WHEN OCD BECOMES ED, OR… WHEN ED IS REALLY OCD

The Center for OCD & Anxiety
Pittsburgh, PA

Training Objectives

01. **Recognize OCD traits in ED patients**

02. **Differentiate between OCD & ED behaviors**

03. **Develop treatment strategies addressing both**

04. **Explore shifts in communication strategies to reinforce progress**

INTRODUCTION

Quick Stats

01. **Those with EDs have statistically higher rates of OCD (11%-69%)**

02. **Those with OCD have higher rates of ED (10%-17%)**

03. **64% of those with ED have at least 1 anxiety disorder, and 41% have OCD**

04. **There are many OCD researchers who have studied the overlap of symptoms**

05. **There are some OCD researchers who have argued that ED is within the OCD spectrum**

06. **There are some ED researchers that have studied the addition of ERP to ED treatment**

WAIT, WHAT?

That may have all sounded like gibberish. Let's lean into a brief diagnostic review to see what this all could mean for actual patients.

ED Differential Diagnosis

Anorexia Nervosa

Core Symptoms: Calorie restriction to significantly low body weight

Eating Behaviors: Calorie restriction due to fear of weight gain

Compensatory Behaviors: Potentially in the binge/purge subtype

Body Image Distress: Yes

Bulimia

Core Symptoms: Binging with compensatory behaviors

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Compensatory Behaviors: Yes

Body Image DIstress: Yes

Binge Eating

Core Symptoms: Binging

Eating Behaviors: Binge-restrict cycle, guilt & shame with binges, secrecy

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ARFID

Core Symptoms: Limited type of food consumed

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Compensatory Behaviors: No

Body Image Distress: No

PICA Rumination

Core Symptoms: Ingestion of non-nutritive and non-food items

Eating Behaviors: Eats both food and non-food items

Compensatory Behaviors: No, but may crave foods/items related to nutritional deficiencies

Body Image Distress: No

Orthorexia

Core Symptoms: Only able to eat “clean” or “pure” foods

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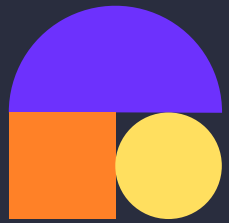
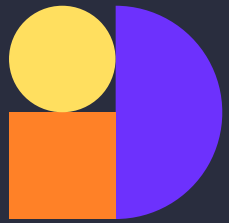
Obsessive Compulsive Disorder

DSM V placed OCD and related disorders into their own category, instead of bundling with anxiety disorders.



OBSESSIONS

Intrusive or unwanted thoughts, feelings, somatic experiences, or imagined circumstances that create doubt and uncertainty.



COMPULSIONS

Repetitive strategies utilized to neutralize or avoid the experience of the obsession; it can be a mental or physical act that creates a sense of certainty or control.

OR BOTH....

DSM says those with OCD can experience just obsessions or just compulsions.
Typically, we see clients experiencing both.

Relevant OCD Subtypes to EDs

Contamination
(fear of getting sick, generically or specifically)

- Wash self, other items until clean enough to eat
- Paying a lot of attention to ingredients
- Limiting consumption or needing someone to taste first

Symmetry
(just right or disgust symptoms)

- Need to even out bites while chewing
- Plates must be organized in specific ways
- Unable to eat unless looks or feels right/the same across bites

Intrusive Thoughts
(fear of harm to self or others, worries about choking, allergies, throwing up)

- May be unable to eat until a harm thought dissipates
- Cannot consume foods that may go against religious or moral beliefs
- May need to repeatedly check food items or preparation for safety

ED Symptoms Through an OCD Lens

Fear of Weight Gain

- Excessive meal planning rituals
- Repeated body checking or weighing in
- Engagement with compulsive exercise

"Bad" or Impure Foods

- Focus on numbers of calories that are "right/wrong"
- Restricted eating based on "rules"
- Compensatory behaviors to "void" foods

Loss of Control

- Rigid adherence to a set schedule, meal plan
- Checking and measuring body size
- Constant comparisons, reassurance seeking

Assessment and Screening Tools

Eating Disorder & OCD Assessments

Eating Disorder Examination Questionnaire (EDE-Q 6.0)

The following questions are concerned with the past four weeks (28 days) only. Please read each question carefully. Please answer all questions. Thank you.

