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The Relationship Between Eating Disorders and OCD: Part of the Spectrum

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When people think of eating disorders they conjure up images of adolescents performing rituals around food and obsessing about what to eat, how much, whether the food will be easily digested or whether the food will sit in their stomachs and make them look ugly. Others think of individuals with eating disorders appearing very similar to those with body dysmorphic disorder, both being very preoccupied with their body image. However, most people do not think of eating disorders as being part of the OCD spectrum and the relationship between the two disorders has gone relatively unstudied. Even more troubling is the fact that, when patients seek help from mental health professionals in order to alleviate their suffering, clinicians may often mistake one for the other. In other words, since the behaviors that result from both OCD and eating disorders may appear so similar, it might be difficult to determine which of the two disorders the patient actually has if both are simultaneously present and, if so, which disorder is mainly responsible for bringing about the other.

Ever since 1939, researchers have speculated on the parallels between OCD and eating disorders. Numerous studies have now shown that those with eating disorders have statistically higher rates of OCD (11% - 69%) and vice versa (10% - 17%). As recently as 2004, Kaye et al. reported that 64% of individuals with eating disorders also possess at least one anxiety disorder, and 41% of these individuals have OCD in particular. In 1983, Yaryura-Tobias and Neziroglu proposed that eating disorders may be considered part of the OCD spectrum but since then the boundaries among anorexia nervosa, bulimia nervosa and OCD remain blurred.

Thus, the challenge for clinicians becomes recognizing whether the condition is a particular form of OCD or actually an entirely separate, but related, disorder with symptoms that merely have an obsessive-compulsive quality to them. More specifically, individuals who suffer from anorexia commonly diet and exercise excessively; those with bulimia usually develop a vicious cycle of binging and purging. In both instances, extreme and often life-threatening behaviors that consist of either consuming too little or too much food typically stem from intrusive, obsessive thoughts. Anorexics in particular exhibit faulty perceptions of body image, an irrational fear of gaining weight, and other food-related obsessions, thereby leading to the categorical refusal to eat. As for bulimics, their disorder is characterized by a consumption of abnormally large quantities of food, followed by overwhelming feelings of guilt and shame. In other words, the sense of helplessness or lack of control they experience during binge periods ultimately gives way to obsessions of physical sickness and self-disgust afterwards.

In the cases of both anorexia and bulimia, obsessions lead to levels of anxiety that can only be reduced by ritualistic compulsions. The compulsive behaviors of anorexics can often be seen in their careful procedures of selecting, buying, preparing, cooking, ornamenting, and eventually consuming food. Just as with OCD, compulsions are commonly strengthened by many other personality traits, such as uncertainty, meticulousness, rigidity, and perfectionism (Yaryura-Tobias et al., 2001). Anorexics also often exhibit overvalued ideation, cognitive distortions such as all-or-none thinking, and attempts to gain control of their environment. For bulimics, the need to feel relieved of the obsessive guilt and shame following binges causes them to compulsively purge the food they consumed, repeating the cycle over and over again. Here too, perfectionism, an excessive desire for social approval or acceptance, and bouts of anxiety or depression play a major role.

In both anorexia and bulimia, the individual clearly becomes preoccupied by incessant thoughts revolving around body image, weight gain, and food intake, leading to ritualistic methods of eating, dieting, and exercising. The common thread linking both of these disorders to OCD is the overwhelming presence of obsessions and compulsions that eventually affects the individual's daily functioning even to the extent of becoming incapacitated. Just as the OCD sufferer feels as though the door is not locked, despite evidence to the contrary, and is then compelled to check those locks hundreds of times in order to remove this doubt, so too the anorexic feels as though she is fat, despite the reality the mirror portrays, and she is thus forever checking her stomach to make sure that she has not gained weight but she is never satisfied and therefore she is compelled to lose weight by any means necessary. As with an OCD sufferer who can never achieve that "just right" feeling on a specific task, so too is a bulimic prevented from ever reaching his or her goals of fullness and emptiness in an endless binge-purge cycle.

