Original Article

Disturbed Eating Attitudes in Obsessive Compulsive Disorder Patients and Its Effect on Quality of Life

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ABSTRACT

Background: Both obsessive-compulsive disorder (OCD) and eating disorders are severe behavioral disorders that have a significant negative social, psychological and physical influence. The present work is designed to identify the disturbance in eating attitude for better management in the future. **Methods:** This comparative case-control study was conducted at the psychiatric department, encompassing both the outpatient clinic and the inpatient ward, located within Zagazig University Hospitals in Sharkia, Egypt. The study involved 80 cases diagnosed with OCD respecting DSM-IV criteria. An evaluation was performed to estimate the quality of life (QoL) and OCD severity among OCD cases, comparing those with and without changes in eating attitudes. **Results:** There was substantial variance between the groups respecting total EAT-40 scores. There was a statistically remarkable relation between eating attitude and OCD severity, quality-of-life domain score and total QoL scores. Sexual, doubt and contamination were significantly associated with high EAT-40 scores. All patients with abnormally high EAT-40 scores had poor QoL versus 50% of those with low scores. **Conclusion:** Individuals with OCD exhibited significantly lower QoL scores, particularly among those with elevated disturbed eating attitude scores, highlighting the pervasive impact of OCD symptoms on overall well-being. These findings underscore the importance of comprehensive evaluation and tailored interventions addressing both OCD symptoms and associated Disturbed eating attitudes to improve the QoL of individuals affected by OCD.

Keywords: Disturbed Eating, Obsessive Compulsive Disorder, Quality of Life

INTRODUCTION

The occurrence of compulsions and obsessions features obsessive-compulsive disorder (OCD). Obsessions are continuous and recurring desires, thinking or visions considered undesired. While compulsions are repeated psychological or mental behaviors that an individual feels compelled to conduct in response to an obsession or under strict constraints. The lifetime incidence of OCD is presently estimated at 2-3% [1].

Eating disorders (EDs) are a set of conditions associated with eating behaviors and psychological conditions that include weight alterations and social abnormalities, which have a potential impact on quality of life (QoL) and social function [2].

Furthermore, persons with EDs may acquire severe somatic issues, which might increase the suicide risk [3]. Individuals with EDs share a lot in common with OCD in that they have body and food-related obsessions and are compelled to engage in compulsive behaviors to relieve anxiety. Ritualized eating habits (e.g., organizing food in a certain way) to avoid a feared disaster (contamination in OCD and weight gain in ED) are disorder-specific behaviors utilized for a comparable target (i.e., anxiety reduction) [4].

As 10% of cases diagnosed with OCD may exhibit ED symptoms at some point in their lives [5]. Health practitioners should understand the relationship between these two conditions. Regular evaluation

and early detection of ED in OCD cases are also critical for the early creation of suitable therapy programs in terms of the treatment and prognosis of both conditions [6]. ED-OCD comorbidity is associated with various undesirable consequences, such as higher levels of depression, anxiety and clinical severity [7].

QoL is defined as how the affected person sees the effects of their condition and, if applicable, related therapy on the case's social, mental and physical well-being [8]. Adults with OCD have reduced QoL compared to healthy and clinical controls [9]. Lower QoL is associated with more severe OCD symptoms [10,11].

Taken together with this background in mind, the present study aimed to estimate eating attitude changes among OCD patients who come to the outpatient clinic at Zagazig University Hospital, comparing it with their healthy controls and how this will affect QOL and severity of OCD. To our knowledge, there is a lack of studies done in Egypt concerning eating attitudes among OCD patients.

METHODS

The Comparative case-control study was performed on 160 subjects in the psychiatric department (outpatient clinic and the inpatient ward), Zagazig University hospitals within 6 months from May to October 2023. The cases were allocated into two groups: Group (1) included 80 OCD cases, and Group (2) included 80 healthy individuals. Informed consent has been obtained from all individuals involved in this investigation. This study was approved by our Institutional Review Board (IRB# 10759/9-5-2023). The research was conducted under the World Medical Association's Code of Ethics (Helsinki Declaration) for human research.

