Web-based Radio Program

Obsessive Compulsive Patterns in Children and Adults

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Good morning. This is Dr. Greenspan coming to you via our Web-based Radio Show. Thank you for joining us today. Today's topic is going to focus on obsessive compulsive patterns in both children and adults so we can understand obsessive compulsive behavior across the life span.

Who among us doesn't engage or indulge in certain ritualistic repetitive thoughts or actions? It's like the old game we all played as children – "Don't step on the line because the bear will get you at the end of the street." Magical thinking to be sure, but a fun game, yet we obsessively avoided the cracks in the street as we walked down it. Who among us as adults doesn't say to ourselves after something good has happened in our lives, have a favorite saying, "I better not feel too good or a dark cloud will emerge." Who among us doesn't have a certain routine we have in the evenings that we feel uncomfortable and anxious if we don't employ that routine. So we all have bits and pieces of obsessive behavior or repetitive thoughts that, interestingly, we often use to ward off danger or fear of danger or some fear or anxiety.

Children are no different. Children will repeat certain actions, often because they are also fearful or anxious and this reduces the anxiety. They may do certain repetitive behaviors. Sometimes with children with special needs or autistic spectrum disorders we call these perseverative behaviors. Some are just repeating motor patterns that they have learned because they don't have the flexibility to do more innovative problem solving actions. Others, maybe to be able to cope with anxiety or emerging fears even as thoughts are being learned; even as ideas are just coming into the child's mind for the first time. Sometimes fears can exist at a preverbal level or a level that is an earlier organizational level than using ideas. For example, the child can be scared who isn't yet speaking of a danger. We see this in 16 month olds who don't have very many words at all, yet will be scared by a scary monster or they may have their own way of experiencing a scary feeling – not in terms of an image of a wolf, lion, or tiger eating them up – but more in terms of just a feeling of fear or dread or doom. We all have these; even as adults we have these fearful feelings with no images at all. We may even say to our spouse or good friend, "I don't know; I just feel apprehensive today for no reason at all, there are no images, I'm not worried about my boss or my spouse or my good friend doing something mean or evil."

What is the developmental pathway towards obsessive thoughts or obsessive behaviors? As with our considerations of anxiety, depression and other common mental health problems, obsessive compulsive patterns also have their own developmental pathway involving biological elements and experiential ones. Let's start off with the biological ones first.

Sharing a certain similarity to anxiety and depression, in early infancy we often find individuals prone to obsessive compulsive patterns experiencing lots of sensory hyper-reactivity. In other words, they are not under-reactive or sensory craving as a group, but in fact tend to be more sensory over-reactive as a group – sounds, touch, or dramatic movements may overwhelm them easily during infancy and toddlerhood, and even into the preschool years. Sometimes this persists into the older child, the adolescent and the adult years. So the group we tend to see a physiologic tendency towards over-responsiveness rather than under-responsiveness or sensory craving. This tends to, as we talked about when we talked about anxiety, make the individual more prone to anxiety because if a cat's meow sounds like a lion's roar or an image on a movie or TV screen that is meant to be fun gets to be too scary too quickly, the world is a fearful, anxiety-provoking place – overwhelming all the time the first time you go to preschool, the first time your boss shouts at you, the first time you get into a real conflict or fight with a friend maybe would be more frightening than would normally be the case.

Now also in a developmental pathway to anxiety, we notice that caregivers can have different responses to the child who is over-reactive. If the caregiver overreacts to the over-reactive child, we get a double-whammy; double anxiety. So if every time the child gets anxious and overwhelmed and starts looking fearful and the mommy or the daddy or the other caregiver says, "OH MY GOD! WHAT'S HAPPENING?! WHAT'S HAPPENING?! WHAT'S WRONG?!" then the child is doubly alarmed. The child who was just a little bit alarmed then sees alarm in the eyes of the "other" (caregiver) and then thinks, "I must really be in deep doo doo if they are looking so panicked." On the other hand, if the caregiver is very soothing and yet very interactive, "Well, what's the matter my little sweetheart? What's got you scared? How can mommy or daddy or I make it better?" in a soothing voice and you are interactive, then the child learns to engage in a series of back-and-forth social and emotional signals that are soothing and organizing.

