

Relationship of Eating Disorders to OCD

Fugen Neziroglu, Ph.D. and Anup Mani, OMS 11

Eating disorders are difficult to treat and in most cases, difficult to diagnose especially if it is superimposed with OCD or its spectrum. Eating disorders happen to be more prevalent (5-10 million people) within the United States than Alzheimer's (4 million) or mood disorders. In fact, 3% of all young women affected by eating disorders suffer from Anorexia Nervosa; 3-4% suffer from bulimia and 15% of the population are affected by some sort of eating disorder. Between 1988 to 1993, Bulimia in females aged 10-39 in this country has more than tripled. Currently, only 6% of the bulimic patients are being treated psychiatrically. Statistics have proven that eating disorders in fact have the highest rate of mortality comparable to any psychiatric disorder within the United States. According to an epidemiological study conducted by Stanford University in 1984, OCD spectrum disorders have a 0.8% -2% prevalence across the country. It is apparent that these disorders are on the rise and the fact is diagnosing each one is a difficult task. It takes a diligent clinician and a willing individual to realize the issue at hand and with the right tools, it may in fact be possible to spot risk factors and/or signs or symptoms of the disorder early on.

Eating disorders generally are indicative of extreme behavior which can be composed of either eating too much or too little, interlaced with certain extreme behaviors and/or cycles which can pose life threatening consequences if not dealt with immediately. Most eating disorders revolve around some psychological trigger or emotion which manifests itself during situations of stress and the person falls into an unfortunate vicious cycle of the stressor followed by a flaring of the disorder and then guilt. There are two primary eating disorders that affect women: bulimia nervosa and anorexia nervosa. An estimated 1 out of every 100 women are involved in purging, bingeing or severe dieting. In fact, 1 out of every 3 'dieters' develop compulsive dieting attitudes and behaviors. The rate at which individuals are starting these dieting attitudes and behaviors is occurring at alarmingly younger ages as well. A recent study conducted on female students aged between 9-15 indicated that over 50% of them dieted, exercised, or reduced food intake in order to lose weight. Men and boys are affected well and in another subcategory of eating disorders, binge eating disorder, are equally affected. In fact, current studies and prevalence studies have shown that between 5-10% of males are afflicted by any of the aforementioned eating disorders, however, due to guilt and shame, it is clearly underreported.

Bulimia Nervosa clinically presents with persons that consumes an abnormally large amount of food in a sitting and after the episode feels disgusted and sickened by the act. The amount of consumption is not as important as the subjective feeling of being out of control. They tend to feel helpless and a lack of control and as a result they will either purge or go through an exhaustive routine of exercise in order to feel 'ok' about their huge consumption of food. The excessive dieting and exercise will result in the person to once again gorge and then re-enter this cycle of purging, exercise and binge. Some individuals will not purge and are classified as non-purging bulimics, but these individuals resort to extreme dieting and fasting. Clinical signs can manifest if the illness is not diagnosed or misconstrued and they can include either or all of the following: chronically inflamed and sore throat, gastro-esophageal reflux disorder, decaying teeth, intestinal damage/irritation (usually as result of laxative abuse), and severe dehydration.

Anorexia Nervosa is a disorder that leaves the affected in a continuous state of denial about their weight, body image and the fear of gaining weight. With this condition, the person will unremittingly continue to not eat and become hazardously underweight. A number of co-morbidities including OCD and depression are

associated with the disorder and r physical signs include: osteopenia (thinning of bones), brittle nails and hair, yellowish skin tone, severe constipation, muscle fatigue/weakness, low blood pressure and lethargy.

In relation to Obsessive Compulsive Disorder, a common ailment and/or sign that is seen in both eating disorders and OCD is the obsession and ritualistic behaviors that tends to be cyclic and incapacitating to the patient. In anorexia nervosa, the afflicted individuals will have unusual methods of eating, dieting and exercising to satisfy their compulsive obsession to keep weight off. According to Thorton & Russell (1997), anorexic individuals are much more likely to have a predisposition to acquiring anorexia nervosa from pre-existing OCD and in fact, almost 37% of anorexic patients have OCD. According to Yaryura-Tobias the cerebral functioning and the primitive brain which contains the basal ganglia, is in particular, related to motor compulsive behaviors. Other psychiatric disorders which are related to this very area in the brain include hoarding, self mutilation etc. The true manifestation behind the compulsive ritualistic behaviors, tendencies and excessive thought processes are a result of a combination of higher cortical decision making melding with the primitive brain's compulsive motor movements.

