



Clinical correlates of obsessive compulsive disorder and comorbid autism spectrum disorder in youth



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ABSTRACT

Very little is known about the comorbid presentation of obsessive-compulsive disorder (OCD) in youth with autism spectrum disorder (ASD) despite the high rates of comorbidity in clinical samples (Ivarsson and Melin, 2008; Stewart et al., 2016). This study examined the clinical expression and treatment response among children and adolescents with OCD with ($n = 25$) and without ($n = 25$) comorbid ASD ($n = 50$; aged 7–17 years). Youth were assessed on gold-standard measures of OCD severity and associated symptoms including functioning, mood, anxiety, comorbidity and family accommodation. The results indicated that comorbid OCD and ASD was associated with significantly higher functional impairment across school, social and home domains; significantly more externalising disorders and more comorbid disorders overall than OCD without comorbid ASD. Furthermore, families of comorbid OCD and ASD children and adolescents engaged in significantly more accommodating behaviours, and moreover, these comorbid youth had poorer treatment response at six-month follow-up. Findings from this study may be helpful in designing more targeted treatment protocols for children and adolescents with comorbid OCD and ASD.

1. Introduction

Obsessive-compulsive disorder (OCD) is an impairing, neuropsychiatric disorder (Geller, 2006; Piacentini, Peris, Bergman, & Chang, 2007) which affects approximately 2–4% of children and adolescents (Geller, 2006; Rapoport, Inoff-Germain, Weissman, & Greenwald, 2000; Zohar, 1999), and if left untreated tends to run a chronic and disabling course (Keeley, Storch, Dhungana, & Geffken, 2007; Storch et al., 2014; Weidle, Jozefiak, Ivarsson, & Thomsen, 2014). Research has shown that OCD in youth has been linked to significant and pervasive psychosocial impairment across social, academic, and family functioning (Piacentini et al., 2007; Piacentini, Bergman, Keller, & McCracken, 2003), and frequently results in reduced quality of life (Storch et al., 2007a).

OCD in youth is highly comorbid with other psychological disorders such as disruptive behaviour disorders (e.g., oppositional defiant disorder [ODD], attention deficit/hyperactivity disorders [ADD/ADHD]), other anxiety disorders, (e.g., specific phobia), tics and Tourette's syndrome, and depression (Farrell, Barrett, & Piacentini, 2006; Flament, Koby, Rapoport, & Berg, 1990; Geller, 2006; Ivarsson & Melin, 2008). Indeed, research suggests that around 80% of youth with OCD have a least one comorbid diagnosis (Lewin, Chang, McCracken, McQueen, & Piacentini, 2010; POTS Team, 2004; Storch

et al., 2008) and around 50–60% have two or more psychiatric disorders during their lifetime (Rasmussen & Eisen, 1990). There has been little research on the clinical expression of comorbid OCD and autism spectrum disorder (ASD) specifically, including their combined impact upon psychosocial functioning, severity of symptoms and response to treatment.

1.1. Clinical expression

ASD is a chronic neurodevelopmental disorder which is marked by restricted and repetitive patterns of behaviour or interests, as well as noticeable deficits in communication and social interaction skills. These restricted, repetitive behavioural patterns include a broad range of behaviours, such as stereotyped motor mannerisms, repetitive speech, restricted interests, fixation on non-functional objects or parts of objects, rigidity in routines and insistence on sameness (American Psychiatric Association, 2013). Research has shown that individuals across the ASD spectrum have poor social and affective relatedness, difficulties with language in the social context, unusual non-verbal behaviours (e.g., gesturing) and difficulty meeting age appropriate cultural expectations for social behaviours; factors which impact social relationships with peers (Bachevalier & Loveland, 2006). In addition to the core symptoms of ASD, youth with higher functioning ASD often

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exhibit symptoms across other diagnostic domains, such as explosive behaviour and aggression, hyperactivity and anxiety (Sukhodolsky et al., 2008). Given that ASD and OCD are each associated with profoundly negative impairments in functioning, the impact of comorbid OCD and ASD represents a particularly challenging and complex clinical presentation.

The phenotypic similarities between OCD and ASD—such as, the repetitive behaviours, fixated/obsessional features, and rigidity/inflexibility, raises the question of whether there may be underlying shared mechanisms of risk which may account for the relative high co-occurrence of OCD and ASD (Farrell, James, Maddox, Griffiths, & White, 2015; Maddox, Kerns, Franklin, & White, 2016). Indeed, due to the extent of overlap in symptoms associated with OCD and ASD, differential or dual diagnosis can be difficult. A particular challenge is discriminating between the restrictive, repetitive behaviour and interest domain of ASD and the presence of obsessions and compulsions associated with OCD. However, subtle points of difference can be noted in the presentation of OCD and ASD. For instance, in the context of OCD, obsessions are experienced as intrusive and unwanted, typically causing heightened anxiety or distress, whereas in ASD, perseverative thoughts may not cause anxiety or distress, but rather relate to an idiosyncratic circumscribed interest or intense preoccupation with novel objects (South, Ozonoff, & McMahon, 2005). Furthermore, compulsions in OCD are often ego-dystonic, unwanted, demanding and performing routines or rituals is negatively reinforcing. However, in ASD, the restricted, repetitive behaviours can be either negatively or positively reinforcing (Farrell et al., 2015). Consequently, challenges for the clinician are to distinguish between repetitive behaviours that are maintained via negative reinforcement and to determine if any obsessional content (including urges or impulses) precedes these behaviours.

