Eating Disorders and Co-Occurring OCD

Nicholas R. Farrell, Ph.D.
Campus Clinical Director – Oconomowoc, WI
Clinical Supervisor – Eating Disorders Services

ROGERS
Behavioral Health

Disclosures

Nicholas R. Farrell, Ph.D. receives royalties from Oxford University Press for his book *Exposure Therapy for Eating Disorders*. Aside from this financial relationship, he has declared that he does not, nor does his family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

Overview

- Description of key features of:
  - Obsessive-compulsive disorder (OCD)
  - Eating disorders
- Review of overlap between OCD and eating disorders
  - Co-occurrence
  - Overlap in key features
  - Maintaining factors
- Discussion of how exposure therapy can apply to both conditions

Case Examples

Example 1: Nathan

- 24-year-old male graduate student
- Extreme preoccupation with lean, athletic physique
- Fearful of weight gain → significant undereating, daily self-weighing, and excessive exercising
- Also worries that he will become “lazy” and “let himself go” physically, resulting in premature death
- Has rigid exercise routine with specific number of activities that must be done

Case Examples

Example 2: Elizabeth

- 19-year-old female college student
- Very focused on high achievement throughout childhood
- Became “obsessed with thinness” as an adolescent
- Withholding food from herself as well as self-induced vomiting
- Concerns with extreme perfectionistic tendencies
- Frequent ordering & arranging belongings and tidying apartment
- Repeated checking homework and emails for possible errors

Case Examples

Example 3: Bill

- 51-year-old divorced male, working as an accountant
- Persistent binge eating episodes that he feels powerless to prevent
- Extremely self-conscious of larger body size and avoidant of many activities due to fears of being judged others
- Experiences unwanted thoughts/impulses of blurting out obscenities when speaking with others
- Pauses when speaking and uses mental “diversions” to keep himself from blurting obscenities
- Often seeks reassurance about whether he offended others

Case Examples

Example 4: Judith

- 30-year-old female living alone, working at daycare
- Intense fears of vomiting → eats very limited range of foods
- Often uses supplements to meet her nutritional needs
- Frequent handwashing and cleaning to prevent illness
- Experiences unwanted mental images of sexually molesting children
- Significant patterns of avoidance at work (e.g., refusing to change diapers)
- On leave of absence due to impairment in functioning

Case Examples

- All 4 people experiencing significant symptoms of eating disorders and OCD
- Different fears and behaviors, but similar underlying themes
  - Preoccupation with feared outcomes
  - High levels of anxiety and distress
  - Repetitive behaviors used to prevent feared outcomes
  - Avoidance of situations that cause anxiety

