccentricities, lets him lead a relatively normal life. The same cannot be

said for Mr. Józef. After tens of years of experiencing intensive obsessive-compulsive symptoms, so far he does not want to accept most of the offered treatment possibilities and tries at all times to dominate in a process of correcting the proposed ideas. It seems that Mr. Józef having had quite a good social status previously, still attempts to keep the power of his personality and first of all to control the current situation in this way. Undoubtedly, he perfectly realises that in his case, the definition of health is so strange, unclear and uncertain, he does not decide on confronting the symptoms because of his current fears of decompensation. Consenting to a regular contact with a psychiatrist, at the same time he manifests the will for change and ambivalence. The possible hypothesis is that Mr. Jozef by manifesting symptoms of a completely formed anancastic personality has a lesser ability of doing even small changes, first of all in the area of motivation and plasticity in making other decisions than pathologic ones. Evidently, the younger patient - Mr. Robert (also fulfilling the criteria of anancastic personality), because of a very early onset of his pathologic symptoms and treatment, shows more ability to change. Although he initially suffered from more intensive or complex rituals, he gets faster improvement and looks for new possibilities of attaining new activities at all times, which induces a better prognosis.

In Mr. Józef's case the next years will show finally if the treatment process may be deepened and can lead to a more significant reduction of obsessive-compulsive symptoms.

2. Similarly, just as my patients do, more and more often I ask myself the question to what limits is the healing process possible in severe cases of obsessive-compulsive disorders and what may I offer to the ill. The lack of effective and simply clear therapeutic tools in confronting such intensive pathologic symptoms very much complicates the possibility for the patient to gain motivation and makes treatment a long-term procedure. Because of the complex etiopathology of the obsessive-compulsive disorder [6, 7], the only possible method of treatment is therefore to combine it into a multilevelled treatment that later demands significant investments and patience of both the patient and the therapist [3, 4, 5]. The initial acceptance of the patients' conceptions seems to be very useful. Even if they have no reasonable effectiveness, it enables one to build a continuous therapeutic relationship. Trust is what decides about a possibility of maintenance of the patient in a treatment process, although many unpredictable conflicts of interests lie in a distant perspective.

3. Maybe the key to finding more effective methods of therapy for severe anancastic disorders is to understand the term of anancastic power. So far the author of this paper has not found any articles convincingly explaining this omnipotent control or the feeling of grandeur to others. On the basis of my own experiences I have noticed a coincidence of appearance of an anancastic power in case of a parallel diagnosis of obsessive-compulsive disorder and anancastic personality. If one assumes that anxiety is the original mechanism of this disorder then the wish to avoid this fearful experience becomes understandable, so practically a complete isolation from the emotions is necessary. Extraordinary rigidity is characteristic for patients with obsessive-

compulsive disorder and anancastic personality. Possibly, by a complete limiting of the activity to ritual forms, the ill avoid new, unclear, and unpredictable experiences that can be potentially anxiogenic. In their understanding there is no interpretation what is their defence but a pathologic mechanism, and it becomes possible to control the predictable anxiety when it is secured by obsessions-compulsions (in practice, it is limited to concordance in realisation of rituals). The more these rituals are bizarre and complex, the less possible for the patient is a threatening improvisation, and at the same time –in a vicious circle mechanism – the rigidity and repetitiveness intensify. In spite of the anancastic patients' need for manifestation of their narcissistic importance and character power, a high intensity of pathologic symptoms determine lower optimism in obtaining successes which could include the generally understood standard or norm. Most likely, the only solution matching personality needs with pathologic symptoms is a further and unique splitting in the world of illness. This would explain irrational and obstinate protection or even support of obsessions-compulsions and at the same time looking for supporters (i.e. family) who could value the uniqueness and perfection in realising the rituals. Every therapist who undertakes treatment of these disorders tries to oppose the pathologic symptoms. This disturbs the existing balance and what is worse; it induces the anancastic power of the pathology. As a result of it the patient intensifies his symptoms because – in accordance to the character of his/her personality – he would be forced to recognise his/her cognitive errors and deny unique features of his pathology, hence - his ego. Searching for new possibilities of manifesting his/her own skills, (not in terms of pathology) the patient would be forced once again to search, therefore - improvise, and this probably would induce anxiety. Probably, people suffering from obsessive-compulsive disorder have some consciousness of the pathologic mechanism described above because (what is exemplified in the cases described above) they start treatment very late, insistently hide their anancastic symptoms earlier on and often passively agree with other diagnoses or taking the prescribed neuroleptics.

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