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Recommended Citation
Smith, Patricia, "The Interrelationship Between Alcoholism, Eating Disorders, Anxiety and Affective Disorders" (1987). All-College Writing Contest.
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THE INTERRELATIONSHIP BETWEEN ALCOHOLISM, EATING DISORDERS, ANXIETY AND AFFECTIVE DISORDERS

by
Patricia Smith

There is all too often a tendency to categorize and group alcoholics as a homogeneous group, thereby overlooking underlying psychological disorders which may share a common profile. Current research findings demonstrate that there are a number of illnesses whose symptoms and etiology overlap; to choose one to the exclusion of another may have profound treatment and relapse ramifications. Taken as a whole, these studies seem to suggest an interrelationship between alcoholism, eating disorders, anxiety, and affective disorders. Although there is a substantial amount of evidence in support of this relationship, the direction of the causality is of primary concern. The question researchers have been addressing is whether underlying clinical depression or anxiety precipitate substance (or food) abuse, or whether instead, depression and anxiety are merely the outward manifestations of these debilitating disorders. The results of these studies more often than not seem to suggest the former.

Anorexia nervosa and bulimia are often cited as the “diseases of the 1980’s.” Although it is thought that these eating disorders have most probably been around for thousands of years (as evidenced perhaps by the “binge eating and vomiting of the Romans,”) they have until recently been relatively uncommon; currently, however, they are taking on epidemic proportions. Although bulimia is about four times as common as anorexia nervosa, the latter seems to be better known to the public. Its victim is usually a young woman who develops an inexplicable fear of growing fat and begins to diet compulsively. Even when emaciated, she continues to see herself as overweight and cannot control her dieting. As many as 5%-50% of anorexics literally starve themselves to death. Bulimia, on the other hand, is characterized by compulsive binge eating and purging, and is accompanied by depression, anxiety and suicidal feelings. The typical bulimic is a thin, attractive, perfectly normal looking woman who is usually successful in her social and occupational life. Often her closest friends (or even husband and children) are completely unaware of her behavior. The binges have a compulsive, automatic quality to them: once they begin, they are unstoppable - the normal shut-off mechanisms of the brain do not seem to work. The binge often continues until some external force interrupts it: abdominal pain, sleep, social interruption or self-induced vomiting. An average binge continues for about one and one-half hours with consumption of approximately 3500 calories. Eight hour binges have also been reported where 11,000 calories are consumed in one sitting. Still others report as many as ten binges a day, of 5,000 calories each - the equivalent of one month’s food supply! The victim becomes obsessed with thoughts of food - 98% of every waking hour is spent preoccupied with calories, weight and
food. When all efforts to control herself fail and she begins binging, profound misery, self-loathing and hopelessness follow. As one woman so aptly described it, she found herself “caught in a nightmare that no ordinary person could imagine or understand” (Pope & Hudson, 1984, p.24). Depending on the population studied, between 10% to 50% of bulimics have a past or current history of anorexia nervosa. There is often a progression which leads from depression to anorexia nervosa, and then anorexia nervosa plus bulimia. The individual becomes depressed and concerned about weight, starts dieting and loses weight, but craves food and begins binging. After episodes of binging and fasting, she discovers diuretics and eventually vomiting.

After noting a greater than normal prevalence of certain psychiatric illnesses in their bulimic patients, Pope and Hudson (1984) performed detailed diagnostic evaluations for 74 of these patients. Results demonstrated that more than 80% of them had at least one (and many had several) of eight specific psychiatric disorders. The ailments found to occur more often in bulimic patients than in the population at large were: anorexia nervosa, major depression, bipolar disorder, alcohol abuse, panic disorder, agoraphobia, obsessive-compulsive disorder and kleptomania. With the exception of kleptomania, these disorders fall into the four basic families discussed earlier: eating disorders, substance abuse, affective disorders and anxiety disorders. Pope and Hudson (1984) proceeded to suggest that these illnesses are related not only to bulimia but to each other. “Many of them seem to run together in family trees, and individuals with one disorder seem to have a higher than average chance of developing one or more of the others during their lifetime” (Pope and Hudson, 1984, p. 65).

Bulimia may easily be viewed as a form of substance abuse, with food becoming the substance of choice. The impulse to consume (whether alcohol, drugs or food) overrides voluntary control, and the disorder becomes gradually more severe and frequently chronic. In the Pope and Hudson study (1984), one-quarter of the bulimic patients also suffered from alcohol abuse or dependence at some point in their lives. A recent college survey reported similar findings: 27% of women who were treated for bulimia were reported to abuse alcohol and drugs as well (Pyle, et al, 1983). Just as a drink can set off a binge in an alcoholic, the same is true for the taste of food to the bulimic. Besides the loss of control over the substance, there are other characteristics of all bulimia patients which are commonly found among other substance abusers: “...preoccupation with the substance, use of the substance to cope with stress or negative feelings, a tendency to remain secretive regarding the behavior...the maintenance of the addictive behavior despite negative social consequences (isolation), possible legal consequences (shopping for food and forging checks to support the addiction), and occupational consequences (missing work)” (Hatsukami, Owen, Pyle, and Mitchell, 1982, p. 435). Other studies have also shown a high prevalence of alcohol abuse among individuals with bulimia and their first-degree relatives (Mitchell, Hatsukami, Eckert and Pyle, 1985; Pyle, Mitchell & Eckert, 1981; Strober, 1981;) Brisman and Siegel (1984) demonstrated that a significant number of bulimics and/or alcoholics report a crossover in addictions.