Key Features of OCD

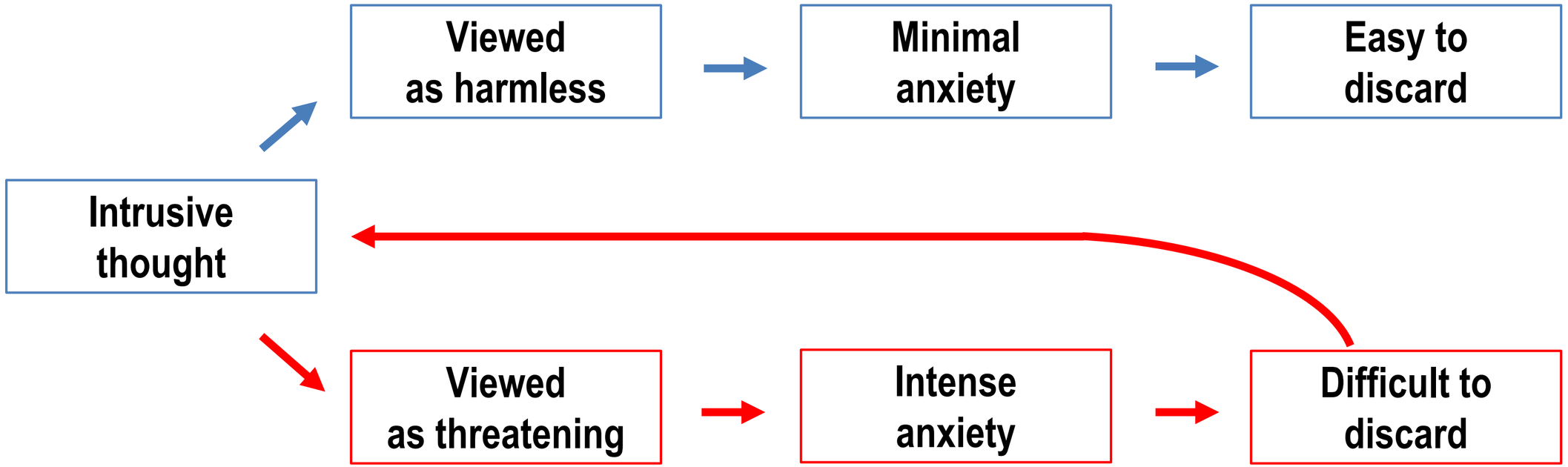
Obsessions

- Intrusive, unwanted mental experiences (e.g., thoughts, images, impulses, etc.)
- Trigger intense emotions
  - Fear/anxiety
  - Disgust
  - Doubt
- In many cases, individual recognizes these thoughts do not make sense and/or are inconsistent with how they view themselves
- Some experience of these intrusive thoughts is normative

Key Features of OCD

Obsessions

- If intrusive thoughts are normal, how do they become obsessions?



Key Features of OCD

Compulsions (also known as “safety behaviors”)

- Repetitive behaviors or mental acts used to address perceived threat posed by obsessions
- Often very time-consuming and get in the way of important, valued life activities
- Individual feels they must engage in compulsions because:
  - they temporarily reduce anxiety
  - they seem to prevent significant negative consequences

Common Pairings of Obsessions & Compulsions

Obsessions		Compulsions
Contact with bodily fluids, germs, and other contaminants	→	Repetitive handwashing, bathing, cleaning, and avoidance of contact
Unwanted thoughts of being responsible for catastrophes	→	Excessive checking to ensure no harm was or will be done
Need for things to be ordered, arranged, or “feel” a certain way	→	Ordering, fixing, straightening, or repeating things until “just right”
Personally unacceptable thoughts of “taboo” sexual or religious themes	→	Mental acts (e.g., praying, “undoing”) to neutralize unwanted thoughts

What is not OCD?

- Obsessions in the more “typical” sense – fixation of thoughts or interests on a particular idea, desire, or fascination
  - Video games
  - Sports
  - Celebrities
  - Stalking
  - Mass shootings

What is not OCD?

- “Compulsive” behaviors that are better described as problems with controlling impulses
  - Lying
  - Gambling
  - Excessive shopping
  - Pornography use
  - Substance use

What is not OCD?

- A wide variety of “quirks” that do not cause significant problems in an individual’s functional ability
  - Insisting on setting the alarm clock for an “even” time
  - Checking texts for spelling mistakes before sending
  - Holding breath when driving past a cemetery
- A synonym for “clean freak” or similar description
- Abnormally narrow range of interests, as often seen in autism spectrum disorder

Co-occurrence of OCD and Eating Disorders

- Among individuals with eating disorders, over 25% also met criteria for OCD (Kaye, Bulik, Thornton, Barbarich, & Masters, 2004)
- Other studies suggest higher rates (e.g., 37%) (Thiel, Broocks, Ohlmeier, Jacoby, & Schüssler, 1995)
- Females with OCD are 16 times more likely to meet criteria for an eating disorder; this risk is more than double in males (Cederlöf et al., 2015)
- In most cases, OCD is present for years before eating disorder begins (Kaye et al. 2004)
- After successful eating disorder treatment, OCD symptoms often persist if not addressed (von Ranson, Kaye, Weltzin, Rao, & Matsunaga, 1999)

Overlap between OCD and Eating Disorders

Shared features (Garcia-Soriano, Roncero, Perpiñá, & Belloch, 2014; Steinglass et al., 2014)

- Obsessional thoughts (i.e., preoccupations) that evoke fear
- Common themes in thinking style
  - Overestimating likelihood of catastrophes
  - Overestimating severity of mishaps
  - Magical beliefs
- Attention is often biased (i.e., directed toward threat cues)

Overlap between OCD and Eating Disorders

Shared features (Garcia-Soriano, Roncero, Perpiñá, & Belloch, 2014; Steinglass et al., 2014)

- Avoidance of scenarios that cause anxiety
  - Touching objects/surfaces that other people have handled
  - Using appliances for fear of being responsible for housefire
  - Attending church for fear of experiencing sacrilegious thoughts
- Compulsive “safety behaviors” aimed at:
  - Reducing anxiety
  - Preventing feared outcome(s)

