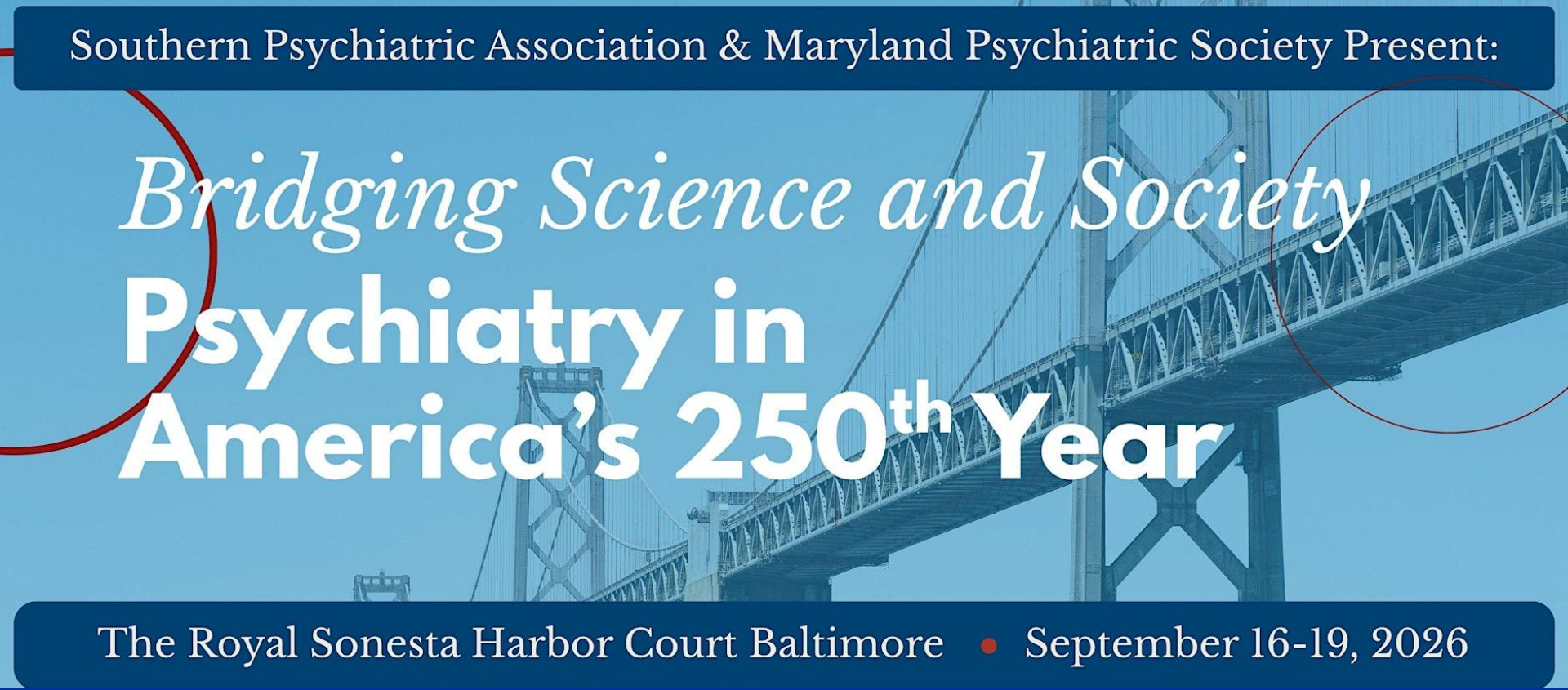


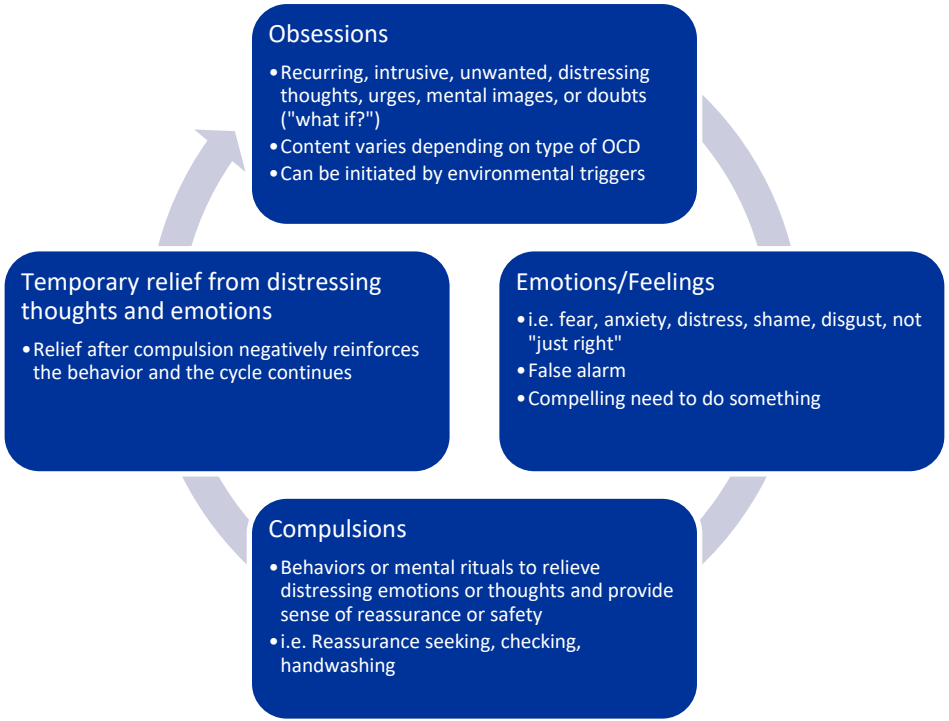
Autism Meets OCD: The Diagnostic and Treatment Gray Zone

