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Intervention for Obsessive-compulsive Disorder Patients with Autism Spectrum Trait

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Abstract

The differences between Obsessive-Compulsive Disorder(OCD)and Autism Spectrum Disorder (ASD) should be considered from the perspectives of onset period, emotional characteristics that come along with obsessiveness, presence of social impairments or communication difficulties, and existence of obsessive thoughts.

Although typical clinical presentations for these two disorders are basically different, clinicians should be mindful as there are many occasions where it is difficult to distinguish ASD from OCD, and where these two disorders actually comorbid.

Exposure/Response Prevention (E/RP) is known as the basic treatment for obsessive symptoms; however, when ASD traits are especially recognized in patient, *conducting outpatient exercise for introducing E/RP*, *providing psychoeducation and parenting skills training for parents*, *using effective tool for the child patients*, and *teaching mindfulness also become crucial factors to treat OCD patients.*

Keywords：obsessive-compulsive disorder, autism spectrum disorder, exposure/response prevention

Introduction.

While both obsessive-compulsive disorder (OCD) and autism spectrum disorder (ASD) share the behavioral component of obsession, their core clinical picture is different. However, there are many cases in which it is difficult to differentiate between the two and in which they coexist. Therefore, it is useful/critical to examine the relationship between the two in clinical practice. In this paper, I discuss the characteristics and differences between the two, and what I am usually aware of when providing psychological intervention to OCD patients with ASD features.

I. The basic clinical picture of OCD and ASD

The diagnostic criteria for OCD are defined by obsessions and compulsive behaviors that either "consume a great deal of time" or "cause distress or functional impairment." In conventional diagnostic criteria, the presence of so-called ego discomfort (the perception and awareness? that obsessions or compulsive behaviors are excessive or irrational) is central to the diagnostic concept.

In the DSM-IV-TR1), OCD was categorized as one of the "anxiety disorders," but in the DSM-52), it was newly categorized as "obsessive-compulsive and related disorders," independent of the anxiety disorders. This is due to the fact that the essence of OCD is not "feeling anxious" but rather qualitative abnormalities such as "obsessing for no reason" as the central concept. In the revision, "presence of ego discomfort," which had been one of the main criteria for OCD diagnosis in the past, was excluded from the diagnostic criteria in the DSM-5.

According to the Epidemiologic Catchment Area (ECA) Study7), the average age of onset of OCD is 20-25 years, but the peak incidence is bimodal, occurring in childhood and adulthood3) . The sex ratio is male-dominated until puberty and female-dominated after puberty5)8). In addition, boys with OCD are characterized by a higher incidence of tic disorders than girls13) and a higher proportion of genetic involvement in the disease10). Taken together, it can be said that the younger the age of onset of OCD, the more "developmental" (often seen in developmental disorders) the disease becomes.

In the DSM-5, the diagnosis was changed to "Autism Spectrum Disorder," and both item A, "Persistent

deficits in social communication and interpersonal interactions," and item B, "Limited and repetitive patterns of behavior, interests, or activities," were required to diagnose ASD. However, the sensory characteristic of "hypersensitivity or insensitivity to sensory stimuli or exceptional interest in sensory aspects of the environment" is also included in item B. In a diagnostic note, it is stated that "if only item A is met, it should be evaluated as social communication disorder," but there is no mention of cases where only item B is met. Item A, "persistent deficits in social communication and interpersonal interactions," refers to communication deficits exhibited in communication disorder as described by Wing, L. and Gould, J.15), as well as other deficits such as delayed language development, literal interpretation, monotonous speech, and poor nonverbal communication. (1) Isolation group: Behaves as if others do not exist, grabs their hands and takes things from them, or steps over them. They appear indifferent to their peers. Lack of facial expression and difficulty making eye contact.

(2) Passive group: Accepts contact with others, but do not try to get involved themselves. (3) Active and strange group: Actively tries to approach others, but is one-way. They become difficult to handle or aggressive when they are not given the attention they want.

II. Differences between OCD and ASD

Until the DSM-IV-TR, the description of "pervasive developmental disorder not otherwise specified" clearly stated that it should be used in cases where there is the presence of homeostatic behaviors, interests, and activities, but the criteria for specific pervasive developmental disorder (abbreviated) are not met. Therefore, many cases of pervasive developmental disorder were diagnosed as "pervasive developmental disorder not otherwise specified." However, in light of the change in diagnostic criteria to DSM-5, OCD should be considered first if the only problem is "excessive persistent obsessive behavior. However, of course, a detailed evaluation of "persistent deficits in social communication and interpersonal interactions," which is item A of ASD, as well as an examination of the qualitative meaning of the obsessive behavior and its pathogenesis should be fully conducted.

