OCD and Mindfulness

Obsessive Compulsive disorder compromises many PwDD lives and limits their potential to be all that they can be. For most PwDD it appears that the main cause is over connectivity of brain circuits in the part of the brain known as the orbital frontal cortex. In 1999 a research team led by Dr. J. Swartz proved that mindfulness could be as good as or even better than the best medications for OCD which reduced symptoms by 50% or better.

Attention Moms

I have a strong hunch that ….

If your child has unresolved OCD tendencies and if your child appears to direct most of their agitation and aggression toward you, then Mom it could well be this is primarily an expression of OCD. It's not about you.

Whereas you have generally always been the main receiver of your child's 'out of control' behaviour, now as a youth or adult, their OCD may demand that you still be the receiver to meet their OCD needs for sameness, predictability and patterning.

Selecting you to experience their aggression may have little to do with your relationship today. Work to resolve the OCD through therapies like Neurofeedback, OCD Medication and the Conscious Care and Support Hierarchy of Needs and the aggression most likely will reduce or be eliminated.

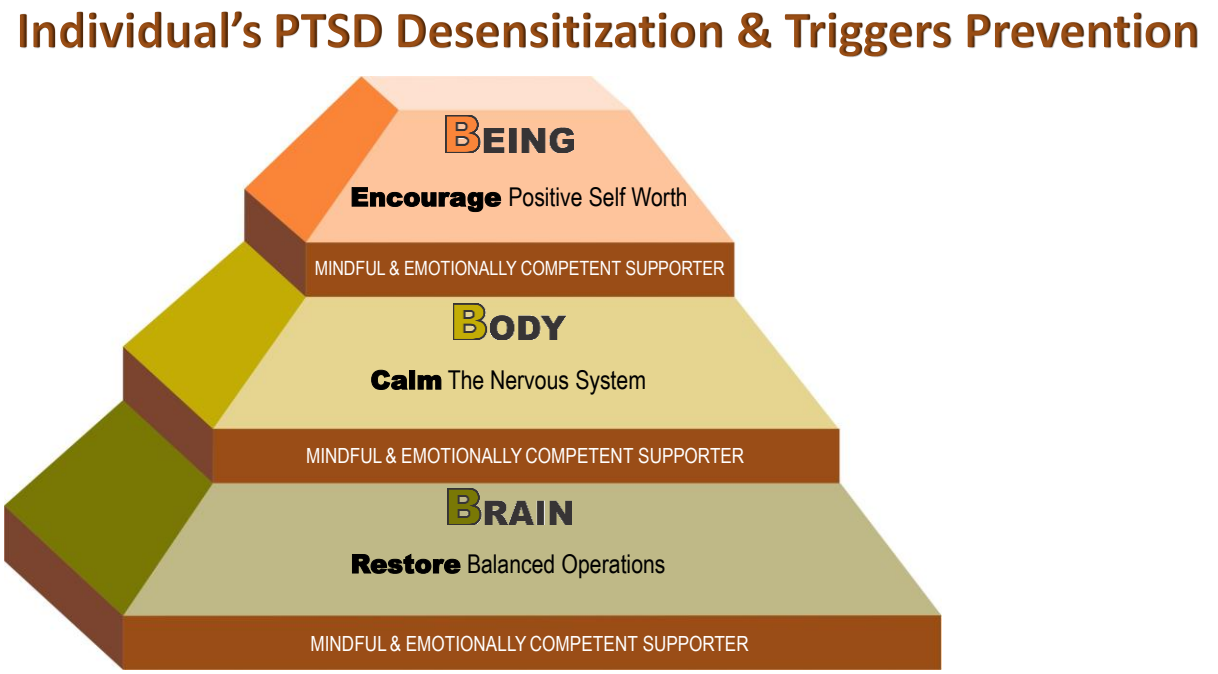
Also Mom and Dad, reference the message from your child at the end of Part THREE, Section Four.

Trauma and PTSD Basic Facts

The prevalence of PTSD in PwDD is most alarming. Given many relevant findings and studies there is a reasonable probability that PTSD at a level sufficient to cause maladaptive behaviours affects one out of every three to four PwDD. PTSD symptoms, when triggered, cause anxiety or even panic. PTSD may have been caused by real abuse or neglect, perceived abuse or neglect, or even anxiety that results from frequently feeling so out of control. PwDD cannot sustain calm as effectively as neurotypical people and experience panic attacks with people or in places that others would not find stressful. Even though the trauma is from the past, the individual's brain keeps giving messages that elicit fear and helplessness.