With anorexia nervosa patients, their persistent dieting and compulsive exercise habits can qualify as an obsession which controls the individual's life and daily activities. A commonality between both these disorders includes social phobia, substance abuse and reclusive behavior. Both in OCD and anorexia nervosa patients have a constant thought process which does not allow them to stray too far away from their obsessive compulsion. In the case of an anorexia patient, he/she will constantly exercise and diet in order to lose weight. The constant practicing of unusual eating behaviors and incessant exercise can be paralleled to an OCD patient that is feels as if he/she is contaminated and must wash their hands 200 times in order to rid themselves of that contamination. It is safe to say that people afflicted with intrusive thoughts that cause them to wash their hands unremittingly and individuals that wish to lose weight when no weight problem exists indicates that both disorders demonstrate obsessions (obsessed with contamination or obsessed with weight, shape and food) and compulsions (hand-washing and compulsive exercising, dieting, cutting up food in small pieces, ordering arranging food, weighing of food etc.)

With Bulimia Nervosa patients, these individuals practice a constant cycle of binge eating-purging-exercising and this vicious cycle continues for years at a time until the patient is diagnosed or physiological factors of the body have deteriorated irreversibly. These individuals tend to eat disproportionate amount of food and then feel horrendous for eating so excessively. They will then purge and begin the cycle anew. The major driving factor in this disorder is the idea that these individuals cannot control their unequivocal food intake only to partake in a binge-purge compulsive habit. A study conducted by the Price Foundation Collaborative Group actually showed that OCD was in fact the most common co-morbid anxiety disorder in individuals with the specific eating disorder of Bulimia Nervosa as well as Anorexia Nervosa. The study also was able to show that the onset of the eating disorder was most likely post onset of the anxiety disorder. Therefore, any ritualistic tendencies and intrusive thoughts leading to compulsive behavior most likely was the precursor to the commonality in both anorexia nervosa and bulimia nervosa: the idea that the individual has a body image leading them to practice inexorable methods to keep off weight.

At times there is confusion over the diagnosis of OCD vs. an eating disorder because of how the behaviors are manifested. To illustrate, an individual with OCD who is so fearful of contamination may be constantly throwing out food after going grocery shopping, or having difficulty preparing food because of fear of mixing a cleaning product with the food, or not being able to move because they do not have the "just right" feeling and thereby losing weight excessively. On the other hand, an individual with an eating disorder may be so afraid of getting oil on any of their food and therefore gaining weight that they may go to excessive ritualistic behaviors, throw out food etc. and the appearance is that of an OCD contamination phobia.

Eating Disorders may also be related to OCD Spectrum Disorders. For example, Body dysmorphic disorder (BDD), a spectrum disorder is highly linked to the eating disorders. In both there is a distorted body image problem, an overemphasis of appearance and constant unremitting obsessions and compulsions centered around the body image. Hypochondriasis may also be involved when the eating disordered individual begins to develop some physical symptoms. Their may be an exaggerated preoccupation with the somatic symptoms.

Diagnosis, prevention and treatment of these disorders are still theoretical and are based on symptomatology of the disorder. Cognitive behavioral therapy along with antidepressant medication has shown better efficacy than just psychological treatment alone in bulimia nervosa. Anti-depressant efficacy is limited and not approved in patients with Anorexia Nervosa. Bulimia Nervosa patients attending group or CBT are more likely to continue with therapy if they are on the medication. Family therapy sessions have proven to be quite effective in aiding the patient's recovery. Parents who were involved in the treatment plan and diet/exercise control of the afflicted person brought out the faster and better recovery results. In addition, anorexia nervosa patients were also seen on an individual basis to help strengthen ego and confidence

Eating disorders in relationship to OCD is still in its infancy stages. The etiology behind both of these disorders still needs further investigation Nonetheless, diagnosis and mainstay treatment must be initiated immediately. The underlying manifesto of these disorders which ultimately links them is that compelling thoughts which continue to badger the person to the point where normal functionality is compromised.

Fugen Neziroglu, Ph.D. and Anup Mani, OMS 11
Bio-Behavioral Institute
Great Neck, NY 11021
www.biobehavioralinstitute.com