When examining the research investigating comorbid OCD and ASD, results suggest youth with comorbid ASD and OCD rate their OCD symptoms as similarly distressing, time intensive, and interfering as do youth without ASD (Lewin, Wood, Gunderson, Murphy, & Storch, 2011). For example, Mack et al. (2010) found no significant differences on total OCD severity ($d = 0.40$), obsessions ($d = 0.21$) and compulsions ($d = 0.50$) in a comorbid ASD and OCD group ($n = 12$) compared to an OCD-alone group ($n = 12$); although on the basis of these reported effect sizes, the comorbid group tended to be higher on the compulsion subscales. Respectively, Lewin et al. (2011) found similar symptom severity scores in their comparison groups (i.e., ASD and comorbid OCD, $n = 35$ and OCD alone, $n = 35$), in total severity ($d = 0.08$), obsessions ($d = -0.13$) and compulsions ($d = -0.47$), on the Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS; Scahill, Riddle, McSwiggin-Hardin, & Ort, 1997). In contrast, Ruta, Mugno, D'Arrigo, Vitiello, and Mazzone (2010), found when children affected by OCD ($n = 20$) were compared to an Asperger Syndrome (AS) only group ($n = 18$) and typically developing controls ($n = 22$), differences in symptom clusters were evident on CY-BOCS. Their findings indicated that children in the OCD group and the AS group reported more obsessions and compulsions than typically developing children. However, children with AS and OCD engaged in different types and frequencies of repetitive thoughts and behaviours. The AS group reported fewer symptoms of contamination, aggressive obsessions, and checking compulsions compared to the OCD group, yet they reported higher frequencies of saving/hoarding obsessions, along with ordering and hoarding compulsions compared to the OCD group. Furthermore, research suggests that children and adolescents with ASD have reduced awareness about the excessive and irrational nature of their repetitive thoughts and behaviours (insight), ostensibly due to an impaired ability to process and talk about their own internal state of mind (Baron-Cohen, 1989). For example Ruta et al. (2010) found that children 8–15 years with ASD ($n = 18$) were significantly more represented in insight *Absent* (CY-BOCS; Scahill et al., 1997) compared to children with OCD ($n = 20$) without ASD (15% of OCD vs. 44% of AS, $\chi^2 = 3.99$, $df = 1$, p

$= < 0.05$). However, noteworthy is that none of the participants (i.e., children with and without ASD) demonstrated *Excellent* insight levels. Conversely, Russell et al. (2013) found that young people and adults 14–65 years) who were randomly assigned to two treatment groups (AM group; $M = 25.3$, $SD 13.5$; CBT Group; $M = 28.6$, $SD 11.3$) with comorbid ASD and OCD demonstrated good insight into their OCD symptoms. Hence, children with OCD and comorbid ASD may display poorer insight into their OC symptoms as a feature of younger age and comorbidity with ASD. Although prior research has shown both similar and some points of distinction in OCD expression between youth with and without comorbid ASD, there is limited research examining the broader impairment and functioning between these two groups.

1.2. Treatment response

Few studies have examined the degree to which youth with comorbid OCD and ASD respond to evidence-based treatments. One study has examined the effectiveness of routine cognitive-behaviour therapy (CBT) in youth with OCD with and without comorbid ASD, (Murray, Jassi, Mataix-Cols, Barrow, & Krebs, 2015) and found that despite there being no statistically significant differences between the two groups on baseline measures of OCD symptom severity, the percentage decrease in symptoms following treatment was significantly lower in the OCD + ASD group ($M = 33.31$) compared to the OCD + NoASD group ($M = 48.20$). Further, response rates for the OCD + ASD group were found to be lower (46%) compared with the OCD + NoASD (73%); although this result did not reach statistical significance. A significant difference was observed on remission rates with the OCD + ASD group showing a remission rate of only nine percent (i.e., 2/22) compared to the OCD + NoASD controls whose remission rates were 46% (i.e., 10/22). These findings indicate that youth with OCD and comorbid ASD respond significantly less well to standard CBT and suggest that further investigation into expression of comorbid OCD and ASD is required in order to improve treatments for these children and adolescents.

Family accommodation has also been shown to be directly associated with obsessive-compulsive symptom severity, functional impairment, family conflict and blame (Lebowitz, Panza, Su, & Bloch, 2012; Peris & Piacentini, 2014; Storch et al., 2007) and to attenuate treatment outcomes (Lebowitz et al., 2012). In a preliminary study by Storch and colleagues (Storch & Zavrou, 2015) family accommodation in youth with ASD was found to be prevalent, with 97.5% of parents reporting that they engaged in accommodating behaviours. Parents reported that the most common types of accommodation were “providing reassurance, avoiding things or situations, modifying the family routine, and modifying the child's responsibilities” (p. 97). As such, family accommodation associated with children who have both OCD and ASD may be particularly high. Moreover, family accommodation has been found to be directly associated with internalising and externalising symptoms, emotional dysregulation (McGuire, 2013; Storch et al., 2007b; Storch, Jones et al., 2012) and to also mediate the relationship between symptom severity and functional impairment (Storch et al., 2007b), as well as between ASD traits and functional impairment in paediatric OCD (Griffiths, Farrell, Waters, & White, 2017). Parental anxiety has also been linked to an increase in family accommodation (Flessner et al., 2011; Peris, Bergman, Langley, & Chang, 2008). Moreover, the degree to which family accommodation may be associated and more extreme across various comorbid presentation in childhood OCD, is an area of research which has had limited investigation.

In sum, little is known about whether children and adolescents with both disorders present as a more severe, impaired or symptomatically different sub-sample of youth relative to children and adolescents without this specific comorbidity. One hypothesis is that there may be additive effects of impairment, as a result of having both OCD and ASD. Alternatively, the expression of OCD when co-occurring with ASD may present as more complex and distinct from OCD and other more

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