The PwDD can explode at the smallest sign of something that reminds him or her of the past or activates complex brain circuits made hyperactive by traumatizing events. It is therefore important to have clear strategies to intervene. When, for example, a scream or yell from a

nearby person triggers anxiety or panic, the supporter needs to consider implementing one of the BB-ABC protocols (reference Need #1). Using this approach will allow the supporter to restore relative calm to the traumatized ASD/DD individual.



Causes of PTSD in PwDD

For neurotypical individuals most trauma results from neglect and abuse. While PwDD can often develop these painful symptoms for the same and different reasons, it is important to take note of the prevalence of abuse among these individuals. Consider the following facts:

- "It is estimated that children with developmental disabilities are more than twice as likely to be physically or sexually abused as their typically-abled peers" (Petersilia, J., 2001).
- Sullivan and Knutson (2000) report children with intellectual disabilities (from 55,000 studied) are 3-4 times more likely to experience sexual abuse before age 18 than children in the general population.
- As children, they are five times more likely to be abused than neurotypical individuals (Monsell and Sobsey, 2001).

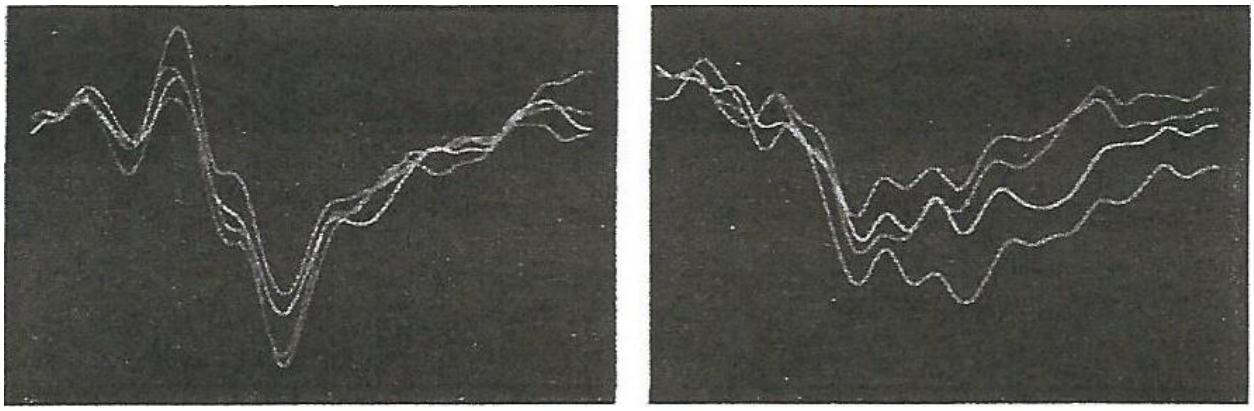
These documented situations of abuse can cause PTSD, but in addition, PwDD can develop PTSD for reasons that are significantly different from those reported for the neurotypical population. Among these causes are:

- sensory irregularities causing feelings of being overwhelmed;
- isolation and lack of socializing;
- cognitive inability to comprehend and assess the safety of many normally stressful situations;

- normal levels of shouting and criticism;
- exclusion, boredom and being bullied.

Whatever the cause, it is absolutely essential to recognize that the behaviours related to PTSD in PwDD are related to unmet needs, and are not simply task avoidance, attention seeking or desire for power and control.

Brain Characteristics of PTSD



(Image reproduced from van der Kolk, B., 2015*)*

The images above compare a normal brain (left) and a PTSD brain (right). Normally all regions of the brain collaborate in a synchronized pattern (left), while the brainwaves in PTSD (right) are less well-coordinated. The brain has trouble filtering out irrelevant information and has problems attending to the stimulus at hand. This causes anxiety that leads to anger and aggression, especially if brain waves are destabilized through an inadvertent triggering of PTSD symptoms. In *The Body Keeps The Score*, Bessel van der Kolk notes, "Trauma results in a fundamental reorganization of the way the mind and brain manage perceptions. It changes not only how we think and what we think about, but also our very capacity to think." van der Kolk's research proves that trauma/PTSD actually changes the hard wiring of the body and brain.

Trauma research also suggests we have to change our treatment strategies for those who have experienced trauma. van der Kolk says, "We have discovered that helping victims of trauma find the words to describe what has happened to them is meaningful, but usually is not enough. The act of telling the story doesn't alter the automatic physical and hormonal responses of the body that remains hyper vigilant as it prepares to be assaulted or violated at any time."

