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The nature and treatment of compulsions, obsessions, and rituals in people with developmental disabilities

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ABSTRACT

Developmental disabilities such as intellectual disability and autism are often accompanied by special sets of behaviors which are major challenges for the person and those in their community. Among the most worrisome of these are compulsions, rituals and obsessions. Often these behaviors are left untreated; however, when intervention does occur it is often with pharmacotherapy. There are psychological treatments for these issues as well but a concerted focus to develop these procedures, unlike efforts in differential diagnosis, has not occurred. Additionally, no reviews of how best to treat these problematic behaviors have been published to date. The present paper reviews what is available with respect to these treatment approaches with an eye to what appears to be effective, what has been treated and what is yet to be explored from a research point of view.

Obsessions, compulsions and rituals are frequently associated with the high incidence of developmental disabilities such as intellectual disability (ID) and autism (Dawson, Matson, & Cherry, 1998; MacDonald et al., 2007; Matson, 2007a; Matson & Boisjoli, 2007; Matson & Dempsey, 2008; Matson & Rivet, 2008; Roebel & MacLean, 2007). Additionally, these two disorders overlap to a large degree (Matson, Dempsey, LoVullo, & Wilkins, 2008; Zachor, Ben-Itzchak, Rabinovich, & Lahat, 2007; Palmer, 2006). When this overlap occurs, the individual is at even greater risk for developing obsessions, compulsions, rituals and other serious problem behaviors (Matson, Dixon, & Matson, 2005; Mybakk & von Tetzchner, 2008; Ringdahl, Call, Mews, Boelter, & Christensen, 2008; Rojahn, Aman, Matson, & Mayville, 2003).

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While form and function of these challenging behaviors may differ for ID and autism and vary by age; a more overriding feature is the debate about whether obsessions, compulsions and rituals constitute core features of the disorders or are co-occurring phenomenon (Matson, Wilkins, & Ancona, 2008; Militerni, Bravaccio, Falco, Fico, & Palermo, 2002). These are not minor issues since these behaviors have traditionally been high priorities for intervention. Additionally, interventions may vary depending on how these behavior targets are conceptualized. Medications have seen a precipitous rise in use and are likely to continue to be seen as a mainstay intervention (Matson & Dempsey, 2008). Nonetheless, learning based procedures subsumed under the terms applied behavior analysis and behavior therapy have been a hallmark for treating rituals (Matson & Coe, 1992; Matson, Fee, Coe, & Smith, 1991; Matson, Smalls, Hampff, Smiroldo, & Anderson, 1998) and other challenging behaviors (Downs, Downs, & Rau, 2008; Love, Matson, & West, 1990; Matson, Benavidez, Compton, Paclawskyj, & Baglio, 1996). Additionally, a more recent trend is to see the individual as a whole person, where enhancing prosocial skill sets can offset or replace problem behaviors. A broad array of skills have been addressed in this regard such as working memory (Loomes, Rasmussen, Pei, Manji, & Andrew, 2008), attention to task (Oka & Miura, 2008), communication (Agaliotis & Kalyva, 2008; Lancioni et al., 2008; Naoi, Yokoyama, & Yamamoto, 2007), physical activity (Zimbelman, Paschal, Hawley, Molgaard, & St. Romain, 2007), social skills (Chung et al., 2007; Howard, Sparkman, Cohen, Green, & Stanislaw, 2005), academic tasks (Verdora & Stromer, 2007), and domestic skills (Goodson, Sigafoos, O'Reilly, Cannella, & Lancioni, 2007) among others. The purpose of this paper will be to review the available literature on behavioral interventions that are specific to compulsions, obsessions and rituals.

1. Compulsions, obsessions and rituals

A number of authors note that obsessions and compulsions are common in adults with high functioning autism (HFA) (Russell, Mataix-Cols, Anson, & Murphy, 2005). These writers also note that such behaviors are associated with significant levels of distress. Autism Spectrum Disorders (ASDs) has historically defined rituals and routines as "core features" of the disorders. Differential diagnosis of obsessive-compulsive disorder (OCD) from these core features can be daunting, and particularly likely to be present, for those persons with Asperger's Syndrome (AS) or HFA. Khouzam, El-Gabalawi, Pirwani, and Priest (2004) observe that while ASD and OCD share stereotyped patterns, persons with ASD have the added difficulties of impaired social interactions and restricted activities of interest (Matson et al., 1996a). Qualitative differences in the behaviors displayed are also evident. Zandt, Prior, and Kyrios (2007) found that children with OCD evinced more compulsions and obsessions than children with ASD. Age was a factor with sameness behaviors dissipating with age for the OCD group but not for the ASD children. Furthermore, repetitive, compulsive behaviors were less likely to change than other core features of autism such as communication and social skills (Fecteau, Mottron, Berthiamue, & Burack, 2003). In a study with adults, McDougle et al. (1995) compared groups evincing high rates of obsessive and compulsive behaviors, although they were qualitatively different. Individuals in the ASD group demonstrated more ordering, hoarding, and touching behaviors while the OCD group evinced more cleaning, checking and counting. Researchers have also observed that when ASD and ID co-occur, rates of these behaviors are at higher, more intense levels (Bodfish, Symons, Parker, & Lewis, 2000; Rojahn, Matson, Lott, Esbensen, & Smalls, 2001; Paclawskyj, Matson, Bamburg, & Baglio, 1997). Thus, the frequent dual relationship of these problems put the individual at even greater risk.

McNally and Calamari (1989) contend that obsessive-compulsive disorder is rare in persons with ID. They do report a case of a woman with mild ID who displayed obsessions about contamination, compulsive hand washing rituals and avoidance behaviors. Vitiello, Spreat, and Behar (1989) provide data to support this opinion. They tested 283 persons with mild to profound ID, and found that 3.5% evinced compulsive behaviors. However, in another prevalence study with person evincing ID, compulsions were reported to occur in 40% of the sample using Gedye's Compulsive Behavior Checklist (Bodfish et al., 1995).

Furthermore, various types of ID may result in different rates and presentations of obsessive, compulsive and ritualistic behaviors. State, Dykens, Rosner, Martin, and King (1999) found high rates