OCD and Autism

Obsessive and ritualistic behaviours have long been considered traits of autism. However, with a growing number of individuals being diagnosed with both autism spectrum disorders and Obsessive Compulsive Disorder (OCD), how do professionals differentiate between the obsessive behaviours stemming from the autism or the OCD in those with this dual diagnosis? And what is the best practice for meeting their needs?

Dr Ailsa Russell, the clinical director for the doctorate in clinical psychology at The University of Bath – "The research that I did as part of my PhD was inspired by the sorts of problems that I was seeing in the clinic. I was working in services for adults with Autism Spectrum Conditions (ASC) and I noticed that there seemed to be lots of OCD around, even though the referral to the clinic might have been made for very different reasons."

Based on this, Ailsa began her research into the area of autism and OCD. Having discovered research undertaken in the USA on this topic, Ailsa felt that there should be a similar piece of research done in the UK, looking at the experiences of individuals with autism who were high functioning. Her findings shed a lot of light on this co-morbidity. Ailsa said:

"The first study we did was to compare the obsessions and compulsions reported by adults with ASC to those reported by adults with OCD. We found that adults with ASC reported a lot of obsessions and compulsions and many met criteria as 'clinical cases'. In fact, from this study and others that have been carried out with children and adults, it seems that anxiety disorders in general and OCD in particular are more common amongst people with ASC. We also found that our group with ASC did not report different types of obsessions and compulsions when compared to adults with OCD."

It can be difficult to work out whether obsessive and ritualistic behaviours are part of the individual's autism diagnosis or whether an additional OCD diagnosis is necessary.

"The main difference between ritualistic or repetitive behaviours which are common in ASC and OCD is anxiety. OCD is shorthand for the experience of intrusive, unwanted thoughts and images which come into someone's mind and make them feel anxious or uncomfortable (obsessions). They then usually perform certain acts (compulsions) to reduce the anxiety or discomfort. When someone feels that they 'have' to carry out a certain act or behaviour because if they don't, something negative will happen, and they will feel anxious, you know it is more likely to fit with OCD."

It’s also important to look at the history of the problem in order to work out how best to address these behaviours:

Repetitive behaviours in ASC usually start very early in childhood and tail off a bit in adolescence. Late childhood and adolescence is when OCD often begins, so a new ritual or worry starting at the time that repetitive behaviours should be reducing is more likely to be OCD.

Despite this, it can still be difficult to differentiate between some autism-related and OCD behaviours.

There are some areas where it is more difficult to disentangle the two and these are: collecting because of special interests in ASC and hoarding in OCD, and distinguishing between needing everything to be ‘just right’ or symmetrical which is common in OCD and a preference for sameness and routine in ASC.

If compulsive rituals help the individual to cope with their anxiety, should they be left as they are? Ailsa said:

“If the worries and rituals ‘take over’ and become one of the most important things we ‘have to do’ and we would prefer to live without them, we might be able to find other ways to reduce and cope with anxiety. OCD has a terrible habit of expanding and becoming ‘bigger’ and people find that they can’t take charge of it.”

So, what is the best practice for supporting individuals with OCD and autism?

The best route of action is to carefully assess the problem and the changes a person would like to make. The clinical guidelines for OCD recommend psychological treatment (cognitive behaviour therapy) as the first line of treatment for children and adults and in severe cases this can be combined with medication.

Based on this, Ailsa and her team were keen to find out the effectiveness of this treatment on individuals on the spectrum.

“We ran two treatment studies with people aged 14 and above: a pilot trial and then a randomized controlled trial. We found that psychological treatment was very effective for people with ASC and OCD – in fact just as effective as for people without ASC. We also found that you needed to adapt the treatment so that people with ASC could access it fully. This meant spending a little bit more time at the start of treatment, so the therapist and the person with ASC could get to know each other well, find out really carefully how the OCD worked, learn about anxiety and how it works if that was needed and then move on to changing the OCD in line with the person’s goals.”