Assuming the frequency of EAT score>30. was 15% vs. 1% in cases vs control. At 80% power and 95% CI, the estimated sample was 160 subjects, with 80 subjects in each group. Cases with the following characteristics were included: all patients should meet DSM 4 criteria for OCD, patients of either sex and cases within the age limit of 18–60 years. Cases with the following characteristics were excluded; age below 18 or above 60, patients with major psychiatric disorder rather than OCD or mental retardation, substance use and presence of significant medical conditions that may affect BMI such as comorbid chronic endocrine, metabolic, neurological and gastroenterological disease. As well as, patients who are pregnant or breastfeeding. Also, patients who are currently undergoing treatment for OCD or

disordered eating attitudes and behaviors. Patients who are unable to provide informed consent or who are unable to participate in the study due to physical or cognitive limitations.

The diagnosis of OCD was based on DSM-4 criteria for OCD and confirmed by the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). SCID-1, according to DSM-4 criteria, was used as it's the last validated Arabic version for diagnosis. (EAT-40) were applied to both healthy and OCD patients to detect changes in eating attitudes.

OCD patients were applied: Yale-Brown Obsessive-Compulsive Scale(Y-BOCS) for severity of OCD symptoms and Yale-Brown Obsessive Compulsive Symptoms Checklist for detection domains of OCD. Beside using WHOQOL-BREF for assessment of QOL.

Psychometric assessment:

SCID-I Arabic version was applied to confirm the diagnosis of OCD; it is considered a gold standard semi-structured evaluation application for clinical disorders. Exclude other psychiatric disorders that interfere with proper assessment as mania /psychosis/mental retardation.The Arabic version was translated and used in previous Egyptian studies [12].

Eat Attitude test-40 (EAT-40) (Arabic version):
The scale comprises 40 items, each marked on a 6-point Likert-type scale with answers ranging from always to never. The overall score of the scale is calculated by summing the ratings provided to each item and a greater score indicates a decline in eating attitudes. The recommended cut-off is 30 because scores above 30 are typically connected with disordered eating attitudes and behaviors [13]. This investigation utilized a validated Arabic version of the scale [14].

YBOCS (Arabic version): Checklist: which classified OCD symptoms into: Autogenic (Aggression- Religious-Sexual), Reactive (Doubt-Hoarding- Contamination), severity rating scale: This test rates the severity of OCD symptoms. The measure is a self-rating, 10-item scale with each item rated from 0 (no symptoms) to 4 (severe symptoms), resulting in a total possible score range of 0-40. The scale contains questions concerning how much time the case devotes to obsessions, how much discomfort or impairment they feel, and how much resistance and control they have over these thoughts. Compulsions are also subjected to similar questions (e.g., time spent, interference, etc.).

The results can be interpreted depending on the overall score: 0-7 is sub-clinical; 8-15 is mild; 16-23

is moderate; 24-31 is severe; and 32-40 is extreme [15].

Quality of Life Scale the World Health Organization Quality of Life Questionnaire-short version (WHO QOL-BREF):

WHOQOL-BREF has four categories: physical health, psychological, social relationships, and environment. It also includes two general items that are investigated separately. Question 1 asks about a case's overall perception of QOL, and question 2 asks about a case's overall perception of their general health. Subjects rated all items on a 5-point Likert scale, with 1 indicating low and negative perception and 5 indicating high and positive perception and high scores indicate [16]; the raw score for the WHOQOL domains was obtained by aggregating values of single items and modified on a scale ranging from 4 to 25, where 4 is the lowest and 25 is the highest HRQOL [17].Dr. Ashraf EL Jedi translated the questionnaire into Arabic—validity and reliability by test-retest [18].

Statistical Analysis: Data analysis was done utilizing SPSS (Statistical Package for the Social Sciences), version 26, w. Categorical variables were reported using absolute frequencies, and comparisons were made using the chi-square test and when suitable, the Fisher exact test. The chi-squared trend test was performed to compare ordinal data between the two groups. The Kolmogorov-Smirnov test was developed to validate assumptions for parametric tests. Quantitative variables were described utilizing mean and standard deviation or median and interquartile range, depending on the data type. We used the independent sample t-test (for normally distributed data) and the Mann-Whitney test (for non-normally distributed data) to compare quantitative data between the two groups. Binary logistic regression discovered independent risk factors related to a specific health issue.

