ASD for OCD Providers

Understanding ASD in OCD clients and adapting OCD treatment

Training Outline and Objectives

1. Overview/Background on ASD
2. Common treatment approaches for ASD
3. Symptom presentations and differential diagnosis
4. Adapting ERP treatment

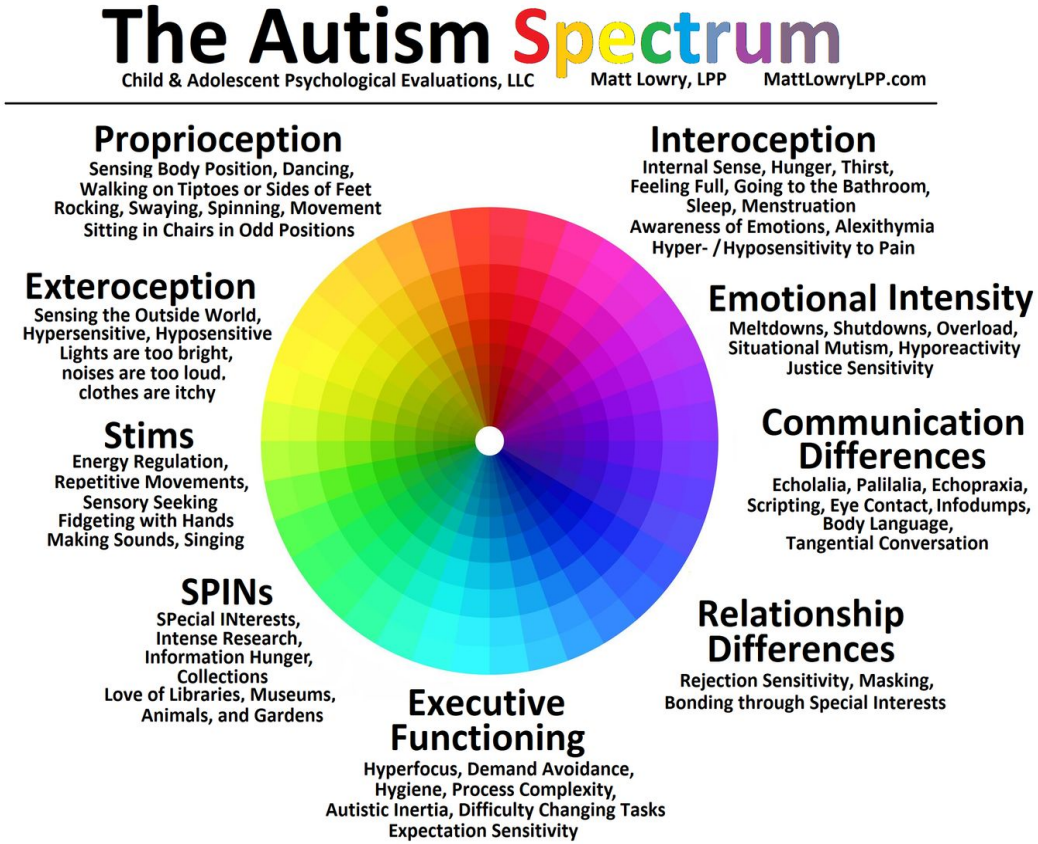
By the end of the presentation, participants will:

- Be able to identify at least 3 common presentations of ASD symptoms
- Identify the most common treatment approach for ASD
- Differentiate 2 key symptomatic differences in OCD and ASD (obsessions and rituals)
- Identify 2 ways that ERP can be adapted to work for individuals with OCD and ASD
- Learn strategies for working with caregivers

Overview/Presenter Background

- Lack of reliable data on the statistical prevalence of comorbid OCD and ASD
  - https://iocdf.org/autism/ocd-and-autism/
- Clinical experience - frequent overlap in symptom presentations
- Exposure and Response Prevention (ERP) is a behavior focused treatment with similarities to ABA & other treatments for behavior concerns
- OCD may be present when repetitive, restricted behaviors are driven by a specific anxiety
  - This can be confusing to untangle, as many stimming and scripting behaviors function to bring relief in uncomfortable or unfamiliar situations or function solely as pleasurable for the person
- Trainer background:
  - Licensed Behavior Specialist 2021-2024
  - Mobile therapist and behavior specialist since 2021
    - Individual and group service provider (in home, community, & clinic settings)
  - Background in general partial hospital and OCD IOP levels of care - pediatric clients & families
  - OCD specialist since 2023
    - IOP and outpatient

Understanding ASD



Strengths-Based ASD Diagnostic Criteria

To meet diagnostic criteria for ASD according to DSM-5, a child must have persistent differences in each of three areas of social communication and interaction (see A1-A3 below) plus at least two of four types of repetitive behaviors (see B1-B4 below).