Long-lasting Effects of Trauma

Trauma from years ago can still cause problems even when present conditions are generally safe and supportive. Understanding the development of the brain helps with understanding this phenomenon. The brain develops from the bottom up in three main separate systems:

1. The brainstem reptilian **lower** animal brain develops in the womb and organizes basic life sustaining functions like breathing, digesting, and excreting. It is highly responsive to threat throughout one's entire lifetime.

2. The limbic **middle** emotional brain is organized mainly during the first six years of life but continues to get "programmed" by, for example, traumatic situations.

3. The prefrontal cortex **upper** thinking brain develops last and also is affected by trauma exposure, including being vulnerable throughout life to go off-line in response to threats.

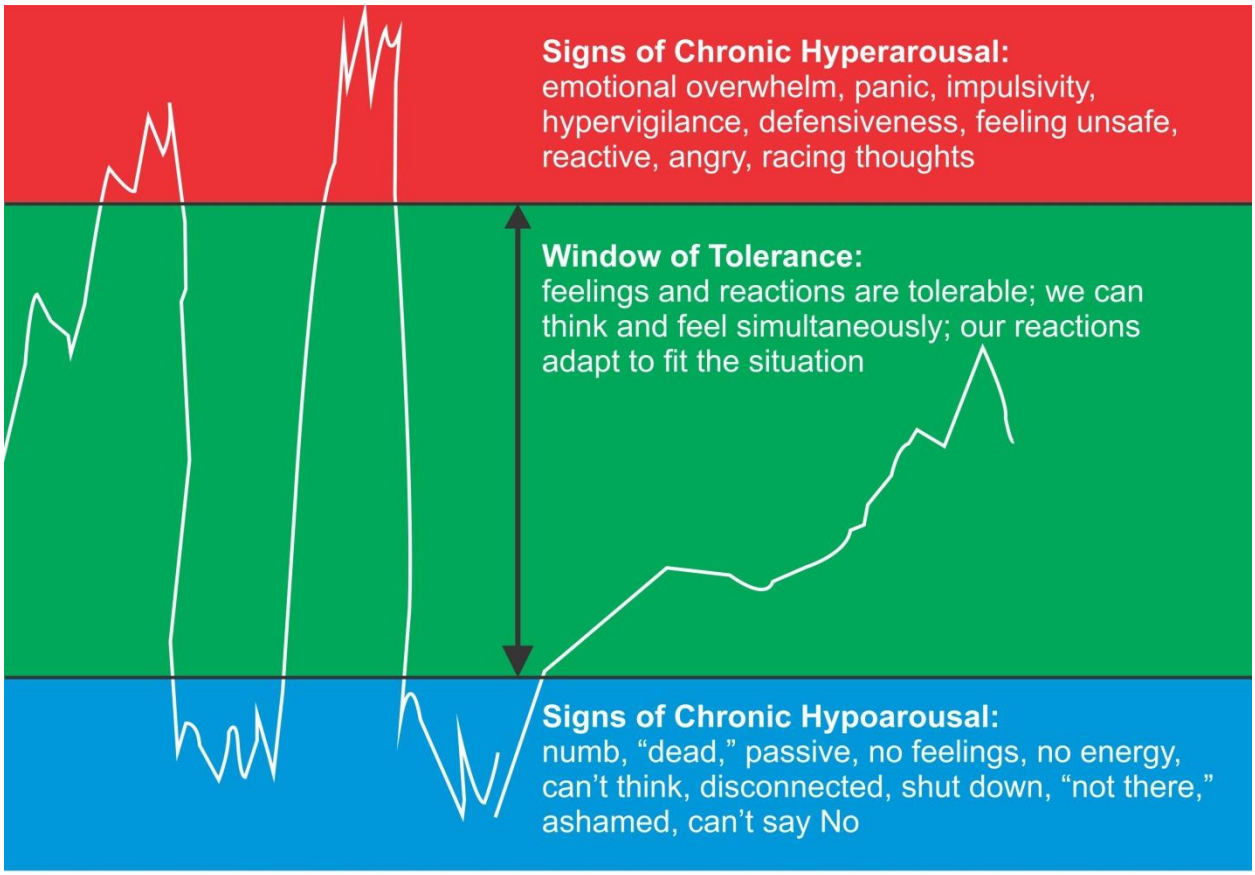
In any situation of threat, the intense reaction of the limbic brain begins with the amygdala, gate keeper to the limbic (middle) brain. It assesses the threat level twice every second. In a brain that has not been traumatized, an objective assessment of the threat is made. If, for example, a person in authority yells at someone, the threat may be perceived as controllable and containable. In that case the upper brain remains activated, and the threat is managed through withdrawal, a power struggle, or social and intelligent engagement.