The key is combining soothing, organizing, and many back-and-forth emotional social signals like we have talked about before – opening and closing circles of communication with lots of facial expressions and exchanging of different emotions. As the child learns to do that, the child is learning to negotiate their anxious feelings. They can communicate even before they use words through this exchange of emotional and social gestures and if that is continuous, and flexible, and yet soothing, and comforting, it is the kind of person who can reach out to others, become soothed, and eventually internalize that soothing feeling. So as a child becomes more verbal and gets ideas and can create fantasies, you'll see that in the fantasy play of the individual. The mommy doll will be reassuring the baby doll, and eventually the four year old child will be able to say to themselves, "It's not so bad, it's not going to be so scary" or "My scary feeling will go away in a few minutes and I'll feel good again." How many adults use that tactic to sooth themselves; will talk themselves down or through an anxious situation, "It's not too bad. My little angel hasn't called me, it's been one week and they have been in college for the first time, but perhaps they are just having a good time and I'll call tomorrow." You talk yourself down rather than just indulging in your worst nightmares and fantasies and say, "Oh my God, was he in an accident? What happened to him?"

The next big question, however, is when this biological tendency exists toward over-reactivity, and the environment is not able to create this soothing back-and-forth

emotional gesturing and then later on soothing to the level of fantasy play and then soothing at the level of exploring feelings logically through our "Thinking About Tomorrow" game and other games we talked about in the past, and where the adult doesn't have soothing relationships with spouses or friends to keep this pattern going at both the exchange of gesture level and then at the exchange of ideas, to talk about feelings and talk about thoughts, why then do some individuals become anxious and panicky and others more obsessive and compulsive and others more depressed? What is the additional factor?

What we found in individuals prone to obsessive compulsive patterns is this factor that seems to separate them from the individuals who just become anxious. Individuals that become more obsessive tend to have, as a group, not every individual, stronger visual spatial abilities, stronger big picture thinking, and along with that, a stronger need for control, and a stronger need for keeping control over their environment. In comparison, individuals just prone to anxiety and panic tends to be more of a tree person; sees the trees rather than the forest, and may not be as strong in their visual spatial processing, i.e., big picture thinking, and therefore often doesn't try to control the world around them as much.

So to take two extremes for contrast, and many individuals are close to the middle, so it's not always as easy to form these neat categories, but to take the two extremes for illustrative purposes, the individual more prone to obsessive compulsive patterns tends to want to control because of their skill in big picture thinking and seeing what is coming, the environment, so they don't get overwhelmed. They become stubborn, they become more negative, they become more controlling and then the obsessive thought patterns or the ritualistic behavior are part of this attempt to exercise control over their environment. The goal here is to calm down before one gets overloaded and keeping control over the environment so it doesn't overload one. Typically here, for example, a child will argue and be very negative and stubborn about what socks to wear so the socks don't feel rough and so they feel smooth and don't feel overwhelming. They may argue about not going to school because it is too noisy. In the adult, may be very narrow and rigid in their activities for fear of becoming overloaded – won't go to certain restaurants, won't take certain jobs, may elect jobs that minimize sensory overload. Basically, we have a rigid, stubborn, negative, non-risk taking, safe-seeking adult, and a negative, controlling, stubborn child that fits in with the obsessive compulsive thoughts and rituals. The rituals and thoughts are part of this overall pattern. That is why originally the obsessive compulsive was described as perfectionistic, controlling, stubborn, negative, etc., in most of the clinical literature.