A. Different social communication and interaction as evidenced by the following:

1- Differences in communication- tendency to go off on tangents, tendency to talk passionately about special interests, and tendency to not engage in small talk.

2- Differences in nonverbal communication, including stimming while talking, looking at something else while talking, and being bored with conversations

3- Due to the above differences in communication, autistic people tend to be shunned by neurotypicals and therefore are conditioned to believe that we're somehow less social.

B) Repetitive behavior or interests as evidenced by at least two of the following:

1- Stimming or engaging in echolalia

2- Security in routines. Autistic people do not have a sensory filter, so the world is perceived as a constant state of chaos. Routines and expectations give comfort to overwhelmed autistic people.

3- SPecial INterests (SPINs)- Due to hyperconnected brains, autistic people feel more passionately about what we love, so when we have a special interest, we tend to fawn over and fixate on it.

4- Hyper or hyporeactivity to stimuli- Again, due to hyperconnections, we feel things more intensely. Sometimes, however, we feel things less intensely because we tune them out in favor of other stimuli.

C- We're born with these traits, but learn how to mask them. Sometimes, they only show up when we're stressed and let our guards down.

D- These traits cause other people distress. Note- the DSM ONLY indicates impairment when it affects other people or jobs, but not when it's a daily issue that we learn to live with.

E- It's not due to intellectual disability.

- Autism has as many nuanced and variable presentations as OCD
- “If you’ve met one person with autism, you’ve met one person with autism” - Dr. Stephen Shore
- Autistic people vary in their levels of support needs, insight, other mental health concerns, interests, and preferences just like any other human

“Three Pronged Approach” for evaluating ASD/OCD symptoms in context:

1. **Consider the person themselves**:
    a. Personality, preferences, things that likely are non-symptomatic
    b. “She is more introverted by preference”, “He enjoys information on historical events”
2. **Consider the developmental stage and support needs**:
    a. Younger kids naturally need more information about the world; adolescents naturally seek independence and have more social concerns with peers
    b. What’s reassurance to an adult might be information to a 7 year old
    c. A 14 year old with ASD might have high support needs but the temperament of a neurotypical 14 year old (seeking independence, experiencing mood symptoms typical of puberty)
3. **Identify OCD/ASD symptoms/other mental health:**
    a. Client has trouble sleeping due to spending all night looking up info on historical events - their focused interest (ASD)
    b. Client has trouble sleeping due to intrusive thoughts of dying in sleep or extensive nighttime ritual to prevent his stack of papers about historical events from being disrupted (OCD)
    c. Client has low mood around their menstrual cycle and feels more susceptive to intrusive thoughts (impact of physical health on OCD)

Important note on terminology

- We recognize that other people can perform compulsions for the client - we call these accommodations in OCD world:
  - Parent who turns off a TV show that is triggering a child even though a sibling wants to watch it
  - Partner who reassures a client that they still love them when asked repeatedly
  - Parent who repeats specific phrases to the child when they are requested
  - Parent/partner who engages in checking (weather, time, traffic, schedules, expiration dates, food) for client
  - Parent/partner who drives a specific way because client OCD requests it

- **HOWEVER -** for the purpose of this training, we will use the word accommodation in reference to modifications made by an individual, system, or caregiver for the purpose of supporting the individual with ASD in a neurotypical world
  - This follows the model of how these supports are discussed by treatment professionals and individuals
- We will use the word reinforcer to reference behaviors done by the individual/others that keep the OCD in place and maintain obsessions and compulsions

Overview of a Common Treatment approach for ASD

- Applied Behavior Analysis (ABA)
  - Most widely used treatment approach for individuals with ASD
  - Focus is on identifying behavioral targets for modification through repeated learning using punishment and reinforcement
  - " A group of principles, strategies, and procedures used to teach, manage, increase, and reduce behaviors. Different ABA approaches include Behavior Skills Training (BST), Discrete Trial Teaching (DTT), Incidental Teaching, Verbal Behavior, Early Intensive Behavioral Intervention (EIBI), Pivotal Response Treatment (PRT), and others."
    - https://www.michiganallianceforfamilies.org/wp-content/uploads/2018/04/ABA-Description.pdf