Michael Young, M.D., DFAPA
and Jon Hershfield, LCMFT

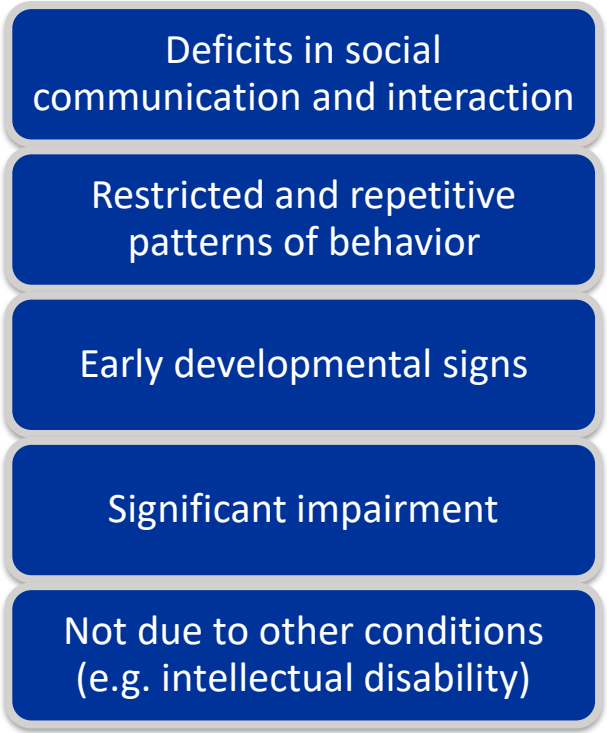
INTRODUCTIONS AND DISCLOSURES

- Michael Young, MD, DFAPA
  - Medical Director, The Retreat by Sheppard Pratt; Adjunct Assistant Professor, University of Maryland School of Medicine
  - NO FINANCIAL DISCLOSURES
- Jon Hershfield, LCMFT
  - Director, Center for OCD and Anxiety at Sheppard Pratt
  - Receives book royalties from New Harbinger Publications Inc.

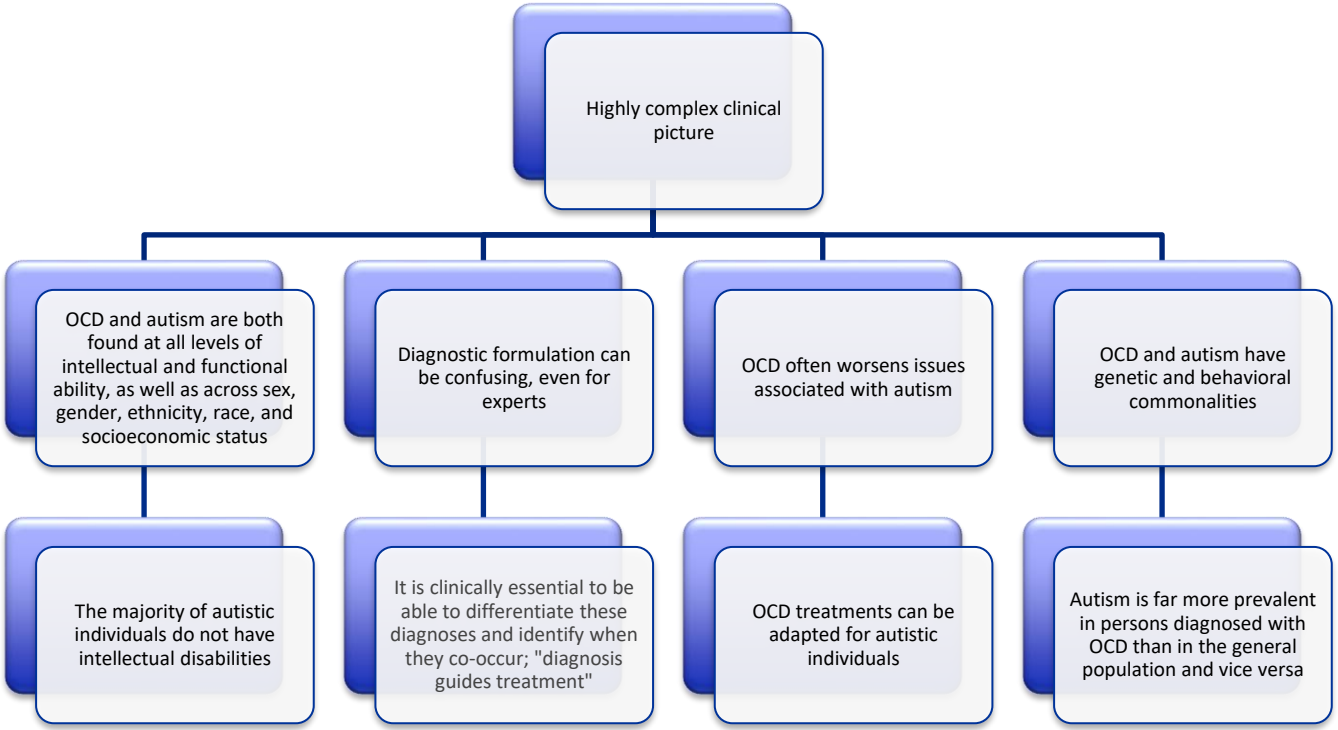
OCD CYCLE


Obsessions
•Recurring, intrusive, unwanted, distressing thoughts, urges, mental images, or doubts ("what if?")
•Content varies depending on type of OCD
•Can be initiated by environmental triggers
Emotions/Feelings
•i.e. fear, anxiety, distress, shame, disgust, not "just right"
•False alarm
•Compelling need to do something
Compulsions
•Behaviors or mental rituals to relieve distressing emotions or thoughts and provide sense of reassurance or safety
•i.e. Reassurance seeking, checking, handwashing
Temporary relief from distressing thoughts and emotions
•Relief after compulsion negatively reinforces the behavior and the cycle continues

AUTISM

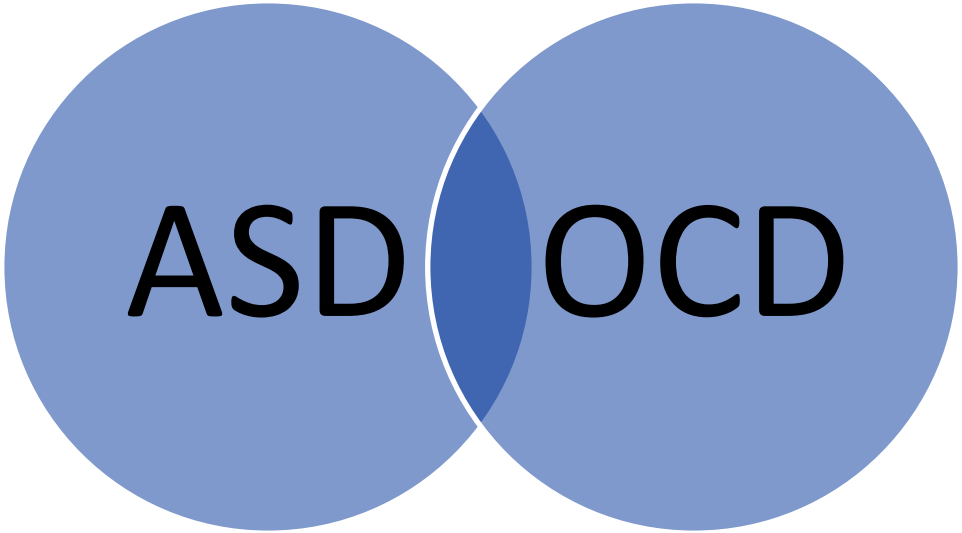

Deficits in social communication and interaction
Restricted and repetitive patterns of behavior
Early developmental signs
Significant impairment
Not due to other conditions (e.g. intellectual disability)
• Stereotyped or repetitive motor movements or speech
• Insistence on sameness/ inflexible adherence to routines
• Highly restricted/fixated interests of abnormal intensity
• Sensory sensitivities

