Why Are You Moving That Way? What Clients' Movements Can Tell Us About Their Condition

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Psychologists are trained observers of human behaviour. What we pay attention to, or ask about, could make a significant difference in our clients' health and well-being. Even if we don't consider ourselves assessment specialists, observation is a form of evaluation we all use. Some behaviours are overt, and hard to miss, which makes our work easier. However, other behaviours take place in secret and can lead to disaster if left unchecked. Taking a moment to dig a little deeper into our clients' lives could save them a great deal of distress and might just save a life.

In this article, I focus on movement-based symptoms and conditions, including rhythmic movements and irregular movements, conscious and unconscious movements, visible and hidden (suppressed) movements. I will begin with the most common that we encounter such as Attention Deficit/Hyperactivity Disorder (ADHD), Obsessive Compulsive Disorder (OCD), and Autism Spectrum Disorder (ASD), before moving on to the less frequent and less overt. Importantly, I will emphasize what typically underlies or motivates the behaviours in question. It is not enough to identify a specific behaviour. We need to elicit a self-report of *why* our client is behaving that way so we can understand its purpose…and then offer help.

Common Conditions

ADHD affects about 5 to 8% of the population and can express itself in repetitive behaviours that are termed *hyperactive*. This includes difficulty sitting still or remaining seated, jiggling legs, and needing to move and be active. Adults can experience this as a sense of inner restlessness, so inquiry is necessary. Hyperactivity also includes fidgeting, such as playing with objects, doodling, twirling hair, and picking at skin or fingernails, behaviours that often go unnoticed. *In ADHD, movement serves the purpose of stimulating the individual to keep them engaged.*

OCD is associated with any number of purposeful repetitive behaviours such as handwashing, checking, evening-up movements (left and right sides), etc. Typically, these behaviours are repeated a specific number of times. Often, these behaviours are masked so that others don't notice. Mental acts are common, which are invisible. Obsessions are repetitive thoughts that can lead to repetitive actions including asking the same question repeatedly (often for reassurance), or completing a ritualistic sequence of activities. *In OCD, these behaviours are intended to reduce inner distress or prevent an imagined negative outcome.*

Autistic people will engage in repetitive behaviours as a form of self-soothing and reassurance (think of grandma's rocking chair, or holding a babe in arms). *They also follow rigid or ritualistic routines in an attempt to gain control over what feels like an out-of-control* environment or sensory system. *Autistic people also express emotions*

through stereotyped behaviours such as hand flapping, toe walking, or spinning – sometimes accompanied by noises. This group of behaviours is a direct extension of emotional states, spanning excitement, frustration, and stress. *Some autistic people appear to manipulate objects ritualistically as a form of self-stimulation to escape into self-induced sensory experiences or inner worlds.*

Stereotypic Movement Disorders (SMD) may look like autism, but are often seen in those who have more significant intellectual disabilities. *In SMD, movements can manifest as self-soothing behaviour* such as mouthing objects or rocking, *but can also take a dark turn toward self-harm:* head-banging, self-hitting, or chewing on their skin.

Tics and Tourette's are associated with repetitive behaviours or sounds that have no obvious purpose. Some can look like muscle twitches or spasms, and most involve the face and head (e.g., squinting, nose wrinkling, headshaking), although any body part can be involved (e.g., arm flicking, shoulder shrugging, full body twists). *In Tourette's, at the mild end of the spectrum these behaviours can be almost unconscious, while at the severe end they are purposeful and intense, like the venting of a pressure valve that has built up.* With some effort, the actions can be consciously suppressed or delayed, but rarely can they be denied. Fortunately, many children who manifest transient tics will grow out of them.

Habit and impulse-control behaviours can range from benign to damaging. This can include nail chewing and cuticle biting, hair twirling and split-end plucking, skin grooming and scab picking, any of which can become self-destructive, leading to infection and scarring. At the mild end, these behaviours are often unconscious. Once they involve OCD circuits and pain feedback loops, they can be highly compelling and hard to control, even addictive. *They are typically associated with stress and release of tension.*

Movement Symptoms Associated with Non-Movement Conditions

Some common conditions seen by psychologists contain repetitive movement components, such as Generalized Anxiety Disorder (GAD), Major Depressive Disorder (MDD), and Bipolar Disorder (BpD). These behaviours include the restlessness and fidgeting associated with the chronic worrying of GAD; the agitation and uneasiness that can be seen in some more severe forms of MDD (which can lead to behaviours such as pacing, handwringing, and excess talking); and the high energy and pressured presentation seen in BpD, including mania and mixed mood states (these can be experienced as increased energy and agitation, difficulty sitting still, feeling jumpy or wired, which in turn lead to behavioural dysregulation such as excess talking, decreased sleep, and risky behaviours like impulsive spending or sexual behaviour). *In all of these conditions, the behaviours are a manifestation of what the person is experiencing internally – emotionally, cognitively, even existentially.*

Less Common Conditions to Consider

There are other non-movement conditions that invite physical movements, which are often overlooked. These include the purposeful physical activity seen in eating disorders

like Anorexia (*with the goal of losing weight* – even while appearing to be at rest); Restless Legs Syndrome (*which is associated with a sense of unease and subsequent repositioning to seek a comfortable sleeping position*); pain and somatic conditions (*which are associated with movement to ease pain, to guard against pain, and to communicate discomfort*). You may also see exaggerated attention-seeking behaviours in some personality disorders such as histrionic and narcissist presentations, or even Factitious Disorder. Finally, there is catatonia associated with psychosis and other conditions. This often presents as the immobile or *retarded catatonia*, but can include an *excited catatonia* version manifesting as stereotopies, wavy flexibility, or excess verbalization.

Since the advent of covid-19, I have seen a novel manifestation of a repetitive behaviour pattern in children and youth. This behaviour includes various self-stimulation activities (e.g., handwaving in front of the eyes, pacing). Initially, it appeared to be an OCD-like behaviour, but when I inquired further the behaviour had positive goals. Ultimately, I determined that to overcome loneliness and social isolation, these youth had been engaging in self-hypnosis to enhance creativity and imagination, or to engage in a form of vivid mental escape. This was a reminder to me of the importance of direct inquiry to understand the purpose of the behaviours that we observe or that clients report. If I hadn't inquired in the first place, I would not even have known they were engaging in the behaviour. If I had not inquired further, I might have drawn incorrect conclusions.