The pattern is markedly different for the traumatized brain. A traumatized emotional (limbic) brain, when exposed to virtually any person, situation, sound, sight, touch or anything else that reminds it of a past threat, however long ago, however real or unreal, will if the individual is not mindful, almost always take the thinking upper brain off-line and react with the intensity learned during the historical experience of threat. Even if the present threat is relatively mild, the middle brain recognizes the same triggers as in the past experience. With the thinking brain off-line, it decides how best to fight or flee. If fight or flight is not possible or is unsuccessful and the person threatened can't get away or is trapped, the brain tries to preserve its life by shutting down the middle brain, therefore expending as little energy as possible. Total shutdown and withdrawal results.

Emotional Response to Re-Traumatization

The following illustration describes the potential emotional response when the person supported becomes re-traumatized from an inadvertent trigger. The trigger could be part of an ordinary day – a person yelling or a dish smashing in the kitchen, but the effect will be dramatic.

The centre portion (green) of the illustration represents the "window of tolerance." This window represents a state of mind in which feelings and reactions are tolerable. Persons in their window of tolerance can think and feel simultaneously and adapt to situations at hand. The sections above or below of the window of tolerance represent hyper-arousal (red) and hypo-arousal (blue). When hyper or hypo-arousal is activated the window of tolerance closes (becomes smaller and smaller) as the nervous system remains prepared for danger.



Trauma Closes The Window of Tolerance

After trauma, the nervous system remains prepared for danger (Ogden, Minton & Pain, 2006).

Dr. Bessel van der Kolk describes the closed window of tolerance as follows:

> Traumatized people live with seemingly unbearable sensations. A traumatized person feels heartbroken and suffers from intolerable sensations in the pit of the stomach or tightness in the chest. Even though the trauma is a thing of the past, the emotional brain keeps generating sensations that make the sufferer feel scared and helpless. Traumatized people are often afraid of feeling and avoid feeling these sensations in their bodies. Sadly this avoidance increases their vulnerability and the likelihood of being overwhelmed by the feelings. Their own physical sensations are now the enemy. Apprehension about being hijacked by uncomfortable sensations keeps the body frozen and the mind shut. It is not surprising that so many trauma survivors are compulsive eaters and drinkers, prone to anger or aggression or avoidance of many social activities. Their sensory world, so painful and debilitating, is largely off limits.

Trauma Recovery Through Mindfulness

> What traumatized persons lose is the body awareness which could put them in touch with their inner worlds. When people are able to pay focused attention to bodily sensations, they are led to recognize the ebb and flow of emotions and therefore increase their control over those emotions. Recognizing annoyance, nervousness, or

> anxiety helps a person shift perspective and find options other than automatic, habitual reactions. Mindfulness (reference Part TWO), through its emphasis on body awareness, puts us in touch with the transitory nature of our feelings and perceptions. Practicing mindfulness is an essential part of recovery for traumatized people with ASD/DD, who need to connect with their emotions through enhanced bodily awareness. (Bessel van der Kolk, 2015)

Fear begets fear, calm begets calm. Supporters must mindfully catch and calm themselves to avoid the influence of fearful emotional contagion on the person-supported. They can:

- Reduce or eliminate the PwDD environmental triggers such as overwhelming stressors, people, places, situations etc. until coping skills are adequate.
- Interact calmly. Gestures of power such as yelling always create fear that results in challenging behaviours or withdrawal.
- Provide cardio exercise such as mini-trampoline or platform swing.
- Introduce bi-lateral, bio-meridian awareness-based calming (BB-ABC) tools (reference Need #1)
- Be intentional with positive emotions. Use body, eyes, smile, voice to influence positive emotions.
- Use hand-to-hand BB-ABC tools #3 & 4 as much as is possible.
- Make sense of the senses by encouraging prescribed sensory integration exercises. By connecting with the senses the individual can regain a sense of calm
- Engage professionals as necessary. Include PTSD specialists such as EMDR therapists and neuro-feedback coaches.

Psychological Well-being

As noted, beyond mental health disorders and trauma treatment, family and support professionals must communicate and relate in ways that complement the PwDD preferred communications style, social inclusion preferences and psychological predispositions, (e.g. filters, reference Part TWO, Appendix I).

Support Options to Assist PwDD To Outgrow Their Mistaken, Limiting Self-Beliefs

PwDD, along with everyone else, develop mistaken limiting beliefs while they grow and mature. The following chart identifies some of the most prevalent mistaken beliefs that compromise their quality of life and can lead to challenging behaviours. Try implementing any of the suggested support options that seem appropriate for the person whom you are supporting.