In contrast, the person more prone to anxiety or even depression tends to get overwhelmed, gets himself into situations where they get anxious and panicky – doesn't anticipate; doesn't see the big picture; doesn't try to control things as well. And he doesn't often evidence these characteristics of control, negativism, stubbornness, etc. In fact, whereas, the obsessive compulsive individual tries to do things on their own and prevent getting overwhelmed, the anxious individual instead gets overwhelmed, helpless, and seeks help from others to calm down. So we have a more needy, helpless person in comparison to a person striving to control and be independent and control their world and environment and those around them. When they are very dependent on others, which is

often the case even in the obsessive compulsive individual, it's a controlling type of dependency – "You do this; you do that for me" rather than "I'm overwhelmed; I need you so much! Please, please, please help me!" So instead of a needy, pleading quality, it is a controlling, demanding quality.

Parents with their children have very different reactions, and two adult patterns, one has very different experiences with the obsessive compulsive individual from the anxious individual.

It is important in understanding the obsessive compulsive person, whether child or adult, to understand these underlying dynamics that at the core, the individual is very anxious and the obsessive compulsive patterns are a response to anxiety. In fact, in the pharmacologic treatment of obsessive compulsive patterns and anxiety states, many of the same medications are used. For example, the SSRI's like Prozac or Paxil or Celexa are anti-anxiety on the one hand and also were shown to have strong properties to help obsessive compulsive patterns as well.

Now the question is, what creates the ideal understanding of this developmental pathway, what creates the ideal environment or program for such an individual so that pharmacologic treatment is not needed? And when it is, it is more likely to be successful because the environment is being more supportive toward developing healthy coping strategies. The key is a multi-faceted approach.

1. The most important first element is to create that relationship that may have been missing in infancy and early childhood, whether the child is a little older or still a toddler, in which case it makes it easier to implement that new experience. Or in an adult who has never had the experience or keeps finding relationships where that experience is not forthcoming. So to create that in both the therapeutic relationship and in the environment the person finds himself in – with their spouse or with their own family if they are grown up or with their nuclear family if they are still a child. So the environment we want to create around such an individual is that soothing, comforting environment. We want to explore with the individual where they are sensory over-reactive (what tends to overwhelm them, what they are scared of) – not treat all their obsessive fears or rituals or thoughts as just irrational but as clues to what they are over-reactive and over-sensitive to. They may be especially ritualistic or obsessive around eating, and it may be that their sense of taste and sense of smell is very hyper-responsive and that is a particularly anxiety-provoking experience for them. They may be very obsessive around sexual behavior because certain types of touch are very overwhelming for them and they want to control it. It may be around getting dressed and undressed. It may be around the type of clothes they wear. It may be around certain work attitudes, having to do with the work environment. It may have to do with the experience of certain feelings – whether they over-react to certain feelings. Very prominent, for example, is fears of anger because it is associated with being out of control and angry feelings and assertive feelings are much more difficult for both anxious individuals and obsessive individuals because of their hyper-responsivity. For any individuals who are hyper-responsive to their environment, they are hyper-responsive to their own affects; their own emotions as well. The hardest of these is anger and assertiveness because it propels one into actions that if one gets out of control, and yet ironically, if one sees obsessive individuals lose it, and have tantrums because they can't

control that anger sometimes, and they do get out of control. That only confirms for them the need for the obsessive compulsive coping strategy, rather than the more flexible approach. So helping the individual to recognize the situations and the context where they become anxious; where they feel overwhelmed, and then to create especially soothing responses with a lot of gesturing; a lot of verbal as well as nonverbal communication in those situations, and helping the older more verbal children and adults become a poet of their feelings in those situations. So the individual is able to describe how they feel overwhelmed, how they feel overloaded, what it feels like physically to them. Like one child said, "My body is about to explode." Or an adult said, "It feels like 1,000 particles hitting my skin at the same time." There will be very interesting metaphors. So this is something spouses can do, therapists can do, teachers can do, family members, and good friends can do to one's friend who happens to be more obsessive and you are trying to be helpful or create that soothing environment. So it's soothing, lots of relaxed tone in one's own voice as one who is pursuing this, and then exchanging soothing gestures, and reassuring nods. But also, at the verbal level for verbal children or adults, exploring the words and soothing tones that describe the experience. So the person becomes a poet of their own inner life and their experience and becomes very knowledgeable about what overwhelms them; the underbelly of their compulsive patterns.