Questions 1 to 12: Please select the appropriate response for each question. Remember that the questions only refer to the past four weeks (28 days).

On how many of the past 28 days...

	No days	1-5 days	6 -12 days	13-15 days	16-22 days	23-27 days	Every day
1. ...have you been deliberately trying to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?	○	○	○	○	○	○	○
2. ...have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your weight or shape?	○	○	○	○	○	○	○
3. ...have you tried to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	○	○	○	○	○	○	○
4. ...have you tried to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you have succeeded)?	○	○	○	○	○	○	○
5. ...have you had a definite desire to have an empty stomach with the aim of influencing your shape or weight?	○	○	○	○	○	○	○
6. ...have you had a definite desire to have a totally flat stomach?	○	○	○	○	○	○	○
7. ...has thinking about food, eating, or calories made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	○	○	○	○	○	○	○
8. ...has thinking about shape or weight made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading?	○	○	○	○	○	○	○
9. ...have you had a definite fear of losing control over eating?	○	○	○	○	○	○	○

Eating Disorder Examination Questionnaire

Semi-structured interview

28 questions about the last 28 days

5 Subscales: Restraint, Shape Concern, Weight Concern, Eating Concern and Global Scale

Yale Brown Obsessive Compulsive Scale

Clinician administered

Symptom checklist (not rated)

Measures (for O & C): Time Spent, Interference From, Distress Associated With, Resistance Against and Degree of Control Over

Diagnostic Overlap

Paying attention to client language and behaviors will go a LONG way towards getting an impactful understanding of symptoms.
Knowing which disorder is more predominant when both are present can help determine course of treatment.

	Eating Disorder	OCD	Both	
Control	E	E	S	ED controls intake; OCD controls via ritual
Compensatory Behaviors	E	D	M	When the ritual is done, it's done!
Preoccupation	E	E	S	ED focus is food, weight; OCD focus is fear
Body Image Distress	E	D	M	OCD has limited body Image distress
Egosyntonic	E	D	M	OCD is egodystonic; ED is egosyntonic

E Engages In

D Does Not Do

S Similar

M Mismatch

Shared Traits Between OCD & ED

Perfectionism

-Socially prescribed
-Self oriented
-Other oriented

Reassurance Seeking

-Repeated requests for confirmation or validation to manage fear, anxiety

Intolerance of Uncertainty

-Exhibit negative (emotional, cognitive or behavioral) reactions to uncertain events

Cognitive Rigidity

-Over reliance on rules
-Inflexible thinking
-Black and white perspectives

Core Fears

-Underlying fear that drives thoughts, feelings, behavior to avoid consequence

Differentiating OCD from ED

What is the motive of the client behaviors?

What is the client trying to accomplish?

What is the client trying to avoid?

What is the client fearful of?

Primary ED Treatment: Interventions for AN, BN, Binge Eating

Nutrition: Consults with nutritionist, dietitian, and/or medical providers; engaging in refeeding according to developed plans

Psychotherapy: Family Based Treatment, CBT, individual or group therapy to target cognitive aspects of ED

Medication Management: Target co-occurring disorders more than ED itself

A combination of the above is often required.

What is Family Based?

Family Based Treatment for Eating Disorders

-Very similar to Maudsley (used for adults). FBT is the most researched intervention for adolescents and while clients show no significant gains immediately after treatment compared to control groups, those who receive FBT have a 50% higher chance of being in remission at their 6-12 month follow up.

-Three components:

- -Phase I: Weight Restoration
- -Phase II: Returning Control
- -Phase III: Healthy Independence

-Focuses on symptoms reduction and elimination of ED behaviors during rapid weight restoration; parents are empowered as agents of change.

-Medical team is required to implement.

Where Family Based Works At the Start

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Primary OCD Treatment: Interventions for OCD and Related Disorders

Psychotherapy: Exposure with Response Prevention (evidence based); Inference Based Cognitive Behavioral Therapy; Inhibitory Learning Model; can be delivered in individual or group sessions

Medication Management: Typically SSRIs to reduce anxiety and increase engagement in therapy

A combination of the above is often required.

Where ERP May Work At the Start

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What is ERP?

Exposure with Response Prevention

-Depending on the study, 60-100% successful!

