OCD and Eating Disorders: Untangling the Diagnostic Web

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It is estimated that 11-13% of individuals with OCD also struggle with an eating disorder. Aspects of both OCD and eating disorders are often misunderstood and mislabeled, leading to ineffective treatment. This article highlights factors that distinguish an eating disorder from OCD, as well as provide simple recommendations for individuals struggling with both of these disorders.

What is an eating disorder?
According to the DSM-IV (Diagnostic & Statistical Manual of Mental Disorders 4th Ed.), there are three types of eating disorders: anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified. People who suffer with anorexia have an extreme fear of gaining weight or being "fat" that typically leads them to severely restrict their food intake. They struggle to see their bodies in realistic ways, often demonstrating a distorted self-view where they see themselves as overweight even though they are significantly underweight. A core symptom of anorexia is a refusal to maintain normal body weight, which is defined as weighing less than 85% of a healthy weight (based on an individual's height and age). Unfortunately, people with anorexia also base their self-esteem and self-worth on their perception of their bodies, which is almost always critical, harsh, and devaluing.

Similar to those who struggle with anorexia, people who suffer with bulimia are very critical of their body and base their self-worth on this negative perception. This often leads to restrictive eating and overwhelming hunger, especially late in the day and at night. When hunger becomes unbearable or stress levels are high, bulimic individuals binge eat. A binge is defined as the consumption of an objectively large quantity of food in a short period of time. In an attempt to ward off weight gain due to bingeing, people with bulimia engage in purging behaviors, such as self-induced vomiting, laxative abuse, or unhealthy exercising. Ironically, this pattern often leads to weight gain, leaving people with bulimia near or above their healthy weight.

Those people who do not meet criteria for anorexia or bulimia, but still struggle with eating issues that impact their lives are considered to be struggling with "eating disorder not otherwise specified" (EDNOS). By far, the largest subset of people with this particular disorder suffers with binge-eating disorder which is characterized by repeated binge-eating without compensatory behaviors such as vomiting or exercising. However, EDNOS also includes those people who struggle with restricting, bingeing, weight loss, or purging that do not meet the level of severity required for a diagnosis of anorexia or bulimia.

According to a study by Hudson and colleagues in 2007, an estimated 0.9% of females and 0.3% of males will suffer with anorexia at some time in their life while an estimated 1.5% of females and 0.5% of males will struggle with bulimia. In contrast, 3.5% of females and 2% of males will struggle with binge-eating disorder.

The overlap of OCD and eating disorders: Obsessive-compulsive behavior in eating disorders
It is not uncommon for people with eating disorders to report that they suffer with OCD as well because of a variety of rigid beliefs and behaviors that plague them on a daily basis. People have described very specific routines for stretching and exercising that they feel compelled to carry out, even if they don't want to do so. Routines or rituals may occur before or after patients eat any meal. Ritualized behaviors may manifest in schedules, eating habits, portion sizes, or ways food is ingested. Some people excessively

count calories throughout the day and have specific numbers they try to meet or avoid which often leads to hours and hours spent researching the caloric value of various food items. People with eating disorders may comment on their drive to eat "the right foods," exercise in "the right way," achieve "the perfect body," or be at "the perfect weight." Those people that are knowledgeable about OCD describe their eating disorder in the language of OCD, reporting intrusive thoughts about weight gain, being fat, or being unfit that cause significant anxiety and resulting "compulsions" such as restricting, exercising, or vomiting that reduces such anxiety.

Although these reports appear to be OCD at first glance, the focus on food, weight, and body makes these symptoms better accounted for by the eating disorder diagnosis than an additional OCD diagnosis. This idea is supported by a classic study conducted by Keys and colleagues (1950) where 36 physically and psychologically healthy men, with no evidence of any eating disorder symptoms, developed near constant obsessional thoughts about food and highly ritualized behavior around meals after losing 25% of their body weight. These symptoms then improved after the men regained the weight. In my experience, I have found that compulsive behavior focused around preventing weight gain also decreases as people move through effective eating disorder treatment and get into recovery. In part, this is due to the fact that effective eating disorder treatment will interrupt these rituals and teach people new ways to manage their anxiety to replace these behaviors.