RESULTS

Table 1 show that there was substantial variance between the studied groups regarding total EAT-40 scores, dietary behavior, oral control, food preoccupation and body image (significantly higher among the case group). About 33% of the case group versus 6.3% within the control group had higher scores of EAT-40 (risk for having abnormal eating attitude) with statistically significant differences.

Table 2: Concerning total Yales Brown scores, 33.8%, 20%, 18.8%, and 16.3% of patients had moderate, mild, severe, and extreme OCD. As regards autogenic OCD, 28.7%, 37.5%, and 28.7% of patients reported aggression, religious and sexual domains.

Table 3: regarding reactive OCD, 61.3%, 41.3% and 15% of patients reported contamination, doubt and hoarding domains

A remarkable relation existed between eating attitude and residence, occupation and body mass index.

Table 4: show that there was a statistically notable relation between eating attitude OCD severity (severity is associated with higher scores of EAT-40) and aggression. Religious. Sexual, contamination, and doubt domains (sexual, doubt, contamination were significantly associated with abnormally high EAT-40 scores. On the other hand, aggression and religious domain contamination were significantly related to low EAT-40 scores)

Table 5: show that there was a statistically significant relation between eating attitude and all qualityof life domain scores and total QoL scores. All patients with abnormally high EAT-40 scores had poor QoL versus 50% of those with low scores.

Table 6: show that there was a remarkable association between QoL and OCD severity (severity is associated with poor QoL), aggression, sexual, and doubt domains (sexual and doubt are significantly related to poor QoL On the other hand, aggression was significantly associated with good QoL).

Table 7: show that among factors significantly associated with abnormally high eating attitude, only increasing scores on the Yales-Brown scale non-significantly independently increases that risk by 3.26 folds. Among factors associated considerably with abnormally poor QoL among OCD patients, only increasing Yales-Brown scale scores significantly independently increases poor QoL by 1.256 folds. Aggression domain significantly decreases the risk of poor QoL.

Table (1): Comparison between the studied groups regarding sociodemographic data and EAT-40:

	Case group Mean ± SD	Control group Mean ± SD	t	p
Age (year)	28.44 ± 8.48	28.46 ± 8.5	-0.091	0.985
BMI (kg/m^2)	27.81 ± 4.81	26.93 ± 4.75	1.164	0.246
	N=80 (%)	N=80 (%)	χ^2	p
Gender: Male Female	31 (38.8%) 49 (61.2%)	35 (43.8%) 45 (56.2%)	0.813	0.521
	Case group	Control group	t	p
Residence: Urban Rural	47 (58.7%) 33 (41.2%)	47 (58.7%) 33 (41.2%)	0	>0.999
Education: Illiterate Read and write Primary education Secondary education University	1 (1.3%) 4 (5%) 1 (1.3%) 10 (12.5%) 64 (80%)	1 (1.3%) 4 (5%) 1 (1.3%) 12 (15%) 62 (77.5%)	0.035¥	0.851
Occupation: Employed Unemployed Student	35 (43.8%) 23 (28.7%) 22 (27.5%)	35 (43.8%) 23 (28.7%) 22 (27.5%)	0¥	>0.999
Smoking Smoker Non-smoker	12 (15%) 68 (85%)	5 (6.3%) 75 (93.7%)	3.225	0.073
Comorbidity	0 (0%)	0 (0%)	0	>0.999
Substance abuse	0 (0%)	0 (0%)	0	>0.999
EAT-40				
Total score	20(13 – 38.5)	12(8 – 19.5)	-5.253	<0.001**
Dietary behavior	7(3 – 11)	2(0 – 8)	-4.127	<0.001**
Oral control	3(2 – 6)	2(1 – 3)	-4.059	<0.001**
Food preoccupation	8(5 – 10)	5(3 – 6)	-5.556	<0.001**
Body image	2(0 – 5.5)	0(0 – 1)	-3.827	<0.001**
	N=80 (%)	N=80 (%)	χ^2	p
Total score Normal (≤30) High (>30)	54 (67.5%) 26 (32.5%)	75 (93.7%) 5 (6.3%)	17.644	<0.001**
t independent sample t test, χ^2Chi square test, ¥Chi square for trend test, Z Mann Whitney test, IQR interquartile range				

