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Anxiety in the eating disorders: Understanding the overlap

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Abstract

This paper reviews research investigating the comorbidity between eating disorders and anxiety disorders. Whilst there is some inconsistency in the literature, it appears that women with eating disorders have higher rates of anxiety disorders than normal controls. Potential causal relationships between eating disorders and anxiety disorders are outlined, though their relative chronology appears to be somewhat inconsistent. Safety behaviours and cognitive avoidance strategies (i.e., cognitive narrowing and blocking) are suggested as potential mechanisms linking the disorders. A model outlining this hypothesised relationship is developed throughout the review. It is suggested that eating disorders and anxiety disorders might share common aetiological factors, and that these factors can increase an individual's susceptibility to either disorder. Potential implications for the treatment of eating disorders are outlined, and suggestions are made for further research.

Contents

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It is difficult to establish accurate prevalence rates for eating disorders, both due to variations in methods used for diagnosis and because much of the research has focused exclusively on the diagnoses of anorexia nervosa and bulimia nervosa. Hoek (1993, 2002) describes how two-stage surveys (using screening measures followed by strict diagnostic interviews) yield lower prevalence rates than earlier surveys based solely on questionnaires. On the basis on these methods, he suggests that the average point prevalence rates amongst females[1] are just 0.28% for anorexia nervosa and approximately 1.0% for bulimia nervosa. However, based on a range of epidemiological studies (including Hoek's, 1993 review), Fairburn and Harrison (2003) suggest slightly higher prevalence figures of 0.7% for anorexia nervosa, and 1–2% for bulimia nervosa. Indeed, these rates are relatively consistent with the American Psychiatric Association's prevalence estimates of 0.5–1% for anorexia nervosa, and 1–3% for bulimia nervosa (American Psychiatric Association, 1994).

Of course, none of these prevalence figures takes into account the diagnosis of 'eating disorder not otherwise specified' (EDNOS; DSM-IV, American Psychiatric Association, 1994), or the equivalent in ICD-10 of 'atypical eating disorders' (World Health Organisation, 1992). These disorders appear to be at least as common in clinical practice as anorexia nervosa and bulimia nervosa combined (Fairburn & Harrison, 2003; Fairburn & Walsh, 2002), and consequently Fairburn and Walsh (2002) suggest that current prevalence rates underestimate the true number of eating disorder cases. Indeed, Grilo (2002) cites evidence that binge eating disorder (one of the EDNOS disorders described in DSM-IV), has prevalence rates of around 2–3% in community samples.

Despite the lack of clarity regarding their prevalence, it is clear that an eating disorder can impact negatively on the sufferer's quality of life. Furthermore, eating disorders have been associated with a high rate of psychiatric comorbidity. For example, Braun, Sunday, and Halmi (1994) reported that 81.9% of their sample of women with eating disorders had at least one Axis I comorbidity, with depression, anxiety, and substance misuse being especially common. Moreover, 69% of this sample met criteria for at least one personality disorder. Since the presence of comorbidities is likely to complicate the formulation and treatment of eating disorders (O'Brien & Vincent, 2003), there is a clinical need to understand more about their prevalence.

Of particular interest in this review are the different manifestations of anxiety found to be comorbid with eating disorders. Although depression is the most frequently diagnosed comorbid disorder (e.g., Braun et al., 1994; Herzog, Keller, Sacks, Yeh, & Lavori, 1992), eating disorder patients have reported that anxiety and anger are more likely to drive binges than depression (Arnow, Kenardy, & Agras, 1992). In addition, anxiety has been associated with further disordered eating behaviours, including vomiting (Carter & Duncan, 1984), laxative abuse (Weltzin, Bulik, McConaha, & Kaye, 1995), and restriction (Chesler, 1995). Moreover, Weltzin et al. (1995) suggest that significant anxiety not

[1] Like the majority of eating disorders research, most prevalence studies are based on female samples, since only 5–10% of patients in clinical samples are male (Hoek, 1993, 2002). The female pronoun will therefore be used throughout this review to refer to those with eating disorders.