INTERSECTION OF AUTISM AND OCD



TWO DISTINCT CONDITIONS

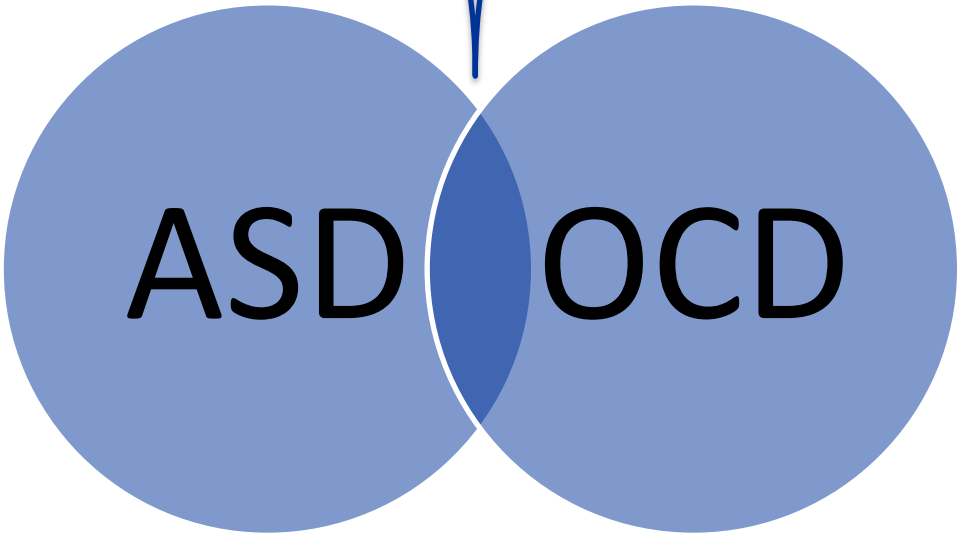
- Social differences (preference for explicit communication; often missing social cues)
- Repetitive behaviors aimed at emotion regulation/self-soothing ("stimming")
- Intense focus on specific interests



- Unwanted, intrusive thoughts, images, and urges
- Repetitive behaviors (compulsions) aimed at reducing anxiety/fear
- Avoidance of triggers to symptoms

...WITH MANY OVERLAPPING FEATURES

Repetitive behaviors, sensory processing differences, intolerance of uncertainty, set routines, perfectionism, anxiety, overwhelm, shame, fatigue



COMMON BARRIERS TO DIAGNOSIS

Clinicians in mental health or developmental disability settings often have expertise in OCD or autism but are often not as familiar with their co-occurrence

Assessment of mental health issues in autistic individuals may not be well-integrated with other autism-related services

Communication deficits, limited language, and alexithymia make identifying co-occurring disorders more difficult in autistic individuals

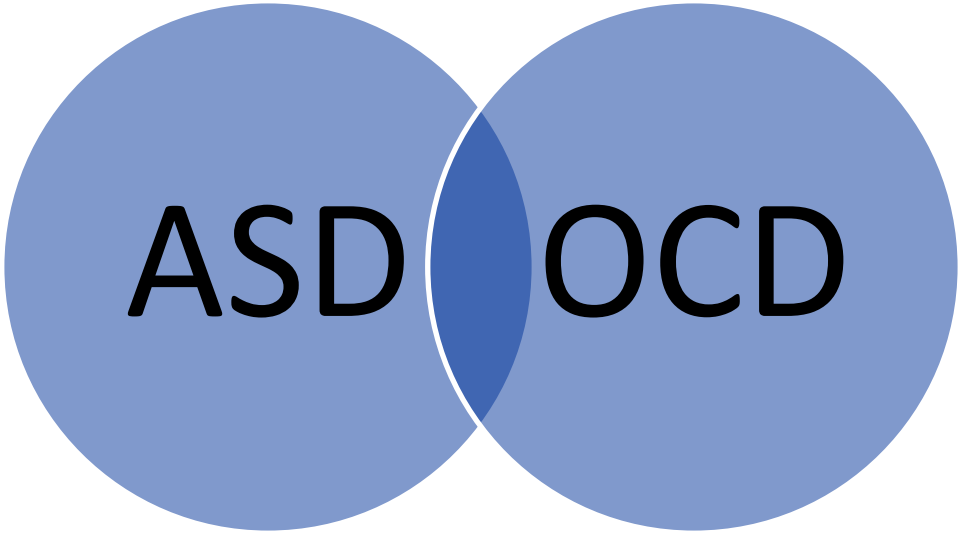
ASSESSMENT FOR AUTISM AND OCD

- Assessment should be interdisciplinary and individualized based on need
- Comprehensive neuropsychological testing can be helpful in diagnosing both autism and co-occurring disorders such as OCD, ADHD, and intellectual disabilities
- Family history from a reliable reporter, including early life development, is gold standard
- Integration of present clinical findings with a thorough developmental and medical history is key

STANDARDIZED/VALIDATED DIAGNOSTIC TOOLS CAN HELP

Clinical diagnoses described in DSM 5-TR

- ADOS-2 (direct observation) combined with ADI-R (in-depth interview with parents or caregivers) has been regarded as the gold standard for assessing children for ASD
- Diagnosis can be missed when masking present