Overlap between OCD and Eating Disorders

Obsessional thoughts that cause anxiety

- OCD
  - The thought of harming loved ones
- Eating disorders
  - The thought of becoming overweight

Overlap between OCD and Eating Disorders

Overestimating likelihood of catastrophes

- OCD
  - “*I will contract a fatal illness from sitting on a public toilet seat.”*
- Eating disorders
  - “*I will choke on any solid foods and suffocate.”*

Overlap between OCD and Eating Disorders

Overestimating severity of mishaps

- OCD
  - “*It would be unbearable to get anything less than 100% on this exam.”*
- Eating disorders
  - “*It would be unbearable if I felt really full and bloated after eating pizza.”*

Overlap between OCD and Eating Disorders

Magical beliefs

- OCD
  - "*If I have a thought about blurting out an ethnic slur, it means that I will do it.*"

    (Thought-action fusion)
- Eating disorders
  - "*If I have a thought about eating a high-calorie food, it will make me gain weight.*"

    (Thought-shape fusion)

Overlap between OCD and Eating Disorders

Attention directed toward threat cues

- OCD
  - Attending to objects/surfaces that other people have touched
- Eating disorders
  - Attending to mild sensations of nausea after eating a meal

Overlap between OCD and Eating Disorders

Avoidance of scenarios that cause anxiety

- OCD
  - Avoidance of being close to children (e.g., changing diapers)
- Eating disorders
  - Avoidance of wearing clothing that “reveals” body size/shape

Overlap between OCD and Eating Disorders

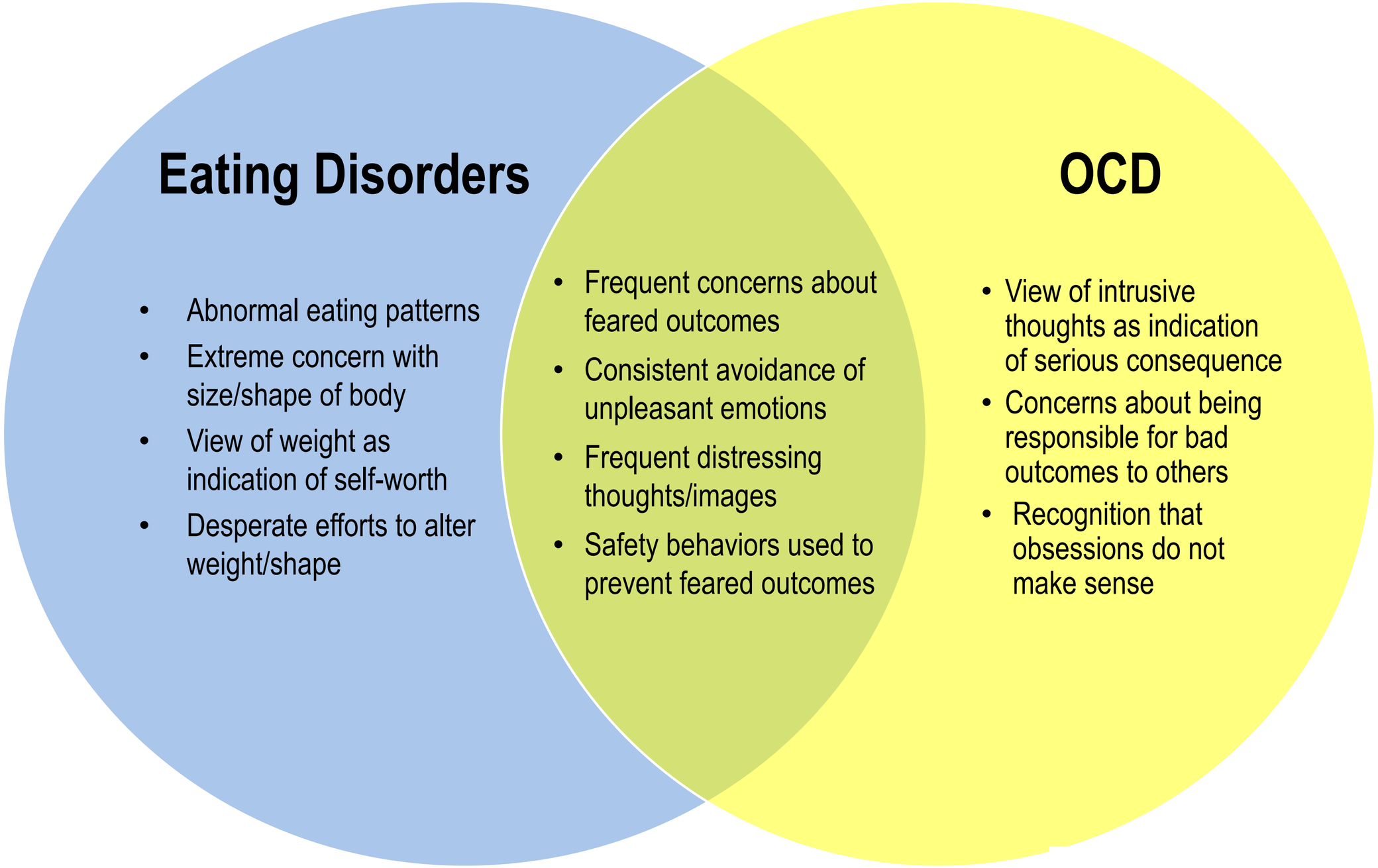
Compulsive “safety behaviors”