Functional Behavior Assessment

- Assessment completed by a licensed behavior specialist (BCBA, LBS) through extensive observation, caregiver reports, teacher/other provider reports **AFTER** a person has been diagnosed with ASD
- Purpose is identifying behaviors that are targets for treatment and information about these behaviors
  - Frequency, intensity, and level of impairment resulting from the behavior
  - Antecedents (setting events - what happened/was happening before the behavior occurred or did not occur)
  - Consequences (what happened as a result of the behavior occurring or not occurring)
- Consequences can also be reinforcers
  - Escape, attention, gain access to something, automatic (sensory, self-soothing, pleasurable)

FBA is similar to YBOCS...how?

- Identifies behaviors (including verbal and thinking behavior) that is causing distress to the person or impairing their ability to function in some way
  - Obsessions
- Identifies what happens as result
  - Compulsions
- Identifies what antecedents are present
  - Triggers

Case Sample of ABA Assessment and Intervention

“Case Study: A 10-year-old child with autism exhibited frequent self-injurious behavior (SIB), including head banging and biting. The behavior had increased in intensity, causing concern for the child’s safety. The behavior analyst was asked to develop a targeted intervention to reduce SIB.

ABA Intervention: After conducting an FBA, the behavior analyst determined that the self-injurious behavior was primarily escape-maintained, meaning the child used the behavior to avoid difficult tasks or demands. A treatment plan was developed that included Functional Communication Training (FCT) to teach the child to request breaks using a communication device. Non-contingent reinforcement (NCR) was also implemented, providing breaks at regular intervals, regardless of behavior, to reduce the motivation for SIB.”

https://path4aba.org/knowledge-base/case-studies-in-behavior-analysis-real-world-applications/

Now…how do we see and treat OCD in individuals with ASD?

- Symptom Presentation and Differential Diagnosis
  - Assessment approaches and options
  - Clinical considerations
- Implementation of ERP for OCD with ASD
  - Adapting ERP
  - Sensory Needs and Inhibitory Learning
  - Cognitive Flexibility
  - SPACE and caregiver training/modeling
- Considerations and Clinical Caveats

Assessment Options for Autistic Individuals

- YBOCS and CY-BOCS were not developed with Autistic individuals in the sample, they are highly verbal assessments and requires some level of insight and ability to communicate with the clinician in some capacity
- Clinician should be versed in different ways Autistic individuals communicate (AAC devices, PECS, receptive vs expressive abilities)

- The Anxiety Scale for Children—ASD (ASC-ASD)
- The Parent-rated Anxiety Scale for ASD (PRAS-ASD)
- The Autism Spectrum Addendum to the Anxiety Disorders Interview Schedule (ADIS/ASA)
- The Anxiety Scale for Autism-Adults

Symptom Presentations

- Similar presentations of symptoms can make it difficult to understand what is stemming from ASD and what is rooted in OCD
- Look at precipitating factors for both OCD and ASD symptom presentation
  - Environment: the level of skill needed to function in that environment will influence what behaviors are present (social skills, ADL, rituals)
  - History of behaviors: change in behaviors over time or sudden, illnesses (PANS/PANDAS)
- Level of anxiety/distress when a behavior is restricted or denied access to
- Common symptom presentations in OCD and ASD
  - Contamination
  - Just right/rearranging/ordering objects
  - Need to know
  - Social anxiety/agoraphobia
  - Sensorimotor/BFRB
  - Hoarding
  - Checking

- Levels of insight
  - OCD: more severe OCD with lack of insight can present as delusional/paranoid disorders
  - ASD: people with ASD can struggle with interoception and theory of mind/understanding and/or communicating the internal experience
- Support needs (often called “high or low functioning”)
  - Higher support needs ASD can result in more repetitive and restrictive behaviors and dependence on caregivers for ADLs
  - Key treatment questions for clients AND caregivers:
    - **What is an ASD accommodation, what is a personal preference that does not interfere with functioning and/or quality of life, and what is an OCD reinforcer?**

Which is which??? OCD or ASD???