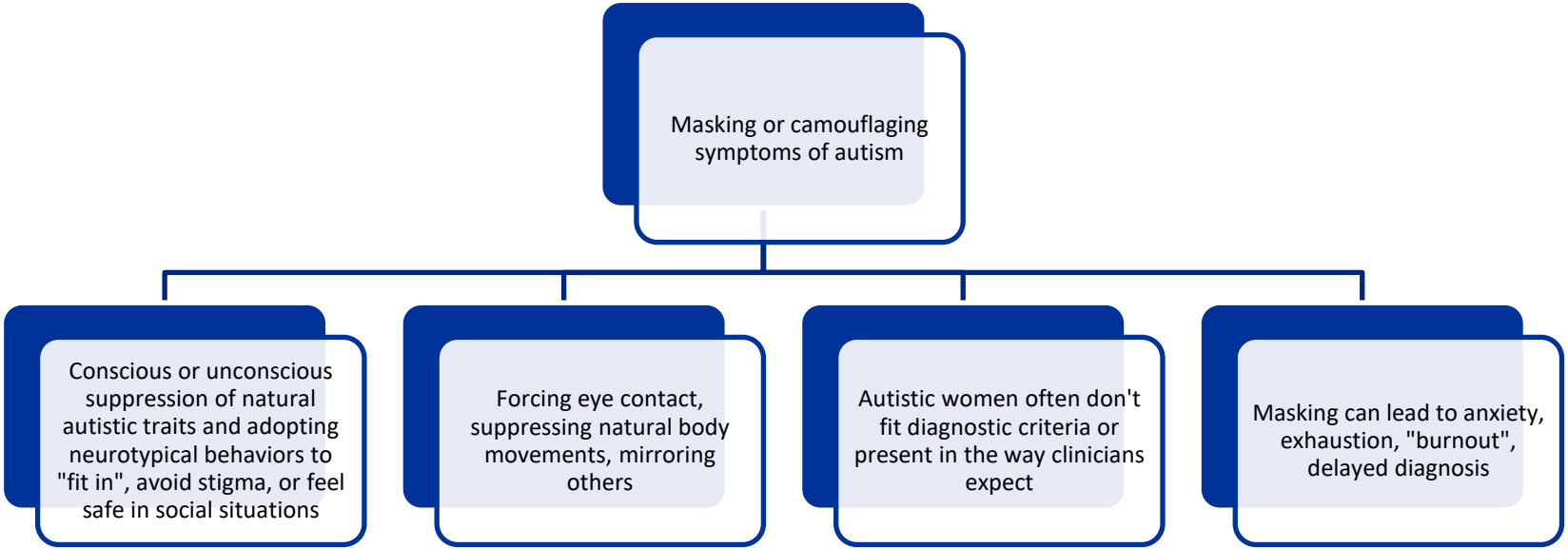


- Y-BOCS rating scale used to measure severity and type of OCD symptoms
- DOCS is a 20-item measure that assesses the severity of OCD symptoms across four dimensions
- Diagnosis can be missed due to diagnostic overshadowing or lack of provider training

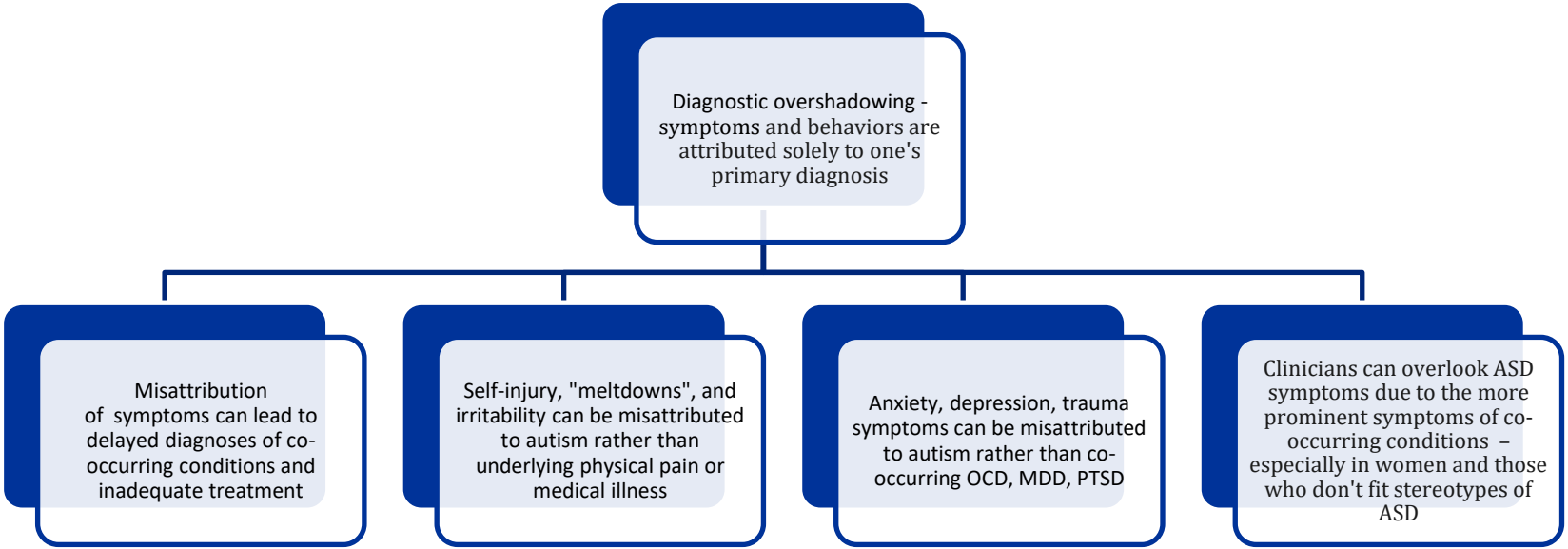
ADOS-2 Autism diagnostic observation schedule, 2nd edition
ADI-R Autism diagnostic interview –revised

Y-BOCS Yale-Brown Obsessive-Compulsive Scale
DOCS Dimensional Obsessive-Compulsive Scale