-Three components:

- -Exposure to a trigger for obsessional thoughts (something that initiates the experience of the obsession)
- -Ritual or Response Prevention
- -Habituation (waiting for the bad feeling to go away on its own; in the case of inhibitory learning, recognizing that you can tolerate the discomfort that is present even without completing the ritual)

-Gradual in nature; grounded in a fear ladder or hierarchy that is developed collaboratively

Building A Fear Ladder

Ways to Create Exposures

01. **Planned or Unplanned**

02. **Imaginal**

03. **In Vivo**

04. **Dynamic (Exposure to thoughts and feelings OR exposure to illusion of feared event)**

Ways to Create & Influence Response Prevention

Delay
Wait to complete the ritual

Walk Away
Conscious choice to avoid access to compulsion

Duration
How long are you spending with the trigger?

Limit
Only perform the ritual a certain number oftimes

Make Fun of It
Laughter is great medicine:)

Environment
Use people or spaces to scale up exposures.

Change
Switch the order

Proximity
How close are you to the trigger?

Interaction
How are you interacting with the trigger?

Integrating ERP into ED treatment

Step 1

Identify and target functionally overlapping behaviors (e.g. food related compulsions)

Step 2

Coordinate exposures across ED and OCD symptoms (e.g. fear of weight gain and contamination fears)

WHY?

-Avoids reinforcing one disorder while targeting the other and teaches families/loved ones how to avoid this pitfall as well!

What It May Look Like in Action

Targeting core fears and beliefs driving ED behaviors alongside the disruption of OCD rituals via ERP may lead to better treatment outcomes because symptoms are being addressed simultaneously.

Step One

Build rapport, provide psychoeducation on all diagnoses and assess for core fears (ED and OCD).

Step Two

Build ladders for OCD and ED fears.

Step Three

Conduct exposures (e.g. consumption of feared foods in varying amounts, touching "contaminated" items, challenging body image rituals).

Step Four

Work on relapse prevention and values-based motivation to continue to progress.