As for the qualitative difference in obsession, the basic pathology of OCD is that "negative emotions such as anxiety and discomfort" are at the core of obsessive-compulsive symptoms. Therefore, patients with OCD do not engage in compulsive behaviors with pleasant emotions, but often repeat

compulsive behaviors in order to drown out anxiety or unpleasant emotional ideas. On the other hand, the obsessive behaviors of ASD are essentially homophobic and repetitive behaviors toward events of interest (i.e., in many cases, the obsessive behaviors of ASD are due to positive emotions). (In other words, in many cases, ASD obsessive behaviors are due to positive emotions.) When these behaviors are forcibly restricted, panic and excitement occur, but the repetitive behaviors themselves are not controlled by anxiety or discomfort.

The onset of ASD is generally recognized at around 18 to 24 months, and is considered to be more pronounced by the age of 3 years, although there are cases in which the symptoms remain hidden. As mentioned above, the age of onset of OCD is later than that of ASD. However, conversely, the younger the onset of OCD, the more difficult it is to distinguish it from ASD. In addition, it is not uncommon for children with ASD to have OCD symptoms at some point in their lives, making it difficult to identify the onset of OCD in such cases.

In many cases of OCD, obsessions are paired with compulsive behaviors, and their identification increases the accuracy of the diagnosis. However, because of the tendency of OCD patients to conceal their symptoms and the inability of OCD and ASD children to talk about their inner life (e.g., when they are very young or intellectually delayed), it is often difficult or time-consuming to identify the obsessions. Therefore, for example, when an ASD child with severe intellectual developmental disorder cannot stop self-injurious behavior and repeats it, or when a young ASD child is unhappy and persists in routine behavior, it is controversial whether it is an obsessive behavior or an obsession related to ASD.

These are some of the differences between OCD and ASD (summarized in Table 1), but since there are many cases of comorbidity, it is an important clinical task to evaluate the characteristics of ASD and intervene appropriately in OCD patients.

III. Psychological interventions for OCD symptoms

As for the obsessive-compulsive behavior of ASD, it is not necessarily the subject of medical intervention. Structuring of the living environment and the understanding of the people around the ASD person so that they can live without confusion are basic yet important support. In this report, I discuss psychological interventions for OCD symptoms, as well as the my ingenuities in the treatment of OCD when the characteristics of ASD are observed.

In the Pediatric OCD Treatment

Study (POTS)11) , 112 participants aged 7-17 years were diagnosed with OCD and were treated with exposure/response prevention (E/RP). The participants were randomly divided into four groups: sertraline, CBT, combination, and placebo. The results showed that all three treatments were clearly more effective than placebo, with 54% of patients in the combination treatment group achieving clinical remission, and 40% and 21% of patients in the CBT alone and sertraline treatment alone groups achieving clinical remission, respectively (compared with 3% in the placebo group). These results suggest that CBT alone or in combination with sertraline therapy should be used first in the treatment of childhood OCD, and that CBT is more effective than pharmacotherapy alone.

The basic procedure of E/RP is to provide psycho-education on OCD, and to make the patient understand that compulsive behavior reinforces OCD symptoms as the first step. After that, the core element of E/RP is to have the patient experience in the interview situation that he or she continues to feel his or her own unpleasant emotions without doing the compulsive behavior, and waits the unpleasant emotions to decrease over time. In order to achieve this, each session sets an appropriate task and challenges the participants to expose themselves to unpleasant emotions.

The treatment procedure for children with OCD in the author's clinic is shown in Table 2. The treatment program itself is conducted by a licensed psychologist separate from the attending physician. The original elements of the program are (1) sessions to teach parenting skills to parents, (2) sessions in which parents and children are basically present, and (3) sessions in which mindfulness exercises are conducted. The following is a list of points that the author believes to be implemented more carefully for children with strong ASD characteristics.

1. Outpatient primary care physician's work to introduce E/RP

The importance of externalizing symptoms is often emphasized in CBT practice, but if we view obsessive symptoms as externalizing without distinguishing between obsessions and compulsive behaviors, we may end up struggling with the thought of obsessions. Basically, we should internalize the miscellaneous obsessive thoughts that come to mind (understanding that it is okay to have any miscellaneous thoughts in one's mind), and externalize the disorder itself, since obsessive compulsive disorder is a condition in which the

behavior is driven by specific thoughts and becomes unstoppable. It is necessary to externalize the disorder itself and conceptualize it as "Let's try to control it well. "In order to introduce E/RP, it is important for the child to understand that it is okay to have any thoughts because the mind is free, and that OCD should disappear. This is true for OCD children in general, but for children with strong ASD characteristics, the outpatient physician should carefully explain this point before introducing E/RP.