The overlap of OCD and eating disorders: Food-, body-, and eating-related OCD symptoms

It is not uncommon for people with OCD to have symptoms that interfere with their weight, eating, or activity level. In my work with OCD, I've seen people who are excessively fearful of choking on particular types of food or vomiting after eating foods with particular textures. Some people avoid mixing certain foods or limit the kinds of food they eat at particular times. OCD patients with contamination fears struggle to find foods that feel "clean" or "safe" to buy, store, touch, or eat. These OCD symptoms often lead to limited food choices and significant weight loss. Other people with OCD obsess about allergic reactions to certain foods or particular chemicals used to prepare food for storage and travel. Some have described excessive concern about how their body will process food and food waste. People can also have ritualized body movements that they feel compelled to do to ward off the risk of terrible harm to them or their family members. While these symptoms impact diet, nutrition, and food-related behaviors, the absence of a focus on weight gain, distorted body image, and a self-worth based on weight make these symptoms better accounted for by an OCD diagnosis.

Distinguishing between OCD and eating disorders can be a tricky task. A person with rigid beliefs, anxiety-provoking thoughts, highly ritualized behavior, and shifts in weight can describe a person with an eating disorder, a person with OCD, or a person with both. When someone suffers with both, it is often the case that a person develops OCD first, which has led some to question if OCD puts people at an increased risk for developing an eating disorder. People with both disorders have also been shown to have a more severe course of eating disorder that starts earlier and takes longer to respond to treatment.

Recommendations

Seek consultation with a knowledgeable mental health professional. Due to the obvious complexity in deciphering OCD and eating disorders, it is important to seek out help from someone who is well trained and experienced in working with both disorders. Since such specialists are often hard to find, I recommend that people meet with an eating disorders specialist for consultation or assessment and ask that this person be in touch with their existing OCD treater in order to help coordinate care and generate a plan to treat a person's symptoms in the most effective way possible.

Make a hierarchy of problems. Empirical research and clinical practice demonstrates little support for the idea that treating multiple disorders at once leads to faster or more significant improvement in the quality of a person's life. Instead, people that struggle with multiple disorders must make decisions about what problems will be the focus of treatment and what problems will be put on the back burner until later. My general rule about making such decisions with OCD and eating disorders is to focus on the problem that causes the most distress and interference on a daily basis. If a person has lost their job and isolated themselves from their friends and family due to severe contamination fears, then I'd treat the OCD first. However, if the same outcome resulted from avoiding time with friends due to nighttime binge-purge episodes that left them too tired to make it into work, I'd focus on the eating disorder. The exception to this rule that often arises is the need to prioritize eating disorder recovery due to acute medical complications (e.g., malnutrition, cardiac problems, electrolyte imbalances).

The case of equally severe OCD and eating disorder symptoms. When a person unfortunately suffers symptoms of both disorders that cause equally severe distress and impairment in daily living, I recommend that improvement in the eating disorder be prioritized for two main reasons. First and foremost, eating disorders are more dangerous than OCD. An estimated 10-20% of people with anorexia die from suicide or the medical complications of malnutrition, which is the highest mortality rate of any mental illness, including OCD, depression, psychosis, and substance abuse. People with bulimia are also at risk for serious cardiac events such as arrhythmias and dangerous electrolyte imbalances. Recall the highly publicized story of Terry Schiavo who spent the final 15 years of her life in a persistent vegetative state brought on by a serious cardiac event that was likely due to a long history of purging. Second, it has been my experience that helping a person get into stable recovery from a severe eating disorder often changes the quality and severity of their OCD symptoms. For those people who are severely malnourished, simply taking in proper nutrition can often shift the quality of their obsessional thinking and the rigid behavior patterns that follow. Because the greatest risk for relapse in eating disorders occurs between 6 and 12 months after discharge from a treatment program, I recommend that people seek out an OCD assessment after reaching this milestone to determine the appropriateness of OCD treatment.

Educate yourself. There are a variety of useful websites for people with eating disorders and their families that offer information and referrals for treatment. The National Eating Disorders Association website (www.nationaleatingdisorders.org) has a wealth of information for people with eating disorders and their families. Another resource is the Academy for Eating Disorders (www. aedweb.org), one of the premier resources for current research and training regarding eating disorders. You can also find a variety of informational and self-help books on eating disorders at nearly any internet or community bookstore.

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