

## "But I Love My Kids" (Parents Who Think About Harming Their Children)

by Fred Penzel, Ph.D.

Make no mistake about it, obsessions, whatever the category, are nasty in content, and very difficult to live with. If I were asked about which ones I think are among the most punishing to sufferers, I would have to say that my own selection as a therapist would be morbid thoughts, and of the many subtypes of morbid obsessive thoughts, wanting to harm your own children would probably get my vote. In actuality, all forms of OCD are unpleasant and torturous for sufferers, so perhaps this may be my own prejudice showing, being that I am a parent myself.

Any normal parent feels a strong protectiveness toward his or her offspring. When they are very young, we feel concern for every aspect of their lives. Even after they have become adults, we worry about their well-being and happiness. Is it any wonder, then, that when a parent suddenly begins to have thoughts about injuring, sexually molesting, or murdering their beloved child (or children) this would strike fear in the deepest recesses of their instincts?

Some of the most anxious and depressed people I ever see in my practice fall within this group. I am not thinking here about parents who obsess about causing their children harm via forgetfulness or carelessness. I am not even referring to those who think of doing harm to other people's children. These, too, are all very difficult thoughts to have to endure. I am strictly speaking about those who experience ideas that they are going to actively stab, strangle, drown, suffocate, beat, sexually fondle, or rape their own children. I would also include here those who think they may have intentionally molested or injured their own child (or children) in the past.

I would ask all those neurotypicals (those of you with normally functioning brain structures and chemistry) who may be reading this to imagine, for a moment, what it is like to experience such unpleasant things being broadcast from within your own mind on a steady basis, and not being able to change the channel. I would further ask you to imagine questioning yourself continually why you are having these thoughts, and what their occurrence might mean in terms of your own motives and intentions. One of the most frequent questions I get asked by patients is, *"Why would I think such things if I haven't done them, or didn't want to do them?"*

Within this subcategory of morbid obsessions, there are further subcategories, that would commonly include thoughts such as I will list for you below. Please note that I divide these thoughts by younger and older children. Also note that these categories are by no means exhaustive and there can be overlap between them.

### **Thoughts More Exclusively About Infants and Toddlers**

- Drowning, suffocating, choking, or smothering them
- Shaking them violently or striking them
- Dropping them out a window, off a balcony, a bridge, or other high place, or dropping them on their heads
- Stabbing them
- Poisoning them
- Sexually molesting or raping them

### **Thoughts More Exclusively About Older Children and Adolescents**

- Stabbing, punching, or striking them with objects
- Poisoning them
- Sexually fondling them
- Raping them
- Suffocating them in their sleep or choking them

### **Within this group of sufferers, there are also three broad categories:**

- Those whose thoughts take the form of severe doubts about the present or past
- Those who experience sudden impulses to carry out these acts
- Those who have both of the above

Those in the first category worry that having these thoughts indicates they are crazy and dangerous and will be likely to act on their thoughts (or, "*Why else would I be thinking them?*"). Their thoughts generally take the form of "*How do I really know I won't harm my children?*" OCD could be summed up in two words: pathological doubt. It is doubt that just won't quit, and cannot be put off with simple answers. A complicating factor is that sufferers tend to mistakenly believe that the obsessive thoughts are their own real thoughts, and therefore must be important and paid attention to, rather than actually being irrelevant and the product of bad brain chemistry. This leads to the idea that thinking is the step before actually doing, and that these thoughts must be heeded and dealt with, simply because they are occurring within their own minds. They tend to respond to them with compulsions.

Simply put, compulsions relieve the anxiety produced by obsession, if only for a short time. There is a compulsion for almost every obsession. The main compulsive strategies that morbid thinkers tend to use to cope with their thoughts include:

- Avoiding being around their children, or at least being alone with them
- Checking their reactions when around their children, to see how they really feel
- Arguing with their thoughts, to try to prove to themselves that they would never do these things
- Analyzing their thoughts, to see if they really do agree with them

Another variation on this would be those who keep questioning themselves as to whether they might have already done some of these things, either very recently, or in the past. An example would be a sufferer who has older children, but looks back in time wondering whether or not they may have inappropriately touched them in sexual ways or molested them when holding, hugging, dressing, playing with, or bathing them. They will continually reanalyze these events, relive them, and try to fill in the missing details or clarify hazy memories. This activity can literally occupy hours of their lives. In some cases, they may question those close to them, either directly, or in subtle ways, hoping to utilize other people's memories in order to fill in the blanks.