2. Help the individual develop a wider tolerance for greater and greater ranges of experience, both the adult as well as the child. So gradual, gradual exposure with knowledge into new situations with lots of soothing, nonverbal interactions, and lots of exploration of feelings as we have just been discussing. And, at their own pace – it's a "one toe in the water at a time" rather than, what some behavioral techniques that are used and we call "implosion" which is where if a person is scared of elevators, you put them in an elevator for four hours and hope to implode out the fear by getting exhausted and learning to relax in the elevator. This is a gradual, one toe in the water at a time approach. We are gradually expanding.

3. Work on assertiveness and constructive leadership as one is moving out more into the world. And work on expressing one's anger to oneself and picking the appropriate ways to express it socially when it is constructive, meaningful, and grounded. It doesn't mean to be a petulant infant and just express one's anger all the time, but it means to be knowledgeable about anger, and then to evaluate it's appropriateness in the situation and then decide if it deserves mobilization into assertive statements, such as in a marriage where one spouse needs to have a serious discussion with the other spouse about things that are annoying them or things that they need to be more assertive about. So anger should a signal that things are "ticking one off" and then one assesses the appropriateness of that to the situation whether it is based on one's own fears or irrational beliefs or whether it's based on real things going on in the relationship. In either case, one should be able to discuss it with a close friend or spouse or therapist. But what one will do or demand as part of negotiation, one will depend on the assessment of that anger. But be aware of one's anger and the degree of it. The reason why the awareness of anger is so important is because with sensory over-reactive individuals, when they or we get overwhelmed, there's often a lot of the feeling of being out of control and a lot of anger, and a lot of fear of being out of control with anger. So it is a very important backbone

feeling that needs to be explored. With this approach, we often see gradual improvement in the need for the obsessive compulsive patterns or ritualistic behavior.

With children with special needs who don't have a great deal of planning, we implement as much of this as possible at the pre-language level. To the degree that we do Floortime and improve the back-and-forth communication with gestures, and negotiate using gestures, different sensory environments and different social situations, we often encourage flexibility and creativity, even at the preverbal level, or the emerging verbal level in children, and we see less ritualistic behavior; less repetitive behavior.

Also, another component of the program, especially for children, is those children who have added contributors. For example, some children have what we call motor planning and sequencing problems where it is hard for them to plan and sequence their actions. As we improve that through occupational therapy and through little games like with obstacle courses or highly motivating activities where they have to add one more element onto a search game, for example, as their motor system becomes more organized, also we see less repetitive actions and more creative actions. Also, we provide constructive ways to meet sensory needs for relaxation, through sensory integration exercises – running, jumping, spinning, deep pressure, throwing, catching, kicking, balance exercises – we also see improvement in the amount of ritualistic or repetitive behavior patterns.

These same principles are important for adults who never had special needs – physical exercise, improving muscle tone, improving motor coordination. It gives one confidence in one's body, which reduces the tendency to over-reactivity, and panic and overload and feeling overwhelmed. It is getting at a very fundamental sense of security. That coupled with more secure relationships that are more soothing and have more fundamental security helps the adults get to be the master of their bodies and therefore, are not prone to obsessive compulsive or ritualistic patterns.

So there are many similarities between our approach to adults who never had special needs to children with special needs with obsessive compulsive patterns. Many things that we can do short of pharmacologic interventions, whether or not the individual then also needs a pharmacologic approach can be determined by the amount of progress they are making. If the problem has been established for a long time, and even if there is progress but it is very slow, there are a number of medications that can be considered, especially the SSRI's, but medications like Tenex and Chlonadine are often effective for anti-anxiety medications as well which can also help with obsessive compulsive patterns. But there you have to weigh the positives and the negatives and look for side effects and see if it is helping the individual and also use it for the shortest term as possible. I like to always recommend at least six months without a trial of medications just to see what the learning curve looks like and see if the progress is moving ahead.