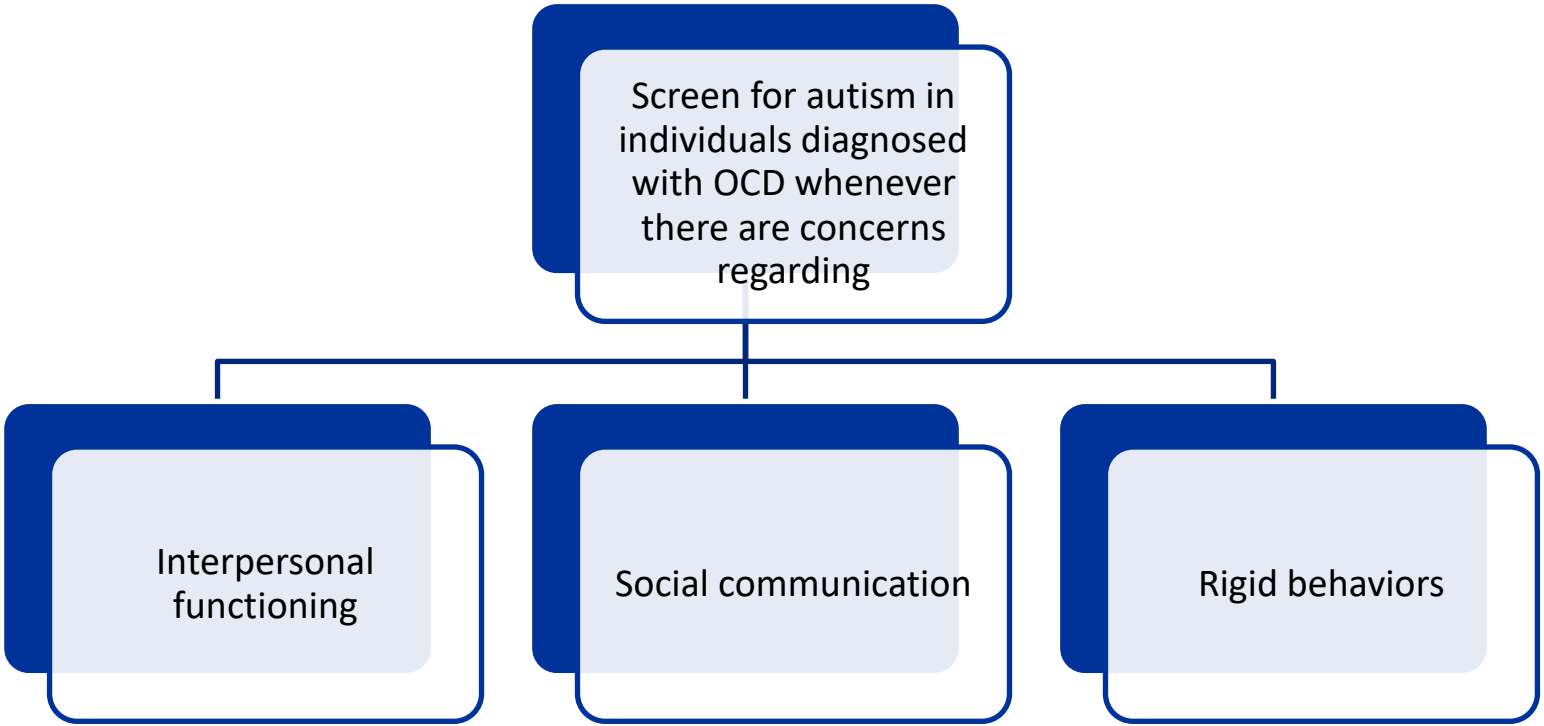
DIAGNOSTIC CHALLENGE 1 - MASKING



DIAGNOSTIC CHALLENGE 2 - OVERSHADOWING



LOW THRESHOLD TO SCREEN FOR AUTISM



KEY DIFFERENTIAL DIAGNOSIS CONSIDERATIONS IN AUTISM AND OCD

THOUGHTS

Autism-related perseverative thoughts vs OCD-related unwanted, intrusive thoughts

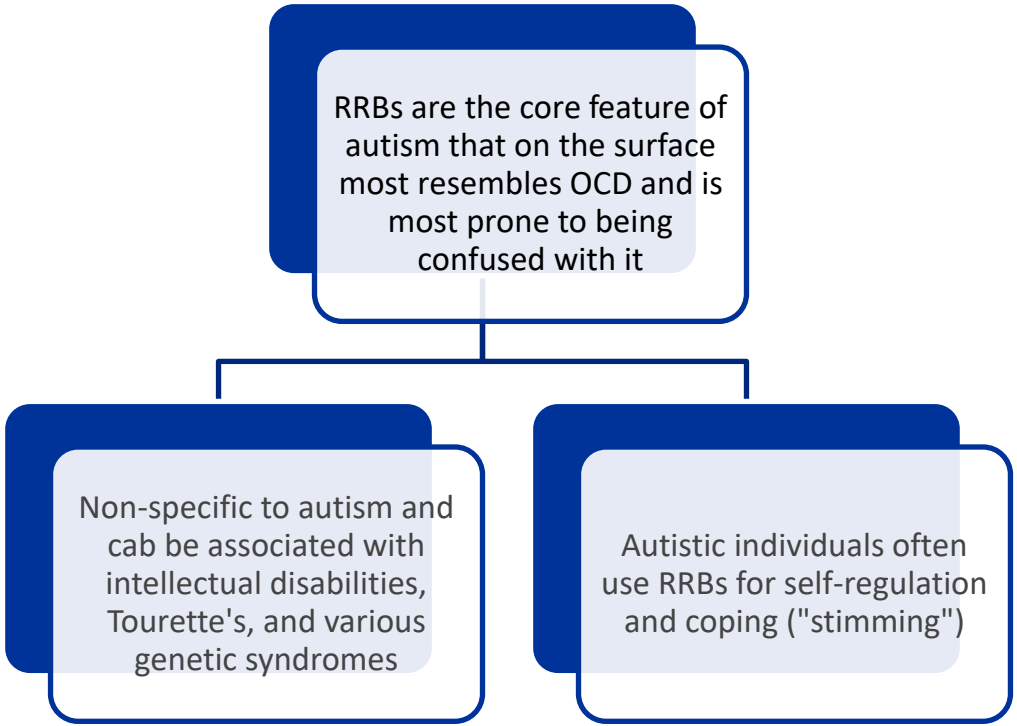
EMOTIONS

Anxiety stemming from the need to continuously adapt to the changing environment vs anxiety related to unwanted, intrusive thoughts