For children who are very interested in OCD, the word "obsessive compulsive" should be explained along with OCD symptoms. It is necessary to pay attention to how not to lower their motivation.

2. Work with E/RP implementers to build relationships

Even if we are aware of the above procedures in the outpatient setting, many children find it difficult to establish the relationship with a therapist in order to implement E/RP. In particular, it is not easy for many children with ASD to deal with obsessive-compulsive symptoms that they tend to avoid with strangers they have just met. In such cases, the licensed psychologist may not start E/RP immediately, but may have sessions (often play therapy-like activities) to build relationships beforehand a while. Although we try to be as empathetic as possible in E/RP, the nature of E/RP inevitably requires the practitioner to be directive. So it is important for the practitioner to establish rapport with the child through empathic contact.

3. How to implement E/RP

However, as the ASD characteristics increase, it becomes more important for parents to be consistent in their interventions and to be empathetic but not overwhelmed by the obsessive symptoms. In this regard, it is extremely important to have sessions to teach desirable parenting skills. An understanding of ASD is also necessary. If necessary, a parenting skills program or a program for parents on ASD can be offered separately from E/RP.

Since E/RP is CBT, it is necessary to divide into "emotion-cognition-behavior" in the course of the program. However, the stronger the ASD characteristics are, the more difficult it is to divide them into emotion, cognition, and behavior. In particular, it is important to know how to recognize emotions. Various materials and tools can be used to succeed in this task. In our clinic, we often use a tool called "The CAT-kit" 4). "The CAT-kit is a tool created by Dr. Attwood, T., a specialist in Asperger's syndrome, and consists of

visual, interactive, and customizable communication tools. For example, the "Feeling Thermometer" is a tool that allows users to select a facial expression that matches their feelings from among faces that show various emotions and attach it to the thermometer with Velcro to communicate their feelings to others. CAT-Kit also allows users to write their relationships with people around them on multiple concentric circles so that they can notice their relationships with their surroundings. These tools are designed to be easy to use for children with strong ASD characteristics to like and understand. It is essential for ASD clinical practice to adopt such tools flexibly. In addition, when interviewing with children with stronger ASD characteristics and trying to teach “emotions, cognition and behavior,” therapists should be particularly aware of the following points: "affirming the fact that they have negative emotions" and "teaching that emotions are a state of calmness when they "return to zero.

The core of E/RP is to experience a decrease in the discomfort index by continuing to feel unpleasant emotions, but this "continuing to feel emotions" is often difficult for children with ASD. For this reason, we incorporate mindfulness sessions as a way to practice feeling emotions, and we aim to handle physical sensory elements along with emotions. In fact, in the mindfulness sessions, we practice "immersing in sensations and emotions" by eating sweets together with the E/RP practitioner.

It is also a goal of mindfulness and a goal of treatment for OCD, but the ultimate challenge is how to leave the unpleasant thoughts that come to one's mind unattended. Wheaton, M. G. et al.14) have identified three basic types of non-functional cognition that are often present in OCD: "excessive responsibility/overestimation of risk," "overestimation of thoughts and need for control," and "perfectionism/intolerance of ambiguity" (Table 3). Although not all of these cognitions are found in people with ASD, it can be said that "overevaluation of thoughts" and "perfectionism" are cognitions that tend to underlie the various symptoms that afflict people with ASD (especially those with high-functioning ASD). The author also believes that it is important to educate people on how to cope with the ideas that emerge from these cognitions (how to reason and make sense of them), and is currently working on such psychological education.

Conclusion.

At present, the treatment of children with OCD who have characteristics of ASD is not fully established, but we hope to continue to discuss the

treatment of cases in which OCD and ASD coexist. We also hope that OCD and ASD will be carefully differentiated and evaluated, and that appropriate interventions will be provided as needed.

Opposite interests

Lecture fees, etc.: Shire Japan K.K., Shionogi & Co.

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	OCD のこだわり	ASD のこだわり
DSM における規定	DSM-5 から「こだわること」を共通項として新しくカテゴリー化	DSM-5 から ASD の診断に B 項目「行動，興味，または活動の限定された反復的な様式」は必須条件 ただし「感覚刺激に対する過敏さまたは鈍感さ，または環境の感覚的側面に対する並外れた興味」も含む
こだわり行動に伴う感情	「不安や不快といった陰性の感情を伴うこと」が症状の中核に存在．不安・不快といった陰性の感情を伴う観念をかき消すために強迫行為を繰り返しているという理解	興味のある事象への常同・反復行動であり，多くの場合は陽性の感情によるもの
発症時期	児童期と成人期の二峰性．ただし ASD に，ある時期から OCD が併存してくる場合もある	一般的には 18〜24 ヵ月頃から判別され，3 歳頃には顕著となる
強迫観念	多くの場合存在する	基本的には存在しない

able 1: Differences in the persistence of OCD and ASD

Obsession in OCD

Obsession in ASD

From DSM-5, "obsession" is a new common category. From DSM-5, item B, "limited and repetitive patterns of behavior, interest, or activity," is a prerequisite for diagnosis of ASD.