Also, nutritional approaches are useful to try before one considers medications. Basically, removing additives, preservatives, chemicals, processed carbohydrates, sugars, and fruit juices from the diet, as well as for some individuals, specific food groups like wheat products or dairy products, may be helpful. That is because the sugars and the processed carbohydrates that convert quickly to sugars or other chemicals tend to often stimulate more epinephrine release in the body or an "adrenaline rush"- that's why a chocolate bar tastes so good late in the afternoon sometimes and we get that rush. But

that can overwhelm the person who is hyper-responsive to their world. It revs them up and makes them more over vigilant and more over-reactive and that will just intensify the anxiety even though it feels good for the moment. So a diet which is with complex carbohydrates i.e., complex grains, lots of vegetables and lots of protein and very chewy fruits rather than fruit juices and free of chemicals will tend to create a more even blood glucose level or blood sugar level which tends to help the moods be more even and the individual a little less over-reactive.

Also, hobbies like yoga that have to do with deep breathing and relaxation can be very helpful; or meditation or any kind of relaxation exercises. So being physically fit, exercising every day, getting one's muscle tone and motor system in order, becoming aware of one's feelings, creating soothing environments and soothing relationships, exploring one's feelings, especially anger, experimenting with assertiveness, exploring one's world gradually, are all part of the developmental pathway to overcoming obsessive compulsive patterns. And again, medication may have a role for some individuals and needs to be on the shelf and considered after about 6 months depending on the learning curve and the individual's circumstances.

Now just briefly, two illustrations: Little Charlie was a 3 year old little boy who is very sensory over-reactive and was already trying to control his world. He wouldn't go to preschool, he fought over which socks to wear, which pants to wear - he only wanted soft cottons, and battled his parents at every front. His parents came for a consultation because they were concerned that little Charlie was so negative and all they were doing was battling with him and they were very worried that he wouldn't go to school and would only play with certain children and not others, etc. The solution for Charlie was relatively simple – we discovered he fit the classic pattern that I was describing, which was that he was very sensory over-reactive, very finicky, mom was herself a very anxious person who over-reacted to him and became hyper-responsive herself particularly whenever he challenged her, dad was basically non-existent, and when he was there he was basically an authoritarian and punitive and he frightened Charlie enormously. We first got the family situation settled down, we got the parents into some counseling so that mom could calm down and be less anxious, dad to get involved and get home earlier, and not be so punitive with Charlie and become his buddy and Floortime partner. We got both parents doing 2-3 Floortime sessions a day with this highly verbal, bright child. We also created a very sensory-soothing environment at home, did lots of activities to improve his sensory regulation in terms of firm pressure and movement, which he loved. We also involved him in fantasy play where he could be in charge and be the dominant person, and in the fantasy play we also challenged him so he could assert himself and flex his muscles, and we also worked on his muscle tone and motor planning, which was a little weak. Gradually, we expanded his friendship base so we started with the kids that he liked and then slowly but surely we added one that was a little rougher and a little less predictable and he tolerated that well over time. Six months later, after he had already left preschool, we started him back in preschool but only for about 45 minutes a day and gradually worked up to two hours. When we worked up to two hours, he tolerated it very well and actually over time became assertive and somewhat, because of his sensitivities and reactivities, he could tune into other kids well and he became somewhat of a leader and we discovered he had a remarkable sense of humor and he could make the other kids

laugh. He became very popular among his peers. As we improved his muscle tone and motor planning, he got into sports as he got a little older and enjoyed team activities as well. Now as a teenager, Charlie is doing very well and he is a gifted teenager who is doing well both socially and academically and is cooperative with his parents.