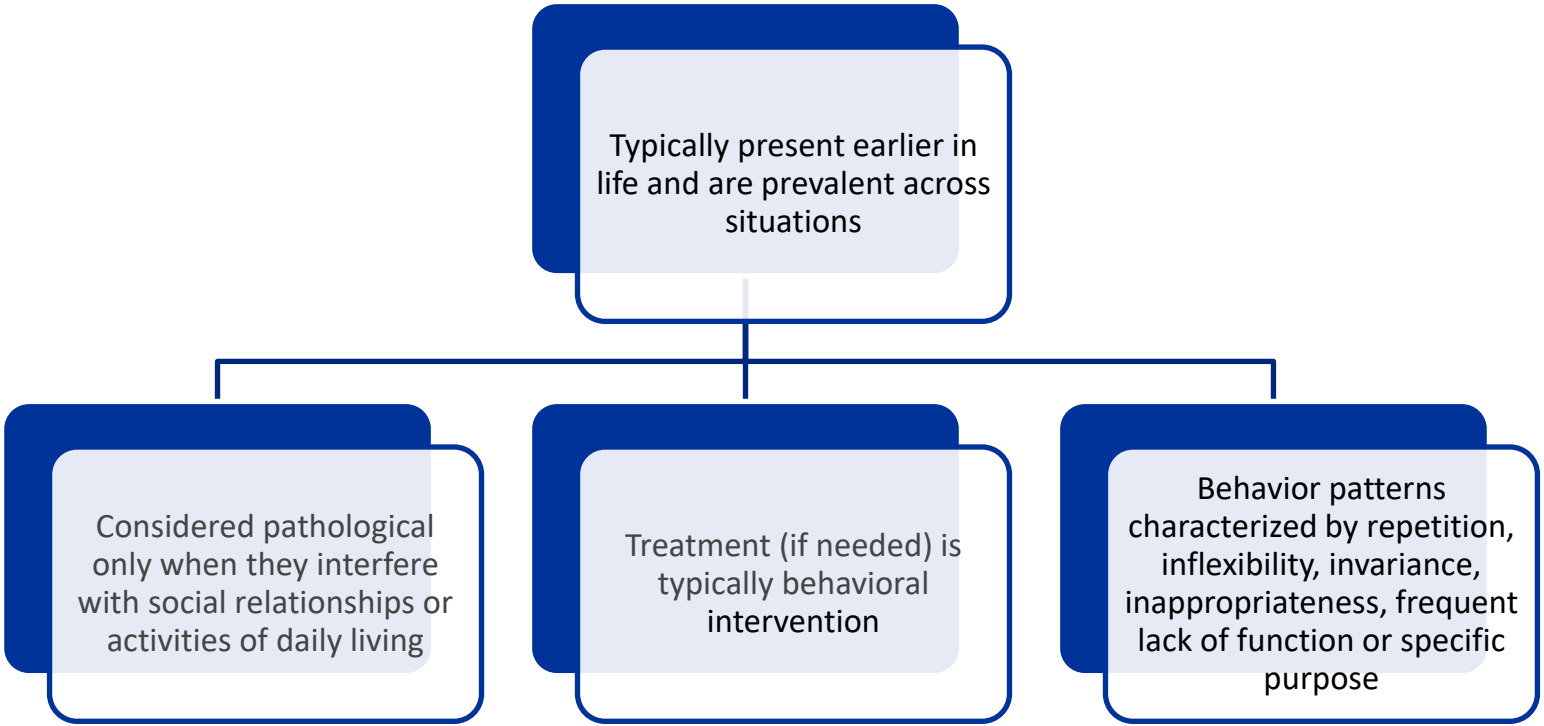
BEHAVIORS

Autism-related restricted-repetitive behaviors (RRBs) vs OCD-related compulsions

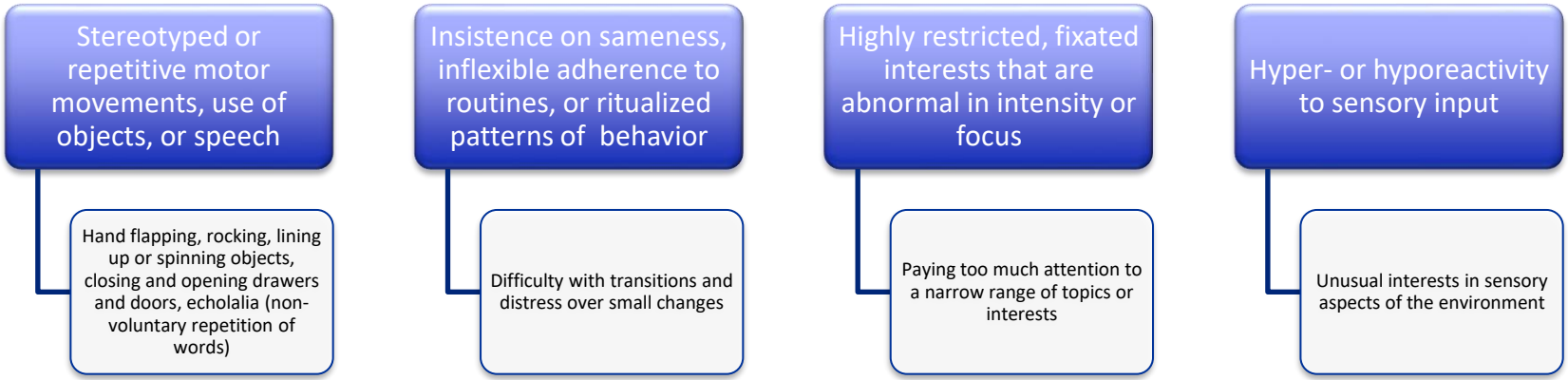
RESTRICTED AND REPETITIVE BEHAVIORS (RRBS)



RESTRICTED AND REPETITIVE BEHAVIORS (RRBS)



RESTRICTED AND REPETITIVE BEHAVIORS (SUBTYPES)



Questionnaires for assessing RRBs

- Repetitive Behavior Scale-Revised (RBS-R)
- Aberrant Behavior Checklist (ABC)
- Repetitive Behavior Questionnaire (RBQ)

RESTRICTIVE-REPETITIVE BEHAVIORS VS OCD SYMPTOMS

Category	Restrictive-Repetitive Behaviors	OCD Symptoms
Function	•To preserve sameness •To reduce, increase, or modulate stimulation •To provide pleasure •To communicate a desire or need	•To reduce or avoid anxiety, or other discomfort
Age of Onset	Before age 5	Typically between 8–12 years old
Context	Universal - not necessarily sensitive to situational contexts, though can be	Situational - occur or don't occur depending on the circumstances
Experience	Desirable and/or pleasant and/or soothing/regulating (EGOSYNTONIC) "I want to "	Unwanted and/or intrusive (EGODYSTONIC) "I have to"

Pearl: For autistic patients with limited language, notice affect before/during the behavior to assess if it is egosyntonic or egodystonic.

POLLING QUESTION 1: RRB RELATED TO AUTISM VS OCD

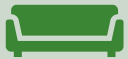


JD wants to sit in the same seat every day. He has gotten used to his seat, likes a predictable and consistent classroom, and gets very anxious if the teacher rearranges the desks or changes seating arrangements. Insists that parents follow specific routines. "I just like it that way".

