Obsessed and Hungry: Understanding OCD and Eating Disorders

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November 9, 2018
Atlanta, GA

Agenda
- Overview of Obsessive Compulsive Disorder (OCD)
- Overview of Eating Disorders (EDs)
  - Anorexia Nervosa
  - Bulimia Nervosa
  - Binge-eating Disorder
  - Avoidant-Restrictive Food Intake Disorder (ARFID)
  - Untangling the diagnostic web of OCD and EDs
  - Treatment strategies
    - A combined approach
    - Practical strategies for managing OCD and EDs

DSM-V criteria for OCD

A. Obsessions
1. Recurrent thoughts, images, or impulses that are experienced as unwanted and intrusive at some point and that cause anxiety or distress
2. Attempts to suppress, ignore, or neutralize thought, image, or impulse and/or Compulsions
1. Physical or mental acts that the individual feels driven to perform or according to rigid rules
2. Aimed at preventing catastrophe or reducing anxiety, but not realistically connected to obsessions or are excessive

B. Symptoms cause distress, are time-consuming (>1 hr/d), or impair functioning

C. Not due to physiological effects of substance or medication.

D. Symptoms are not better accounted for by another disorder

! With good or fair insight: believes obsessions are definitely or probably not true
! With poor insight: believes obsessions are probably true
! With absent insight/delusional beliefs: completely convinced that obsessions are true

Common Obsessions
- Contamination fears
- Harm/aggressive obsessions
- Intrusive, unwanted violent/sexual thoughts
- Fear of acting on unwanted impulses
- Religious/moral concerns
- Magical thinking
- "Not-Just-Right" experiences
- Masochism
- Perfectionism
Common Compulsions

- Washing, cleaning
- Checking
- Tapping, touching
- Rereading/rewriting
- Counting
- Mental compulsions
  - Words, images, numbers repeated mentally to neutralize obsessions; replacing "bad" thoughts with "good" ones
  - Praying, counting, reviewing, list-making

Anorexia Nervosa

A. Low body weight in the context of age, sex, developmental trajectory, and physical health.
B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
C. Disturbances in the way one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Anorexia Nervosa (con’t)

- Mild: BMI ≥ 17 kg/m²
- Moderate: BMI 16–16.99 kg/m²
- Severe: BMI 15–15.99 kg/m²
- Extreme: BMI < 15 kg/m²
- Restricting type and binge-eating/purging type
- Lifetime prevalence: 0.9% female, 0.3% males (Hudson et al., 2007)
- 10:1 female to male ratio

Bulimia Nervosa

A. Recurrent episodes of binge eating characterized by both:
   - Large amount of food in 2-hour period
   - Feel lack of control (e.g., cannot stop what or how much one is eating).
B. Recurrent compensatory behaviors to prevent weight gain
   - Self-induced vomiting, excessive exercise, laxative abuse, etc.
C. Self-evaluation is unduly influenced by body shape and weight.

Bulimia Nervosa (con’t)

- Mild: An average of 1–3 episodes of compensatory behaviors per week.
- Moderate: An average of 4–7 episodes per week.
- Severe: An average of 8–13 episodes per week.
- Extreme: An average of 14 or more episodes per week.
- Lifetime prevalence: 1.5% females, 0.5% males (Hudson et al., 2007)
- 10:1 female to male ratio

Binge-Eating Disorder

A. Recurrent episodes of binge eating
B. The binge-eating episodes are associated with three (or more) of the following:
   - Eating much more rapidly than normal.
   - Eating large amounts of food when not feeling physically hungry.
   - Eating alone because of feeling embarrassed by how much one is eating.
   - Feeling disgusted with oneself, depressed, or very guilty afterward.
C. Marked distress regarding binge eating is present.
Binge-Eating Disorder (con’t)

- **Mild**: 1–3 binge-eating episodes per week.
- **Moderate**: 4–7 binge-eating episodes per week.
- **Severe**: 8–13 binge-eating episodes per week.
- **Extreme**: 14 or more binge-eating episodes per week.

Twelve-month prevalence among U.S. adults females and males is 1.6% and 0.8%, respectively (Hudson et al. 2007)

Avoidant-Restrictive Food Intake Disorder (ARFID)

- **Eating disturbance with**
  - Significant weight loss
  - Significant nutritional deficiency
  - Dependence on supplements
  - Impaired psychosocial functioning
- **Avoidance due to**
  - Sensory characteristics
  - Intensive consequences of eating

Food- and body-related OCD (ARFID?)

- Fear of choking or vomiting
- Fear of allergic reactions to foods
- Fear of ingesting contaminants through foods or drinks
- Excessive concern about digestion and defecation
- Religious or moral concerns about food

Obsessions and compulsions seen in EDs

- Ritualized behaviors before, during, and/or after meals
- Rigid schedules and plans for meals or exercise
- Excessive researching around food/nutrition
- Calorie counting for eating and/or exercise
- Feeling “compelled” to exercise or burn calories
- “Just right” experiences around purging (“completely empty”)
- Perfectionism
- Striving for perfect body, shape, or weight
- Exclusively eating “good” foods
- Criticizing “lazy” behaviors
- Striving for perfection in school, work, and relationships

Distinguishing OCD vs. ED

1. Feared consequences will illuminate root cause
   - Ask “What would happen if you didn’t (engage in ritual)?”
   - Fear of weight gain = ED
2. Thoughts about weight gain in EDs are not experienced as unwanted or intrusive
   - Obsessions in OCD are clearly felt as foreign, not part of a person’s identity (i.e., ego dystonic)
3. ED thoughts and behaviors are rarely seen as senseless (Mazure et al., 1994)
   - Insight is often present at some point in OCD