Another case, just very briefly, the case of Margie, who is a 45 year old working mom who is involved in computer sciences, and she found herself involved a lots of obsessive thoughts about her oldest daughter who was about to go off to college and she had lots of obsessive worries about bad things happening to her daughter and being in accidents and this was interfering with mom's relaxation and also she found herself getting involved in certain repetitive behaviors to keep her daughter safe, like she would get on the phone and call her five times a day on her cell phone, or sometimes just dial her number and listen to her daughter's voice, and she thought, "This is irrational – I don't know why I do it but I feel compelled unless I call and listen to her cell phone, I know this doesn't reassure that she is safe but I get more anxious." We discovered that Margie had also this characteristic pattern – was very sensory hyper-responsive, and in fact got into computers because it was an environment that she could control. She married a passive man, who basically allowed her to control him, and he would do everything she asked, and he was, in fact, interestingly the more maternal of the two in terms of being softer and more soothing where she wanted to control things and be in charge of everything. It was more like she was a big dictator at home, but she hadn't anticipated the challenges of her first daughter, who was a clone of her, somewhat, who models herself after mom. She was very bright, successful, but controlling and sometimes a negative girl, but basically a safe and secure person who was careful and cautious so it didn't require a lot of worry. But she was quite independent and she was a girl who had friends and she was basically coping well within her basic personality structure and she didn't really require mother's worry.

As we saw mother's patterns and we analyzed her hyper-reactivity and her anxieties and her fears, and the fact was further that because she was so controlling at home, her husband had pulled away from trying to be helpful to her and soothing to her because she had always been in charge. She had never been very anxious. So we started off by getting them involved in a more intimate relationship where he could soothe her and help talk her through her anxieties. And we helped him become a soothing caregiver and recognize the source of her anxieties. We helped her acknowledge that she was scared and worried underneath her need to control and call her daughter all the time and worry all the time. Also there had been fears of loss because her daughter had been the one person she was closest to in the family, even closer than her husband. And that she was scared and overwhelmed by her own feelings. She was also, not yet at a conscious level, but more on an unconscious level, very angry at her daughter for choosing a college away from home, even though consciously she wanted her daughter to go away from home, to have an independent life. But she secretly hoped the daughter would choose something very close so she could see her daughter all the time. So she was very angry with her daughter too and needed to get in touch with those angry feelings, but was very scared of being overwhelmed by them and leading to all kinds of destructive acts.

We took the same approach with her that we basically did with little Charlie – becoming more aware of her feelings, creating a soothing environment for her, especially

with her spouse so he could take the place of his daughter which was rightfully his, and should have been there all along, at the preverbal and the verbal level. We got her involved in some talking therapy where she could learn to become a poet of these feelings, particularly at the angry feelings. We helped her expand her sensory world, do more activities, rather than to limit herself to just work and some very ritualistic hobbies at home which just involved the computer; involved very controlled activities. She was not prone to do exercise - she had low muscle tone and not very good coordination, so we got her involved in an exercise and gym program and some activities. It turned out that she enjoyed ice skating and we got her involved in a skating program which is very good for muscle tone and balance and coordination. With some teaching and coaching, which she enjoyed, with a very soothing instructor, I should add, over time she improved dramatically, over a course of a year period of time, without the use of medication. She would have been the kind of person who one might have gone to medication with very quickly and we held it on the shelf for her as a possibility. She had come in really seeking medication for her "obsessive compulsive and anxious states," but it turned out it didn't require it once we strengthened all the elements on her developmental pathway that had created the problem in the first place. The advantage of that was that she became a more flexible, stronger, more creative person in the process, in addition to having relief from her symptoms.

Well here we had two examples of individuals where understanding their developmental pathways helped create a program for them. Not every individual will be as successful or as quickly successful as Charlie and Margie. But these elements can only help. Even where medication is needed or required or a longer term is required, these elements will help the individual begin a course of recovery that enables them to broaden their capacities and become more flexible individuals.

The key to remember is whether overcoming obsessive compulsive patterns or other patterns, the symptoms should be an opportunity for overall improvement and overall gains and flexibility.

Thank you for joining us today, and next time we will talk about another area of challenges very common to many individuals.