Obsessional interest vs obsessional doubt

- Obsessional interests are not targets for ERP unless due to amount of time/intensity the person is engaging in them affects ADLs and other goals of the client
- Can use interests to facilitate ERP for other areas or as reinforcements:
  - Client is very interested in architecture but fears leaving the house, can see if they would be willing to engage in exposure of taking a short walk or drive around a historic building to see interesting architecture (Cathedral of Learning in Pittsburgh)
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  - Client enjoys songs from a specific show, sing them while working on reducing hand washing ritual, put a limit on how long they can sing the song before ending the handwashing, then re-start singing after they end the ritual as a reward/positive reinforcement

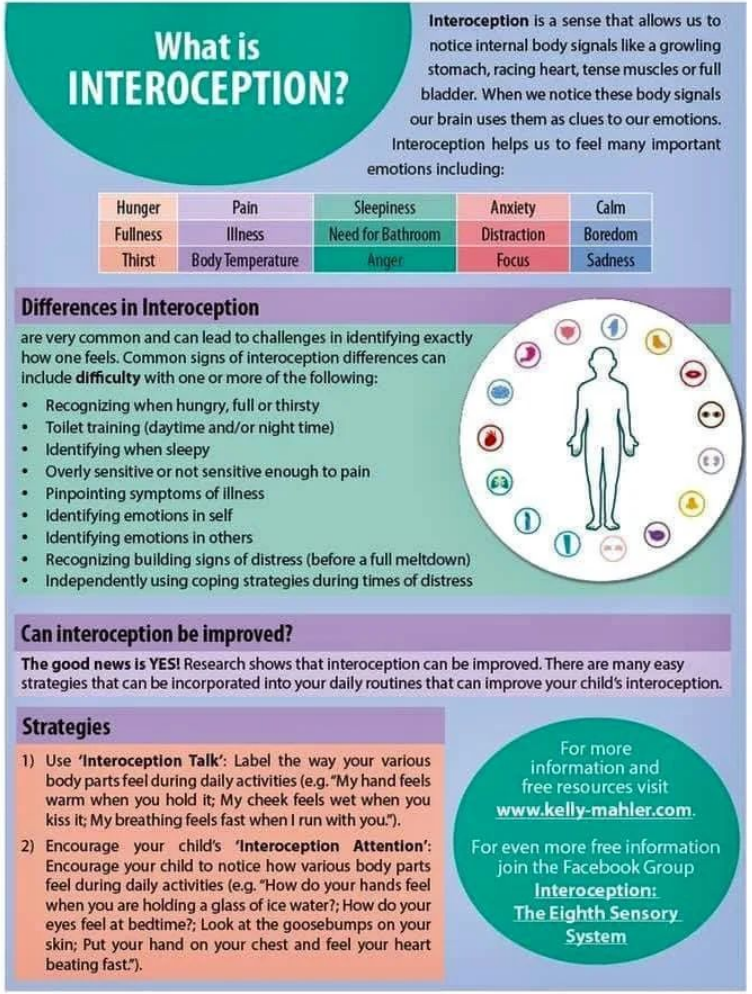
- Rigid behavior vs ritualized behavior
    - Preferences vs anxiety driven behaviors
    - Many people with OCD or ASD have routines and preferences that they would not like to change if they didn't have to (skincare routine and products, workout routines)
    - Not having sameness can trigger more anxiety and discomfort for people with ASD
        - Buy in for working on change may look different
        - Clients with ASD may be highly dis-interested in working on "change for the sake of tolerating change" if no need is present or is only hypothetical
        - Focus on natural exposures they encounter & how they respond or simulate them for the client:
            - Change the layout of furniture in your office, have the client sit in a different seat, don't have a preferred fidget available, have parent buy a slight variation of a preferred food or don't buy it at all that week, switch day and time of session
    - Cognitive flexibility work as a tool for both ritualized and rigid behaviors/thinking patterns

ERP...can it work for individuals with ASD?

- ERP can be effective for individuals with co-morbid ASD
- Level of modification of ERP is dependent on support needs and level of insight the client has as well as the clinician's skills/ability to adapt
  - Ability to communicate expressively and receptively
  - Ability to recognize and label internal experiences (interoception)
- May not have a level of buy-in for change or see a typically motivating purpose for working on exposures
- Often focus can be more heavily on response prevention
  - Similar to ABA replacement of/reduction in non-functional or unsafe behaviors
  - Example: teaching replacement behavior of going to a safe designated spot in an area instead of elopement when presented with a trigger
- ERP Adaptations For Our Autistic Members: 20 Things to Know

Treatment Implementation: Sensory Needs and Inhibitory Learning

- “Itchy sweater problem”
  - Sensory issues don’t tend to habituate the way obsessional fears do through ERP – no anxiety response/feared outcomes, simply learning to develop tolerance, use accommodations, or mask internal responses/discomfort in the moment
- The Inhibitory Learning Approach to Exposure and Response Prevention
- Tolerate vs habituate
- SUDS scaling and challenges with, “What does anxiety feel like?”
- Adapt SUDS scaling using “difficulty vs willingness” scale
  - “How difficult would it be for you to try to do XYZ, and how willing do you think you would be to try it?”