A. AUTISM

B. OCD

POLLING QUESTION 2: RRB RELATED TO AUTISM VS OCD



JE insists on sitting in the same seat every day. Before settling, she must stand up and sit down until having the “just right” feeling when landing in the seat. She cannot calm herself and begin class until this happens. This is distressing to her and disruptive to the class.

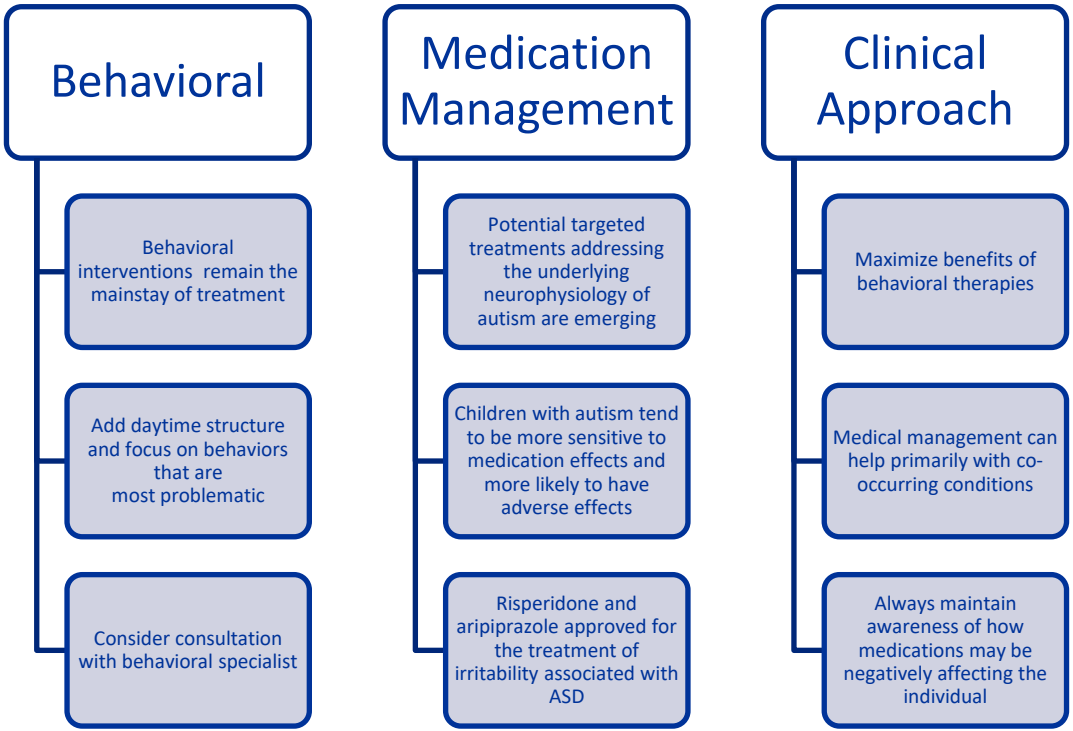
A. AUTISM

B. OCD

INTERVENTIONS FOR OCD

- Exposure response prevention (ERP)
  - Effective with both neurotypical and autistic young adults
- Acceptance Commitment Therapy (ACT)
  - Alternative approach focusing on changing one's relationship with thoughts and adopting a more values-driven life
- Family Therapy
  - Often essential to address family accommodations working against treatment
- Medication Management
  - Most effective when combined with psychotherapy
  - SSRIs, TCAs, augmentation with atypical antipsychotics and other novel approaches can be helpful for some
- IOP/PHP/Residential Programs
  - Helpful when impairments in functioning are more severe

INTERVENTIONS FOR RRBS IN AUTISM



Aishworiya R, Valica T, Hagerman R, Restrepo B. An Update on Psychopharmacological Treatment of Autism Spectrum Disorder. Neurotherapeutics. 2022 Jan;19(1):248-262.

KEY TREATMENT PRINCIPLES WHEN AUTISM AND OCD INTERSECT

Autistic individuals (with and without OCD) have heterogeneous presentation

- Focus on patient's individualized needs (often involves social and communication skills)

OCD treatment can be adapted for autistic individuals

- Encourage adaptations that allow individual to feel better about themself and navigate the world with more ease

Goal is to increase flexibility and decrease rigidity

- Family involvement and family psychoeducation is essential

OCD AND ASD 101

- OCD - Psychiatric diagnosis characterized by unwanted, distressing intrusive thoughts, images, and urges (obsessions) and repeated or ritualized physical and/or mental behaviors (compulsions) *unrealistically* oriented toward eliminating associated distress. The combination of obsessions and compulsions is *impairing* and causes suffering to the individual experiencing them. Onset typical in early adolescence, but can also develop later, including in the context of another disorder (e.g. PTSD). Thoughts are typically ego dystonic and behaviors are compelled burdens. **Distress arises from irrational fear, intolerance of uncertainty, and ineffectiveness of rituals.**
- ASD - A neurodevelopmental condition involving differences in social communication and interaction, specific patterns of behavior, special or restricted interests, and divergent sensory experiences—present from early development. Thoughts are typically ego syntonic, and behaviors are pleasurable or identity-affirming. **Distress arises from unmet needs, social/environmental consequences, and sensory or emotional overwhelm**

WHAT DO YOU MEAN BY "RIGHT-CLICK"?

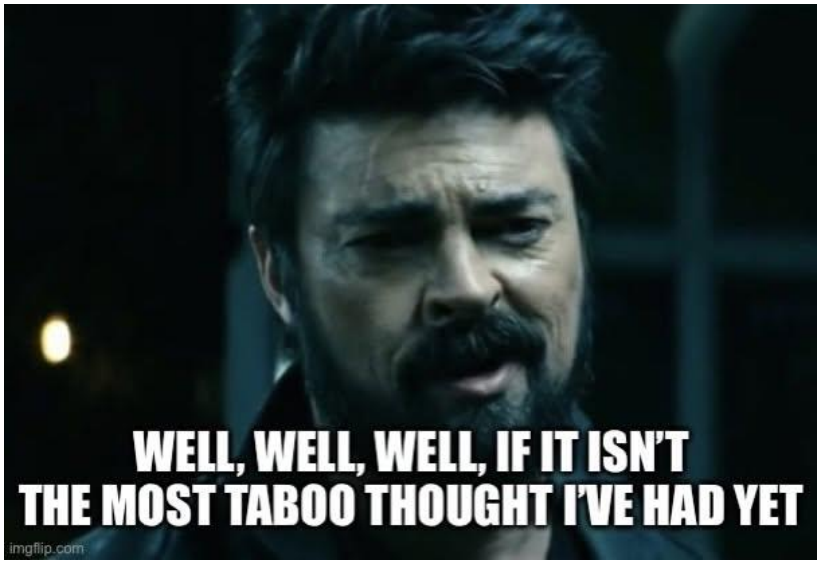
- The term "neurodivergence" is going through ongoing clinical and linguistic development. Many people exhibit clear traits suggestive of ASD without the initial developmental criteria and it is common to encounter individuals who score "non-spectrum" but to whom these clinical considerations still apply
- ASD, and to a broader extent, “neurodivergence”, are umbrella terms referencing neurodevelopmental differences in the brain from the statistical average. They are the type of computer system (Mac vs Windows), not the applications on it. The system *can* be used more effectively but it *cannot* be changed.