Those in the second category experience what I like to call 'impulsions,' or mental calls to action that, for example, might sound like "Go ahead, stab them!" They might also get physical dysperceptions. By this I mean experiencing sensations that they:

- Moved their hand in an almost imperceptible way, as if to strike their child, or to fondle them in an improper way
- Thrust their pelvis toward their child in a sexual way or leaned or brushed against sexual areas of their child's body, or held them in their lap while moving in a sexual way
- Somehow pushed or shoved their child because they wanted to make them fall or injure themselves
- Somehow exposed a private area of their body to their child

These are not just thoughts, but physical sensations in their bodies that seem very real and almost (but not quite) certain. There has always been a question as to whether or not symptoms of this type may fall into a gray area between OCD and the tics seen in Tourette's disorder. This has yet to be determined.

New mothers make up another distinctive subgroup where thoughts of harming one's child are frequently seen. Post-partum OCD is a well-known phenomenon, which may have links to post-partum depression. It can result in the sudden appearance of OCD where no symptoms were previously seen, or else may involve the worsening of mild OCD, or OCD that was previously under control. I have encountered a number of cases of women with or without prior histories of OCD, who within a short time after giving birth began to think of ways in which they might be able to harm their newborns. In one particular case, a patient of mine, a new mother, shared these thoughts with an obstetrics nurse, and was then denied contact with her baby by hospital administrators, who feared an act of violence might occur. Only an intervention on my part with the hospital's department of psychiatry set the situation right, after I convinced them that my patient, a known OCD sufferer, was being obsessional, and was absolutely not capable of such behavior.

One potentially difficult situation for parents who suffer from morbid thoughts is feeling anger, as in their minds, this could surely lead to acting their thoughts out. We all lose our tempers with our children now and then. None of us are saints, and it is a rather normal occurrence except when you then move on to experiencing thoughts about how you might now want to kill your child. In such cases, ordinary parental anger over everyday occurrences quickly turns to fear. Parents with this form of OCD tend to work extra hard to never lose their temper, or to squelch their rising emotions. This leads to constant fears of emotion, and a great deal of over-control when around their children.

So, having reviewed the various forms of this insidious form of OCD, then question remains, "What to do about it?" I think that in tackling OCD, it is crucial to have an understanding of what it is you need to do. The first thing to understand is that OCD is chronic; that is, you cannot be cured, but you can recover and live a normal life like everyone else. It won't simply go away, but with work, you can get it under control and keep it under control. Secondly, when it comes to controlling OCD, I think the single most important thing to understand this: "The problem is not the anxiety--the problem is the compulsions." If you think that the problem is the anxiety, then you will most likely keep doing compulsions as a way of relieving it. This is, of course, wrong, as the compulsions only keep things going, and convince sufferers that the thoughts really are important and should be acted upon. In actuality, when you stop doing the compulsions, the anxiety eventually subsides, when nothing bad occurs. It is also important to realize and accept that you cannot block the thoughts out, switch to a different set of thoughts, argue with them, or reason them away. You need to see that when it comes to escaping the thoughts, you have lost this

particular battle, and that it is one you will never win. Once you understand this, you can then get down to the business of confronting and overcoming your frightening thoughts.

This is obviously a bit of an oversimplification. Learning to not do compulsions has to be done gradually, takes time, and along with it, you have to learn to stay in the presence of what you fear, not run away or avoid. In this way, you build up tolerance to what you fear, and at the same time, discover the truth of the situation. That is, you learn to test your theories of what may happen to you or others if you don't avoid things, or perform compulsions. As I mentioned earlier, nothing ever happens. It is really a lot like being a scientist.