Going one step further, there are many instances in which patients demonstrate behaviors that, at first glance, appear to be indicative of an eating disorder, but actually turn out to be a result of OCD. As an illustration, consider the OCD sufferer who may lose weight excessively and appear anorexic, yet is doing so merely as the result of contamination concerns or time-consuming rituals that prevent him or her from eating on a regular basis. Conversely, consider the anorexic patient who seems to be engaging in obsessive-compulsive rituals of cutting or weighing food, yet only doing so in the hopes of restricting food intake and losing weight in the process. The potential for one disorder to appear as the other is virtually endless; below is just a small list comparing the very different underlying causes of strikingly similar behaviors in individuals with obsessive-compulsive disorder versus those with eating disorders:

EATING DISORDERS	OBSESSIVE COMPULSIVE DISORDER
• Individual counts the number of mouthfuls chewed or pieces of food in a meal, according to some fixed or magical number that is "correct" or "just right" and thus effectively losing more	• Individual counts mouthfuls or pieces of food as a means of limiting portions and thus effectively losing more weight
• Individual repeatedly washes hands, due to a fear of germs, contact with waste products, or a number of other sources of possible contamination that exist	• Individual excessively washes hands to remove trace amounts of oil that might cause weight gain if ingested
• Individual throws out food in a can that has been lightly dented, for fear that it might contain food poisoning and later cause serious illness to person	• Individual throws out food in a can because it was discovered to contain poisoning and later too many calories upon reading label
• Individual repeatedly asks waiter in restaurant about different dishes on menu, doubtful that he or she has enough knowledge to make the perfect meal decision	• Individual constantly asks same waiter different dishes about contents of dishes, so as to stay enough knowledge to make the away from having any butter, oil, or fat
• Individual refuses to enter kitchen in order to eat due to fear of accidentally mixing cleaning items with the food	• Individual refuses to enter the same room, for it will only lead to the temptation to eat and thus get fat
• Individual repeatedly checks refrigerator, shelves or other parts of house, in order to make sure that every piece of food bought is in its proper, designated place	• Individual constantly checks same locations, in search of food to eat in an extensive bulimic binge period

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(Relationship Between Eating Disorder, continued)

Thus, in order to differentiate between the two disorders and make the proper diagnosis, it is crucial for the clinician to more closely examine the specific behaviors that are being observed and the motivations behind those behaviors. Whereas patients with eating disorders are primarily driven by concerns of physical appearance and consequently alter their eating patterns in order to lose weight accordingly, OCD patients may be restricting their eating for reasons very different than body image concerns. Furthermore, for cases in which an individual qualifies for both diagnoses, such as an anorexic or bulimic who also experiences non-food related OCD symptoms like checking or contamination, it is still imperative to consider whether or not their symptoms are being motivated by both disorders simultaneously. For example, consider a patient washing his/her groceries due to the fear of contamination, as well as the fear that the products may contain high fat ingredients.

It should be noted that the recommended psychological treatment for both OCD and eating disorders usually involves some combination of cognitive-behavioral therapy, antidepressant medication, and family counseling. Successful treatment for bulimics, in particular, often entails classic exposure and response prevention, in which patients are exposed to their favorite foods, asked to eat, and then prevented with careful monitoring from vomiting, using laxatives, or otherwise purging. Additional techniques involve gradual alteration of eating rituals and increased flexibility in eating behaviors, which may include breaking rituals such as the need to use the same utensils, to measure food, to time meals, and to avoid certain restaurants. Because eating disorders typically result in numerous medical complications, we strongly encourage physicians and nutritionists to be part of the team.

Significant advancements have recently been made in both the diagnosis and treatment of OCD and eating disorders as separate entities, but ample scientific research into the connection between the two, the commonality of their symptoms, and the possible biochemical similarities behind them is presently lacking. Fortunately, some of the most promising psychiatric investigations into the overlapping symptoms of spectrum disorders have focused on these neurophysiological similarities. One such study asked participants to engage in a task believed to activate the prefrontal cortex and caudate nucleus of the brain, so as to compare the performance of participants with OCD to that of those with anorexia. The study found that both groups had difficulty with the task and had higher cerebral glucose metabolism, suggesting a connection between the two disorders and offering evidence that "ritualized, obsessive and compulsive behavior (with reference to eating disorders as well as washing and checking OCD) could have its origin within common neurobiological abnormalities" (Murphy et al., 2004).

Although such results are clearly signs of progress, they are still indirect and speculative at best. More work is therefore needed in order to properly isolate the clinical symptoms, biochemical factors, and genetic causes behind OCD and eating disorders. In one of our studies, we found that obsessive-compulsive overeaters responded to exposure and response prevention, while another group of overeaters responded better to more traditional stimulus control methods of treatment (Mount & Neziroglu, 1991). This shows that those eating disorders that are similar to OCD may respond better to treatment strategies used to treat more typical OCD behaviors. Consequently, for the sake of all those who suffer, the obsessive-compulsive related disorders need to be studied further in order to enhance our understanding of their similarities and dissimilarities. In doing so, we will hopefully not only arrive at better treatment strategies, but also increase our knowledge of the psychological and biological mechanisms by which the disorders develop.

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