However, it also includes "hypersensitivity or insensitivity to sensory stimuli or exceptional interest in sensory aspects of the environment.

Emotions associated with obsessive behavior "accompanied by negative emotions such as anxiety and discomfort" are present at the core of the symptoms. Understanding that the obsessive behavior is repeated in order to drown out negative emotional ideas such as anxiety and discomfort.

Onset Bimodal, in childhood and adulthood. OCD may coexist with ASD at some point, but is generally identified at around 18-24 months and becomes prominent by age 3

Obsessive thoughts Often present Basically absent

	内容	参加	評価	資料
#1	CY-BOCS	保護者・子ども同席	CY-BOCS	
#2	心理教育	保護者・子ども同席		「心理教育資料」 「OCD10か条」
#3	ペアレンティングスキル	保護者のみ		「ペアレンティングスキル」 「家族の対応について」
#4	E/RPの心理教育	保護者・子ども同席	CY-BOCS	「1週間の記録・目標シート」
#5	認知の三角形 不安階層表作り	保護者・子ども同席	CY-BOCS	「認知の三角形」 「不安階層表」
#6	マインドフルネス	保護者・子ども同席	CY-BOCS	「マインドフルネス・エクササイズ」
#7	E/RP①	保護者・子ども同席	CY-BOCS	
#8	E/RP②	保護者・子ども同席	CY-BOCS	
#9	E/RP③	保護者・子ども同席	CY-BOCS	
#10	E/RP④	保護者・子ども同席	CY-BOCS	
#11	E/RP⑤	保護者・子ども同席	CY-BOCS	
#12	CY-BOCS	保護者・子ども同席	CY-BOCS	

CY-BOCS：Children's Yale-Brown Obsessive Compulsive Scale

Table 2 OCD treatment procedures in the author's clinic

Content Participation Evaluation Materials

#1 CY-BOCS with parents and children

#2 Psychological education with parents and children "Psychological education materials" "10 principles of OCD

#3 Parenting skills with parents only CY-BOCS "Parenting Skills" "Family Responses"

#4 Psychological Education for E/RP with parents and children CY-BOCS "Weekly Record and Goal Sheet"

#5 Cognitive triangle, Making an anxiety hierarchy chart with parents and children CY-BOCS "Cognitive triangle" "Anxiety hierarchy chart"

#6 Mindfulness with parents and children CY-BOCS "Mindfulness exercise"

#7 E/RP① with parents and children CY-BOCS

#8 E/RP② with parents and children CY-BOCS

#9 E/RP③ with parents and children CY-BOCS

#10 E/RP④ with parents and children CY-BOCS

#11 E/RP⑤ with parents and children CY-BOCS

#12 CY-BOCS with parents and children

CY-BOCS: Children's Yale-Brown Obsessive Compulsive Scale

信念	解説
過剰な責任感/リスクの過剰評価	・自分は，ネガティブな結果を生じさせてしまうような力をもっている，または（かつ）ネガティブな結果を防ぐことが自分の責務だと信じている ・ネガティブな出来事はおそらく起こり，制御不能になると信じている
思考の過剰評価とコントロールへのニーズ	・思考というものが極めて重要だと信じている ・思考を完全にコントロールすることは，必要かつ可能なことだと信じている
完璧主義/曖昧さへの耐えられなさ	・ミスや不完全さには耐えられないと信じている ・ネガティブな結果を起こさないためには，100%でいなければならないし，それは可能なことだと信じている

Table 3: Nonfunctional cognition often seen in obsessive-compulsive disorder

Beliefs Explanation

Believes that he or she has the power to cause negative outcomes or that it is his or her responsibility to prevent negative outcomes.

Believing that negative events will probably occur and become uncontrollable

Overestimation of thoughts and need for control - Belief that thoughts are extremely important

Believes that complete control of thoughts is necessary and possible

Perfectionism/Inability to tolerate ambiguity - Believes that mistakes and imperfections are intolerable

Believes that it is necessary and possible to be 100% in order to avoid negative consequences.

I believe that it is possible.

(Japanese translation from Reference 14.)