- OCD
  - Repeatedly checking intersections to make sure one did not run over pedestrians
- Eating disorders
  - Repeatedly chewing food into very small pieces before swallowing to prevent choking

Overlap between OCD and Eating Disorders

Other areas of overlap

- Similar to relationship between obsessions and compulsions, eating disorder thoughts:
  - cause anxiety
  - are often followed by safety behaviors (Levinson et al., 2018)
- Many eating disorder behaviors have strong OCD quality
  - Handwashing/cleaning excessively to remove calories from hands
  - Repeatedly checking nutritional information on food labels
  - Rigid exercise routines that need to be completed to burn calories


Eating Disorders
Abnormal eating patterns
Extreme concern with size/shape of body
View of weight as indication of self-worth
Desperate efforts to alter weight/shape
Frequent concerns about feared outcomes
Consistent avoidance of unpleasant emotions
Frequent distressing thoughts/images
Safety behaviors used to prevent feared outcomes
OCD
View of intrusive thoughts as indication of serious consequence
Concerns about being responsible for bad outcomes to others
Recognition that obsessions do not make sense

Maintenance of OCD and Eating Disorders

- Preoccupation with feared outcomes:
  - Increases attention toward threat cues
  - Leads to views of safe situations as genuinely threatening
  - Causes high levels of anxiety
- Safety behaviors used to prevent feared outcomes
  - Reduction of fear is relieving = more likely to use in future
  - Prevents opportunity to learn that feared outcome does not occur
  - Non-occurrence of feared outcome attributed to safety behaviors
  - Prevents opportunity to develop improved tolerance of anxiety

Preoccupation with Feared Outcomes

"Thinking about hurting kids must mean I'll do it."

Increased Attention Toward Threat

Attention drawn toward kid-related stimuli

Fear Expectation

"If I get close to these kids, I'll harm them."

Excessive Anxiety

Heart racing, breathlessness, trembling

Avoidance and/or Safety Behaviors

Walk away from kids, use mental "chant"

Preoccupation with Feared Outcomes

"If I feel full, I will gain weight uncontrollably."

Increased Attention Toward Threat

Attention drawn toward fullness sensations

Fear Expectation

"Feeling this full means I'm gaining a ton."

Excessive Anxiety

Nausea, overheating, chest tightness

Avoidance and/or Safety Behaviors

Checking weight, exercising, purging

Exposure Therapy

- What is it?
  - Gradually confront feared stimuli
  - Stopping use of safety behaviors
- Aims:
  - Reduce fear/anxiety
  - Develop more helpful beliefs about feared stimuli
  - Increase tolerance of distress
- Key component of cognitive behavioral therapy for anxiety disorders
- Highly effective strategy for treating OCD
- Has been effectively applied to eating disorders

Exposure Therapy

- Why does it work?
  - **Habituation** → anxiety decreases with increased exposure to feared scenarios
  - **Violation of Expectancies** → fears about negative outcomes are disconfirmed
  - **Self-Efficacy** → increased confidence in tolerating distressing emotions

Exposure Therapy: Treatment Steps

Functional assessment of symptoms

- Goal: develop an understanding of the OCD and/or eating disorder fears and how these fears are *maintained*
- What is assessed?
  - Fear cues (“*What causes you to become afraid?”*)
  - Feared consequences (*“What do you fear will happen?”*)
  - Safety behaviors and avoidance (“*What do you do to prevent it?”*)