WHAT DO YOU MEAN BY "RIGHT-CLICK"?

- “Mental health” refers to the way in which the person is interacting with their internal and external environments and *is changeable* through learned behavior/conditioning. It is made up of the specific programs that have been "installed" through experience and some of which can be modified or even uninstalled.
- OCD is biopsychosocial and exists on the border of the hardware (genetically inherited developmental trajectory) and software (learned from and in response to environment).
- The world is mostly designed for the comfort of the neurotypical individual. In other words, a neurodivergent individual may be a Mac in a largely Windows-driven world. Both systems have strengths/assets and deficits/liabilities.
- **Neuro-affirming care means putting genuine effort into communicating across operating systems**

DIMENSIONS OF OCD AND ASD CLUES

- DOCS: Dimensional Obsessive-Compulsive Disorder (Abramowitz, et al, 2010) identifies 4 dimensions of OCD
- Contamination
  - Fear of illness or sensory disgust?
  - Rules and scripts for food?
- Concern with Harm, Injury, or Bad Luck
  - Misappraisal of intrusive imagery related to emotions
  - Excessively logical deductions about harm
- Unacceptable thoughts
  - Moral rigidity, justice and rejection sensitivity
  - Rules for taboo sexual or violent thoughts
- Symmetry and Evenness
  - Sensory differences
  - Rules for task completion



COMPULSIONS VS REPETITIVE AND RESTRICTIVE BEHAVIORS

- Mental Rehearsal and Scripting Conversations
  - Replaying conversation repeatedly
  - Pre-planning dialogue in detail before social interactions
  - Mistake for: Rumination or obsessive thinking
  - Serves as predictability and social navigation
- Internal Stimming (Cognitive Repetition)
  - Repeating phrases, words or music internally
  - Silent counting, pattern-based thinking
  - Mistake for: Intrusive thoughts
  - Often soothing or organizing not distressing
- Highly Structured Routines
  - Eating the same food in the same order
  - Specific sequences for daily tasks
  - Mistaken for: OCD rituals
  - Driven by sensory predictability or efficiency



COMPULSIONS VS REPETITIVE AND RESTRICTIVE BEHAVIORS

- Intense, controlled interest
  - Deep dives into topics like psychology, health, books, superheroes, make-up, music, etc
  - Interest are highly immersive, and used for regulation
  - Mistaken for: Obsessiveness
  - Enjoyable, identity-affirming
- Perfectionism
  - Needing things to be "just right" to proceed
  - Difficulty shifting tasks until something feels complete
  - Mistaken for: Perfectionistic OCD
  - Tied to the process, sequencing or executive functioning
- Sensory-Based Repetition
  - Touching textures repeatedly (fabric, hair, skin)
  - Rewatching the same show
  - Mistaken for: compulsive behaviors
  - Provides sensory regulation and emotional grounding



COMPULSIONS VS REPETITIVE AND RESTRICTIVE BEHAVIORS

- Moral or Justice-Focused Cognitive Loops
  - Repeatedly thinking about fairness, right/wrong
  - Difficulty letting go of perceived injustice
  - Mistaken for: Obsessive guilt or moral OCD
  - Often values-driven and identity-based, inflexible
- Information Rechecking for Comprehension
  - Re-reading messages multiple times
  - Doubling-checking understanding
  - Mistake for: Checking compulsions
  - Driven by processing clarity



ASSESSMENT QUESTIONS

- Does this person like what they are doing, meeting a need, or are they *compelled* to the behavior in order to avoid a feared outcome?
- Is this behavior disruptive to the individual? To others?
- Is the structured or ordered nature of the behavior *increasing* or *decreasing* its effectiveness?
- Is the person masking/nodding in agreement or actually understanding what is being said?
- Is there a conflict between the *logical* and the *rational*?



ESSENTIAL EXPOSURE AND RESPONSE PREVENTION (ERP) FOR OCD

- Identify obsessions and compulsions
- Develop hierarchy of challenges to do exposure to...
- Utilize in vivo, imaginal, and interoceptive exposures
- Practice resisting compulsions in the face of gradually increased OCD triggers with the goal of habituation (distress reduction) and/or inhibitory learning (reduction in threat-association of trigger).



- ASD positions the person to need to do things in a way that feels right (cognitive and sensory)
- OCD positions the person to need *certainty* that this is being done
- ERP for individuals with OCD and ASD seeks to make behaviors more effective and more flexible, reconciling the cognitive/sensory regulation needs with acceptance of uncertainty

ERP MODIFICATIONS FOR ASD

- More time spent on a clear differentiation between OCD compulsions and self-regulating behaviors (routines, sensory seeking/avoidance, stimming, etc).
- Additional attention on clarity of rationale for ERP, including written and visual aids and verification that concepts are understood
- Stronger focus on *logic* behind uncertainty tolerance in specific contexts (as opposed to tolerating uncertainty for its own sake)
- Lower expectation of generalization and higher repetition for each context. Remember – repetition first, then insight.
- Generally less emphasis on rating Subjective Units of Distress (SUDs) in exposures or using alternative distress measuring system (e.g. color code)



ERP MODIFICATIONS FOR ASD

- Generally higher introduction of non-compulsive down-regulation skills (less urge surfing or embracing the burn). Intentionally avoiding sensory/emotional overload.
- Increased verification of consent to do ERP
- Give opportunities to mask and unmask (e.g. using a buzzer or visual cue to express failure to understand a concept)
- Connect OCD treatment to special interests
- Remember, if you experienced the world this way, you would also behave this way