Case Example

Matt is 12 year old child with low support needs ASD and comorbid OCD who attends mainstream classes in public school and has a 504 plan for his sensory accommodations and breaks. Matt experiences social anxiety but also sensory sensitivity (anxious response due to overwhelm) to crowds and noise. This year, Matt attempted to eat in the cafeteria at the new middle school. Matt had a table by himself and tried using noise cancelling headphones, but he was still not able to eat. A sensory accommodation would be to provide quiet separate environment for lunch time. If this was OCD driven, providing an accommodation would be reinforcing avoiding crowds/social situations, but Matt has shown growth in other areas that are more OCD related (not wanting to leave house on the weekend, trouble being away from parents, going to stores and sports practices) and the lunch time concern persists, so a sensory accommodation in one specific area is warranted in order to support decreased anxiety at school and increase in functional behavior of eating.

Treatment Implementation: Building Cognitive Flexibility

- Cognitive flexibility: the ability to shift or change mental and behavioral strategies
  - Greater flexibility is associated with higher creativity and resilience to negative life events
- Executive functioning: set of cognitive processes used to learn, work and manage everyday life; includes working memory, flexible thinking and self control
  - Executive functioning deficits in cognitive flexibility, response inhibition and nonverbal memory often present with OCD and ASD
- Cognitive rigidity: difficulty with adapting to new information, demands or changes
  - Shows up as perfectionism, stubbornness, excessive attention to detail, difficulty with leaving things incomplete, difficulty tolerating uncertainty, low distress tolerance, difficulty with emotional regulation

Sample ways to build cognitive flexibility with an exposure approach

- Pediatric client:
  - Targets: asking for help, understanding the perspectives of others, decision making
  - Play games and change or add rules – allow client a turn to be in charge as well to model being flexible back
  - Quiz games, jeopardy, Kahoot, Blooket, logic puzzles
- Adult client:
  - Targets: becoming clear on what is an accommodation for their ASD and what is reinforcing their OCD, ways to self-accommodate through coping skills, navigating social situations where they might be misunderstood (ordering food/beverage for themselves, dating)
- Almost anything can be an exposure when working on cognitive flexibility when you are asking a client with ASD to do something differently than they would typically or do something they would typically avoid
- Can still create an exposure hierarchy for these goals
  - Modification: perceived level of difficulty vs willingness to try instead of SUDS scaling

Treatment Implementation: SPACE and Caregiver Training

- Remember that question from earlier - what is an ASD accommodation and what is an OCD reinforcer?
- SPACE: Supportive Parenting for Anxious Childhood Emotions
  - https://www.spacetreatment.net
- Using SPACE to support parents/partners/caregivers with ways to communicate and identify ASD accommodations vs OCD reinforcers
- Helpful Tips:
  - Label OCD for person
  - Remind them of response prevention skills
  - Remind them of coping skills
  - Discuss/provide sensory accommodations
  - Remind individual of the caregiver's own autonomy and choice to disengage from providing reinforcers to the OCD

Case example: Adult Client with ASD

Megan is a 25 year old client who was recently diagnosed with Autism. She shares it has been helpful in understanding how this has impacted her socially and the many sensory discomforts she has experienced throughout life. Megan presents with contamination OCD, symptoms include disgust response to “feeling dirty” with no clear fear of germs or illness but excessive hand washing, sanitizing, ritualized shower routines, and strict use of the same exact type of each of shampoo, conditioner, etc. Megan shares that she isn’t sure what she can get out of ERP, since she will never like feeling dirty and doesn’t understand why she can’t continue her shower routines. She denies anxiety related to thinking about exposures, so SUDS scaling seems ineffective here.