Exposure Therapy: Treatment Steps

- Functional assessment (example)

Fear Cues	Feared Consequences	Safety/Avoidant Behaviors
Holding sharp objects around others	“I will lose control and stab someone.”	Avoid sharp objects Move away from others
Wearing a bathing suit at a beach or pool	“I won’t be able to handle being so embarrassed about my body.”	Covering up with large shirt Stay submerged in water
Taking normal-sized bites of food	“I will choke on the food and die.”	Eat slowly and take small bites Wash down each bite with water

Exposure Therapy: Treatment Steps

Development of exposure hierarchy

- *Exposure hierarchy* lists fear-evoking activities from least to most feared
- Subjective Units of Distress Scale (SUDS) → 0-100 scale used to rate fear intensity
- Creates a “roadmap” to address fears throughout treatment
- Individual does each hierarchy item repeatedly until:
  - fear reduces
  - individual can manage adaptively in the situation
- Goal of treatment is to complete all items on hierarchy

Exposure Therapy

Exposure tasks addressing common OCD concerns

- Contamination fears
  - Contact with common, “high traffic” objects (e.g., money, door handles)
  - Approaching “dirty” scenarios (e.g., use public restrooms)
- Fear of being responsible for harm to others
  - Use appliances without checking to be sure they were turned off
  - Hold sharp objects while near family members
- Need for symmetry/exactness/precision
  - Purposefully leaving belongings disorganized
  - Send emails with deliberate grammar errors/misspellings

Example Hierarchy – Contamination Fears

Exposure	Fear Rating (0-100)
Eat food after using restroom without washing hands	100
Touch dumpster lid, then rub hands on face	95
Run hands across the bottom of shoes before eating	85
Take out trash, then eat something without washing hands	70
Change baby’s diaper before touching clean clothing	60
Hold “dirty” dollar bill to face	55
Drop cell phone on high-traffic area of floor & pick up	45

Exposure Therapy

Exposure tasks addressing common eating disorder concerns

- Feared/avoided foods
  - Gradually include normal portions of feared foods into diet
  - Violating eating disorder “rules” (e.g., eat dessert in the morning)
- Body image disturbance
  - Prolonged exposure to body size/shape in mirror
  - Fear-evoking clothing (e.g., tank top) and activities (e.g., swimming)
- Recurrent binge eating
  - Confronting common binge scenarios (e.g., large quantity of rich foods)
  - Exposure to common emotional “cues” that precede binge episodes

Example Hierarchy – Fear of Eating Desserts

Exposure	Fear Rating (0-100)
Go out for ice cream with friends, eat full serving	100
Have a slice of apple pie after a family meal	95
Eat ice cream for dessert alone at home	85
Go out for gourmet cupcakes with a friend	70
Bake cookies with family and eat one cookie	60
Have a few bites of cake after dinner	55
Have one spoonful of ice cream after dinner	45

Exposure Therapy

Completing exposure tasks

- Begin with exposure at moderate fear rating in hierarchy
- Individual is encouraged to stay engaged in exposure activity without using any safety behaviors
- Therapist:
  - Provides consistent support/encouragement
  - Occasionally assesses SUDS (0-100) rating
  - Discourages use of safety behaviors or other avoidant strategies
- Individual is guided in doing exposures in variety of settings in order to generalize learning

Effectiveness of Exposure Therapy for OCD and Eating Disorders

- 56 individuals with OCD and eating disorder were treated in specialized residential program using exposure therapy
- Exposure was delivered concurrently for both conditions
- Eating disorder and OCD severity was assessed before and after treatment
- Results showed significant improvement in both domains as well as reduced depression severity
- Length of stay (~60 days) did not differ when compared to OCD-specific residential program (Simpson et al., 2013)

Summary

- Overlap between OCD and eating disorders
  - Frequent co-occurring
  - Many shared symptom features
    - Preoccupation with feared outcomes
    - Safety behaviors aimed at reducing anxiety and preventing feared outcomes
- Exposure therapy
  - Involves confronting feared scenarios and preventing safety behaviors
  - Demonstrates good treatment outcomes in both OCD and eating disorders

THANK YOU

ROGERS
Behavioral Health

Call or visit:

800-767-4411

rogersbh.org