Research by Henzel (1984) uses a smaller sample of subjects to investigate the relationship between alcoholism and anorexia. Results are very similar to the bulimia findings: 33%
of anorexic patients scored “likely” candidates for alcoholism (while 27% scored “uncertain”). Sixty-seven per cent of the subjects reported alcoholism and depression among relatives, and forty per cent reported suicidal attempts. Henzel speculates that perhaps “anorexia nervosa can be (considered) an addictive process with some anorexics developing more than one addiction” (Henzel, 1984, p.465).

Hatsukami, et al. (1982) investigated the similarities and differences between women with bulimia and women with alcohol or drug abuse problems using the Minnesota Multiphasic Personality Inventory (MMPI) and the MacAndrew Alcoholism Scale (MAC). Results demonstrated that the two groups shared similar mean MMPI profiles and predominant codetypes. These profiles were characterized by elevations in scales relating to depression, impulsivity, anger, rebelliousness, anxiety, rumination, social withdrawal, and idiosyncratic thinking. It might also be worth noting that 36% of the original bulimic group were excluded because they indicated problems with alcohol or drugs, in fact, 20% had actually entered treatment for chemical abuse.

The relationship between alcoholism and food abuse also appears in clinical findings reported by the Adult Mental Illness Service in North Wales, who document twenty-seven cases where either eating disorders had been followed by alcoholism or where alcoholic patients had previously experienced episodes of eating disorders (Jones, Cheshire and Moorhouse, 1985). Approximately one quarter of the sample studied had an alcoholic parent, and depression was a serious problem in all but three of the 27 cases (10 had a firm history of suicide, and 14 others had been treated for clinical depression). These authors concluded that patients with eating disorders present a particularly hazardous group; both clinical experience and research suggest a “close and intimate relationship between anorexia, bulimia, eating disorders generally, and alcohol abuse” (Jones et al., 1985, p.379).

Major affective disorder is the single most common psychiatric disorder seen in bulimic patients (Pope & Hudson, 1984). Various studies have shown that up to 75% of bulimics also suffer major depression (Hatsukami, Mitchell and Eckert, 1984; Pope & Hudson, 1984). Although it might seem natural to conclude that the uncontrollable binges which leave misery, guilt, and feelings of worthlessness in their wake are the obvious causal agents, studies suggest that depressive illness may be the precipitating agent (Hatsukami, et al., 1984; Pope & Hudson, 1984). Since the onset of the disorder is an important factor in determining causality, Pope and Hudson researched this question in their study. They found that, in their sample, the depression began more than a year before the bulimia. Familial incidence was also discovered to be quite common: 52% of bulimic patients had at least one first degree relative with bipolar illness or major depression. Counting second degree relatives would, of course, raise this percentage. Yet another indication that this depression may have a genetic base and therefore be the underlying culprit arises from the fact that bulimic patients tend to experience endogenous rather than reactive depression (Pope and Hudson, 1984). While a reactive depression develops as a consequence of a specific situation or circumstance, endogenous depression is believed to arise from a biochemical abnormality in the brain. Although the exact nature of this brain abnormality is not known, it is accepted that it is an inherited condition. Two thirds of Pope’s bulimic patients had experienced at least one episode of what appeared to be endogenous, or major, depression. Other studies concur with
these findings, reporting a high prevalence of depressive symptoms among bulimic patients and their first degree relatives (Hatsukami, et al., 1984).

A recent study was conducted to comprehensively examine the occurrence of affective disorder and alcohol abuse among women with bulimia (Hatsukami, et al., 1984). Results demonstrated that, of 108 women with bulimia, 43.5% had a history of affective disorder, 18.5% had a history of alcohol or drug abuse, and 56% scored within the moderate to severe range of depression on the Beck Depression Inventory. Similar, although smaller, studies have reported even higher prevalences of affective disorder in bulimics: 6 out of 10 (Gwirtsman, Roy-Byrne and Yager, 1983), 10 out of 19 (Pope, Hudson & Jonas, 1983). Not only are symptoms of major depression common in patients with anorexia nervosa, but major affective disorder has also been found to be the most prevalent psychiatric disorder in their relatives (Gershon, et al., 1984). This has led some researchers to conclude that there might be genetic factors shared between anorexia nervosa and affective disorder (Hatsukami, Mitchell and Eckert, 1984).