Starting points of ERP with Megan could be explicitly discussing any buy in she has for treatment (even if this differs from what our goals might be with ERP) and psychoeducation about inhibitory learning. Staying away from hypotheticals “what if your favorite conditioner is discontinued…?” could be helpful here, as that’s not a current reality that presents enough buy in to do exposure. ACT could be a helpful supplement here - for example, does she value independence but currently live with parents? Would she like to be able to live on her own? Would that mean getting a job where she might have to tolerate being dirty for longer periods of time? Can exposure work look like getting a job first, then targeting contamination rituals as they show up?

ERP/SPACE Ideas for Megan:

- Discuss sensory issues related to feeling disgust
  - How has she tried to accommodate herself to avoid feeling disgust?
  - Are these accommodations functional? Do they keep her from anything? Do they impact other people in the family, her social life, her education?
- Identify if rumination is present
  - When can I shower next? When can I wash my hands? How can I get somewhere where I can get clean?
- Identify if she relies on others for OCD reinforcers and collaborate with those people to limit reinforcers
  - This can also promote ADL development while being an exposure
  - Megan might rely on mom to buy the shampoo because she doesn't want to go to the store ("people at the store are dirty, it's crowded and overstimulating, they might touch me")
  - Mom can start by providing the money for Megan to buy the shampoo, but Megan needs to go with mom to the store, go in the store…you get the idea!
  - Set a date with mom where she will stop buying shampoo for Megan - provide alternates. Can Megan shop online for the shampoo? She might be able to, but she might have to wait awhile for it to be delivered, so…
  - **Megan might refuse to use shampoo at all if mom buys the wrong one or will adapt her routine to avoid going to the store. Keep in mind this is a good place to discuss autonomy (yes, Megan is allowed to choose to have dirty hair and only use her preferred shampoo. We can't make her do anything) BUT she knows she doesn't like that sensory feeling of dirty hair…can she experience the consequences of her rigidity and determine it's enough to make a change?**

Clinical Caveats

- The “teaching neurotypicality problem”
  - OCD example → client asking “how often do ‘NORMAL’ people do XYZ (check doors, wash hands, etc)
  - ASD example → many treatments teach masking and not self-advocacy or understanding of internal processes/needs
- “Gold Standards”
  - ABA/Behaviorism can sometimes reinforce OCD patterns – teaches a “just right” or “only” way of responding
  - Case example:
    - Client with limited expressive language states, “You want school in one week with fun learning?”
    - Client was taught using VB MAPP with the common mand, “I want”
    - Client struggles with verbalizing “I feel/I need/I think”
    - Client over uses the learned mand as modified communication but caregivers and therapists can misinterpret this
    - Client was actually communicating sadness about having to transition from in person setting to home school
  - In order to understand this, we need to see “scripting” as sometimes a functional communication in the way the person is capable of communicating and adapt our responses

Clinical Caveats

- A helpful part of treatment can be supporting parents or others in a person's life with best ways to communicate with them as the individual is being taught to communicate with non-ASD individuals
    - Examples include understanding a person with ASD may feel stress from open-ended questions, have limitations on eye contact, use sensory tools such as headphones, not seek social interactions in a typical way

- What level of compulsive/restrictive behaviors and accommodations by others are functional for the client and their support system/family?

Questions/Feedback to Improve this Training:

Contact Information:

- The Center for OCD and Anxiety: www.pittsburghocdtreatment.com
- Olivia Wolfe, LPC — olivia@pittsburghocdtreatment.com

References and Resources:

- OCD and Autism Resource Center - International OCD Foundation
- Treatments for Obsessive-Compulsive Disorder comorbid with Autism Spectrum Disorder
- Treatment For Autism And OCD | Resources And Recommendations
- Co-occurring obsessive–compulsive disorder and autism spectrum disorder in young people: prevalence, clinical characteristics and outcomes: https://pmc.ncbi.nlm.nih.gov/articles/PMC7595977/pdf/787_2020_Article_1478.pdf
- The Live Experience of Dr. Yael Interviewed By Dr. Sachs (ASD individual and OCD therapist)
- ERP Adaptations For Our Autistic Members: 20 Things To Know (Autism Cultural Competence & OCD Tips Training, NOCD, 4.2022, April Kilduff, Sarah Stanton, Tia Wilson)
- ABA Fact Sheet - BACB
- https://www.mattlowrylpp.com/
- ASD Treatment Overview
- https://path4aba.org/knowledge-base/case-studies-in-behavior-analysis-real-world-applications/