All this is best done within a program of behavioral therapy--that is, Exposure and Response Prevention. Within such a program, patients learn to gradually expose themselves to what they fear, be it thoughts or situations, and at the same time, resist performing the compulsions they usually do to relieve their anxiety. In this way, as I have said, they learn the truth. As part of my own approach to treatment, we first make a listing (called a hierarchy) of all possible situations and thoughts relating to the problem, which can cause any noticeable anxiety, and assign number values to them from 0 to 100. From this list, patients are given weekly homework assignments to help them do these things, and which they, themselves, are responsible for carrying out between visits. Some typical assignments might include the following (and I list these in no particular order of difficulty, as this can be different for each sufferer):

- Agreeing with thoughts of harming the child (or children) in question, instead of analyzing or studying them
- Resisting the reviewing of past events in detail to determine if they actually did something harmful or unacceptable
- Not questioning others, directly or indirectly to determine if they might have done something wrong in the past, or will do something in the future
- Writing, taping, and then listening repetitively to compositions about how they really want to do (or really did) the unacceptable things they are thinking about
- Holding their young child near a window, balcony or other high point
- Becoming more physical in playing with their child (if they are avoiding this), and creating more opportunities to hold, hug, massage, cuddle, etc.
- Reading news articles or books about parents who have injured, killed, or molested their children
- Being around their child while holding sharp, or pointed objects, or other weapon-like things
- Visiting websites concerned with child molesters and murderers

A sufferer might look at such a list and say, "*You are asking me to do these scary things as if you think they're easy!*" My answer is that I would never tell anyone that these assignments are easy, but then, having unrelenting OCD isn't easy either. No one usually argues that point. When correctly educated, the overwhelming majority of patients are able to successfully carry out these assignments. Some have suggested that having people carry out such therapy work is cruel or mean in some way, but thirty-five years of research contradicts this. It is a complete misrepresentation of behavioral therapy. If the therapy ultimately relieves people of their suffering in the quickest and most efficient way, and enables them to function as parents again, I would label

it as kind. Besides, as I tell my patients, "You know what I would really do if I wanted to be mean? I'd leave you the way you are."

When most sufferers come to see me for the first time, they are, of course, seeking reassurance that they aren't crazy, and won't act on their violent thoughts. I explain to them that they aren't (OCD sufferers do not act on their thoughts; in fact, quite the opposite), and they won't, but I also make it clear to them that I do not give ongoing reassurance about these things, as this will only make them worse. I also try to disconnect family and friends from any involvement in responding to compulsive pleas for reassurance or help in avoiding as well. This is often a crucial factor in treating these types of symptoms.

One typical fear that patients sometimes express goes something like this: "Maybe I really don't have OCD, and my anxiety about doing something awful to my children is the only thing keeping me from acting on it. If I get rid of my anxiety, will I then do it, because nothing will be holding me back?" I will initially reassure them that this is never seen to happen in those with OCD. If they can't stop worrying about it, we then treat it as just another obsession.

Over the following weeks, patients systematically work their way through their hierarchy, carrying out the homework assignments at their own pace, and in order of difficulty. While everyone would like an exact figure as to how long this takes to finish, it may vary from person to person. I tell them that on the average, it can take from about six to twelve months, barring complicating factors, such as depression, serious life problems, or other types of disorders.

Medications can also be of help. They should be viewed as a tool to help you to get through therapy and not as a magical complete treatment by themselves. What they can do is lower the level of obsessions, anxiety, and depressed mood. What they cannot do is teach you how to face what you fear, or how to develop the tools necessary to resist compulsions or avoidance. That is where the behavioral therapy comes in.

With current technology, OCD can be successfully treated, and the vast majority of sufferers can recover. This can only happen, however, if you get yourself out there and get help. Too many individuals still suffer in silence, or put themselves in the hands of practitioners who lack the expertise to treat them. My advice is to not wait, and start working to find the way to recovery today.

*Fred Penzel, Ph.D. is a licensed psychologist who has specialized in the treatment of OCD and related disorders since 1982. He is the executive director of Western Suffolk Psychological Services in Huntington, Long Island, New York, a private treatment group specializing in OCD and O-C related problems, and is a founding member of the IOCDF Science Advisory Board. He can be reached at penzel85@yahoo.com or through the phone number on his website, <http://www.wsps.info>. Dr. Penzel is the author of "Obsessive-Compulsive Disorders: A Complete Guide To Getting Well And Staying Well," a self-help book covering OCD and other O-C spectrum disorders.*