The relationship between alcoholism and affective disorders has also been investigated by studies which demonstrate their link (Sherfey, 1955; Winokur and Clayton, 1967; Mayfield and Coleman, 1968; Schuckit and Morrissey, 1976; Liskow, 1982, as cited in Lex). History of affective illness or intercurrent clinical depression has frequently been found in association with alcohol problems. It has also been observed that “among women, affective disorders and alcoholism often appear to be related illnesses, close relatives are more likely to be diagnosed as affective disorder alcoholics, and primary depression is more likely to occur antecedent to alcohol problems (Pitts and Winokur, 1966; Winokur and Clayton, 1968; Schuckit, 1983)” (Lex).

Although it is a generally accepted fact that anxiety may be an underlying cause of excessive eating or drinking, current research is more clearly focusing on clinically diagnosed anxiety disorders and their relationship to both alcoholism and bulimia, with the question of causality also being addressed. Within the DSM-III, the larger category of “anxiety disorders” is broken down into subgroups which include panic disorder, agoraphobia, and obsessive-compulsive disorder. (These constitute three of the eight specific bulimia-associated diseases that Pope and Hudson speak of). In the latter, the bulimic’s uncontrollable obsessions and compulsions are seen to spill over into yet other areas of life, “leaving her dominated by obsessive thoughts and compulsive rituals beyond those which concern food and weight” (Pope and Hudson, 1984, p.60).

Severe panic disorder has been called “one of the most distressing afflictions known to humans” (Hudson and Perkins, 1984, p.462). This syndrome of spontaneous panic attacks is characterized by the sudden onset of severe anxiety and fear which usually strikes the person with no warning. The accompanying physical symptoms include heart palpitations, sweating, hyperventilating, light-headedness and an overall feeling of doom. Agoraphobia is the most extreme instance of panic disorder; dominated by the fear of attacks, the patient restricts all life situations, to the point of eventually refusing to leave home. The individual is dominated by a fear of being in crowds or even out of doors, away from the safety of home. Agoraphobia may also develop without being precipitated by panic attacks; increasing anxiety is experienced in public situations particularly ones in which there is no easy escape.
Interestingly, Pope and Hudson (1984) mention that the first case of bulimia ever described in medical literature was a woman whose bulimia was accompanied by agoraphobia. Like bulimia, this disorder often goes undiagnosed because people are simply unaware that it is an illness.

The prevalence of phobias among alcoholics had been documented by Mullaney and Tripett (1979). Out of 102 in-patient alcoholics completing the Fear Survey Schedule, Survey of Social Inadequacy, and the Symptom Check List-90, one-third were found to be fully phobic (i.e., had debilitating agoraphobia or social phobia), while another one third were borderline phobic. Many of the subjects reported the onset of anxiety prior to the onset of regular drinking. This study empirically supported earlier observations that some patients with phobic anxiety syndromes drink in order to obtain relief from anxiety.

The findings of a recent study by Weiss and Rosenberg (1985) concur with the Mullaney and Tripett report. In the Weiss study, 84 subjects were drawn from three hospitals where they had been admitted for alcohol detoxification. They were then rated for anxiety, using the Structured Clinical Interview for DSM-III (SCID). The prevalence of anxiety disorders among alcoholics was 22.6%, much higher than the 2%-4% to be expected for the general population. In looking at the question of causality, it was discovered that in two thirds of the anxious patients, the alcoholism reportedly developed after the anxiety disorder. The authors’ conclusion here was that although “undoubtedly alcoholism will be found to be both a cause and consequence of anxiety” (which they expect to hold true of other substance abuses as well), they are in agreement with Mullaney and Tripett who stressed the importance of screening all alcoholics for phobic disorders (Weiss & Rosenberg, 1985). Hudson and Perkins (1984) concur in these sentiments. They present four cases of panic disorder in which the diagnosis was delayed or obscured by alcoholism. Since tricyclic antidepressants have proven to be effective in the treatment of anxiety disorders, diagnosis is of utmost importance.

Another study replicating the findings of Mullaney and Tripett found approximately 25% of alcoholic patients to be suffering from agoraphobia and social and mixed phobias. Additionally, 44% were diagnosed as suffering from anxiety disorders and 46% had suffered from an episode of major depression (Bowen et al., 1985, p.50). “Data from the self-rating questionnaire were consistent with the diagnostic data. The alcoholics with phobias had experienced more severe dysphoric feelings than nonphobic alcoholics with other psychiatric disorders” (Bowen et al., 1985, p.50). The authors here contend that they are diagnosing legitimate psychiatric illness rather than simple fears.

The research findings addressed herein all seem to point to an interrelationship between major affective disorder, anxiety disorder, eating disorders and certain cases of substance abuse (alcohol and stimulants). They run in family trees, and individuals with one disorder appear to have a higher than average chance of developing one or more of the others during their lifetime (Pope et al., p. 65). Pope and Hudson suggest the possibility of an underlying biological abnormality which might produce or predispose an individual to one or more of these ailments. This does not mean to suggest that all cases of alcoholism (or any of the other disorders) are part of the same condition; however, given the hereditary and symptomatic similarities, it seems plausible that this may be true in many cases. Although more
research is needed to untangle the complications of such a theory, the treatment implications it suggests may prove useful in the interim as a means of easing or alleviating the debilitating symptoms experienced by these patients.

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