Distinguishing OCD vs. ED (con’t)

4. Consider the role of malnutrition
The Minnesota “Semi-Starvation Study” (Keys et al., 1950)
- 36 physically & psychologically robust men
- Average weight loss to below 75% IBW

Food is medicine!
- Obsessed with food
- Spent free time planning meals
- Researched food/hoarded cookbooks
- Ritualized eating habits
- Mood Swings
- Depressed & isolated
- Irritable
- Anxious
- Decreased sex drive
- Cognitive Changes
  - Decreased concentration
  - Decreased alertness
  - Poor judgment
  - “Cognitive dulling”
- Bingeing

Distinguishing OCD vs. ED (con’t)

4. Consider the role of malnutrition
   - May be the cause of ritualized behaviors, obsessive thoughts, and emotional liability
   - The DSM seems to be right!
   - Better nutrition may alter the OCD symptom picture, but may take months

Comorbidity by the numbers

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<tr>
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<th>AN-BN</th>
<th>AN-BP</th>
<th>BN</th>
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<tbody>
<tr>
<td>Lifetime prevalence</td>
<td>10-62%</td>
<td>10-66%</td>
<td>0-43%</td>
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<tr>
<td>Point prevalence</td>
<td>19-35%</td>
<td>29-44%</td>
<td>10-40%</td>
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(Godart et al., 2003; Kaye et al., 2004; Iacono et al., 2001)

Comorbidity in practice

- OCD typically predates the onset of ED (Thornton & Russell, 1997)
  - OCD as a risk-factor for developing an ED?
- Comorbid OCD is associated with a longer and more severe course of ED that starts at a younger age (Milos et al., 2002; de Zwaan et al., 1997)
- No general consensus on most common subtypes of OCD associated with ED
Treatment strategies

- Determining a primary focus
- Exposure and Response Prevention (ERP)
  - First-line treatment for OCD
  - A combined approach
- Practical strategies for handling comorbidity

Factors to consider when determining treatment targets

1. Risk and mortality
2. Distress and/or Impairment
   - Activities of daily living
3. Symptoms that will generalize to other symptoms
   - Topographical vs. functional similarities
4. Motivation
   - Pre-treatment vs. active treatment
   - Willing to give up old strategies?
   - Goals for recovery?

Exposure and Response Prevention (ERP) for OCD

- Prolonged exposure to obsessions with...
- strict prevention of anxiety-reducing rituals
- leads to NEW LEARNING
  1. Weaken habit of responding to obsessions with compulsions
  2. Repeated trials promote habituation to obsessions
     - Lower peak anxiety
  3. Disconfirm feared consequences
  4. Increase tolerance of uncertainty/doubt
  5. Increase mastery: feel more in control when you see you can “boss back” OCD

So what does good exposure look like?

Social anxiety - Low
Can ERP be applied to EDs?

1. Frequent, anxiety-provoking thoughts about weight gain or being “fat”.
2. Restricting, exercising, or purging to reduce anxiety
• Appear to fit O-C model
Managing OCD and EDs
- When in doubt, treat the ED due to high mortality
- Prioritize weight restoration (food is medicine!)
  - For low weight patients:
    - Agree to a “floor weight” below which the treatment focus will shift to refeeding
    - Prepare for emotional lability and potential cognitive difficulties
    - Exposure is activating
    - Prepare for increased ED urges
    - Search for functionally similar behaviors
      - Is there an OCD symptom that helps patients feel in control, similar to the way restricting does?
      - Perfectionism is a common bridge

The role of perfectionism
- A multidimensional concept
  - High standards of performance
  - Excessively critical evaluations of behavior
  - Concern over mistakes (Franco-Paredes et al., 2005)
  - Often a part of OCD rituals and sometimes the primary obsession...
- And...
  - A demonstrated risk factor that predates and exacerbates ED symptoms and remains intact after weight restoration in anorexia (Fairburn et al., 1999; Halmi et al., 2000; Kaye et al., 1998)

A combined approach (Simpson et al., 2013)
- ERP for OCD was effective, even in the presence of comorbid ED
  - Applied to ED:
    - Constructing meal plans with increasingly challenging foods
    - Exposures to avoided situations due to body image concerns
    - Eliminating rituals/avoidance around clothing
  - Improvement in ED
    - Lower pre-meal anxiety, but no increase in overall intake or reduction in body dissatisfaction
  - Caveat: Naturalistic study at residential program done in conjunction with other typical ED treatment components
Addressing perfectionism

- Perfectionism can be viewed as a personality trait and not a disorder
  - It’s both adaptive and maladaptive
  - The intentions are good, but behaviors sometimes “pay off” and sometimes “backfire”
- Goal = Conscientiousness
  - Matches perfectionism’s intentions with effective strategies to maximize adaptive outcomes
- Targeted areas of change
  - Increase awareness of pros and cons of current perfectionism
  - Analyze cost-benefit ratio of current behaviors
  - Explore the impact of perfectionism on goals and standards – consider client strengths and weaknesses
  - Sensitizing people to “mental habits” during evaluations
  - Turning failure into learning

Summary

- OCD and eating disorders frequently co-occur, especially within ED populations
- Prioritize target symptoms according to risk, distress, impairment, motivation, and then therapeutic “bang-for-the-buck”
- Using ERP for both OCD and ED content is a promising concurrent treatment option
  - Move gradually from easier to harder triggers (i.e., foods, environments, clothes, etc.)
  - Most attractive for treating ARFID
- For safety reasons, ED may take priority, especially if underweight
- Target shared underlying themes such as perfectionism

Thank You!

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