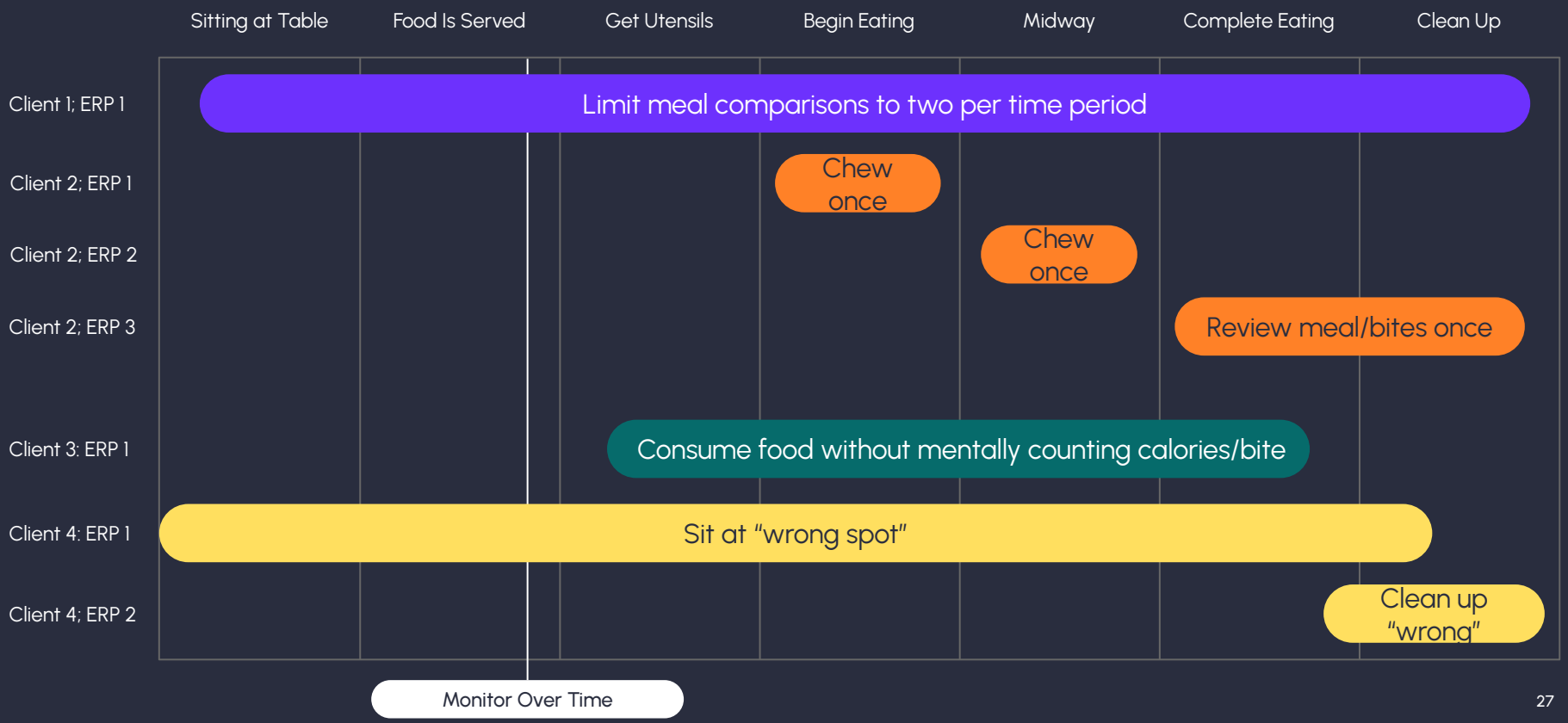
ERP in ED Treatment: Implementation

-Individually developed protocols/ladders to target nuanced OCD symptoms and ED core fears; completed independently, in individual treatment, or in a group setting

-May consider coordinating ERP with meals to target compulsive and ritualized behaviors related to eating process

-May need to discuss with nutritionist/dietitian/medical team to find foods that meet client needs but also generate less fear/disgust response for client as starting point

Meal Based Exposure Plan for Multiple Clients



Pacing Treatment for an ARFID Client

Adjuncts for OCD & ED: Therapy Interventions For Both

-Acceptance and Commitment Therapy: can help OCD clients engage in value driven ERP; may help ED clients identify values beyond appearance, eating which can lead to increased compliance with ED treatment

-Cognitive Remediation Therapy: Designed to increase cognitive flexibility and executive functioning (which can help reduce cognitive rigidity and intolerance of uncertainty)

-Dialectical Behavior Therapy: focus is often on building distress tolerance skills, mindfulness and emotion regulation skills; these skills can increase efficacy of ERP and ED treatment participation

CASE EXAMPLES

Sarah

Sarah avoids purchasing any foods high in fat content so she does not gain weight. She purchases only organic foods and has complex cleaning procedures for all groceries brought into her home–from a special rinse for all produce that is performed three times before items are put away to a complex system of cleaning herself and shelf stable items as well. Items are stored only in specific places to prevent contamination. Sarah pre-portions all meals and tracks calories. If she is "over" her calorie allotment, she makes sure to walk off four times as many calories as she was over "in case" she miscalculated more than she is aware of.

TREATMENT OUTLINE

CLARIFY DIAGNOSIS

OCD OR ED? OR SOMETHING ELSE?

-Weight loss?

-Orthorexia?

-Contamination rituals and compulsions?

-Just right?

EDUCATION

INCREASE CLIENT AWARENESS

-Provide summary of diagnostic clarity and introduce treatment models to client, noting how they will blend together.

-Explore core fears and core beliefs.

BUILD LADDERS

GENERATE TREATMENT PLAN

-Manage weight with refeeding if needed

-Create fear ladders for food placement, storage and cleaning

IMPLEMENT ERP

REFINE & MAXIMIZE ERP

-During meals, engage and call attention to what is "wrong" about food being consumed to target core fears and beliefs.

-Scale and refine ladders as needed.

MAINTENANCE

RELAPSE PREVENTION PLAN

-Emgae in ERP on their own in treatment, outside of treatment and practice scaling for "ERP lifestyle"

KEY REMINDERS

KEY LEARNING 1

Time and energy on diagnostic clarification will improve treatment outcomes

KEY LEARNING 2

Blending ED and OCD treatment means language shifts and change in focus during treatment

KEY LEARNING 3

Relapse prevention planning is focused on continued management of ED and facilitation of continued ERP to target OCD symptoms

Any questions? Ask away!

Thank you!