Table (2) Distribution of the studied patients according to Yales Brown scale and domains of OCD:

	N=80	**%**
Total score: Subclinical	9	11.3%
Mild	16	20%
Moderate	27	33.8%
Severe	15	18.8%
Extreme	13	16.3%
Autogenic		
Aggression	23	28.7%
Religious	30	37.5%
Sexual	23	28.7%
Reactive		
Contamination	49	61.3%
Doubt	33	41.3%
Hoarding	12	15%

Table (3) Relation between eating attitude and sociodemographic data of OCD patients:

	Low (≤30)	**Abnormally high (>30)**	**t**	**p**
	Mean ± SD	**Mean ± SD**		
Age (year)	2731 ± 7.27	30.77 ± 10.32	-1.533	0.134
BMI (kg/m^2)	26.97 ± 3.82	29.55 ± 6.14	-2.303	0.024*
	N=54 (%)	N=26 (%)	χ^2	p
Gender: Male	19 (35.2%)	12 (46.2%)	0.89	0.346
Female	35 (64.8%)	14 (53.8%)		
Residence: Urban	25 (46.3%)	22 (84.6%)	10.633	0.001**
Rural	29 (53.7%)	4 (15.4%)		
	Low (≤30)	Abnormally high (>30)	t	p
Education: · Illiterate	1 (1.9%)	0 (0%)	0.097¥	0.756
· Read and write	2 (3.7%)	2 (7.7%)		
· Primary education	1 (1.9%)	0 (0%)		
· Secondary education	8 (14.8%)	2 (7.7%)		
· University	42 (77.8%)	22 (84.6%)		
Marital status: · Single	35 (64.8%)	11 (42.3%)	5.533	0.137
· Married	16 (29.6%)	14 (53.8%)		
· Widowed	2 (3.7%)	0 (0%)		
· Divorced	1 (1.9%)	1 (3.8%)		
Occupation: · Employed	15 (27.8%)	20 (76.9%)	11.371¥	<0.001**
· Unemployed	21 (38.9%)	2 (7.7%)		
· Student	18 (33.3%)	4 (15.4%)		

	Low (≤30)	Abnormally high (>30)	t	p
	Mean ± SD	Mean ± SD		
Smoking			0.541	0.462
• Smoker	7 (13%)	5 (19.2%)		
• Non-smoker	47 (87%)	21 (80.8%)		
t independent sample t test χ²Chi square test ¥Chi square for trend test *p<0.05 is statistically significant				

Table (4) Relation between eating attitude and domains and severity of OCD:

	Low (≤30)	Abnormally high(>30)	χ^2	p
	N=54 (%)	N=26 (%)		
Severity:			51.282¥	<0.001**
• Subclinical	9 (16.7%)	0 (0%)		
• Mild	16 (29.6%)	0 (0%)		
• Moderate	27 (50%)	0 (0%)		
• Severe	2 (3.7%)	13 (50%)		
• Extreme	0 (0%)	13 (50%)		
YBS [median(IQR)]	16(8.75 – 19)	31(28 – 34)	-7.165§	<0.001**
Autogenic				
Aggression			8.338	0.004*
• No	33 (61.1%)	24 (92.3%)		
• Yes	21 (38.9%)	2 (7.7%)		
Religious			8.038	0.005*
• No	28 (51.9%)	22 (84.6%)		
• Yes	26 (48.1%)	4 (15.4%)		
Sexual			25.237	<0.001**
• No	48 (88.9%)	9 (34.6%)		
• Yes	6 (11.1%)	17 (65.4%)		
Reactive				
Contamination			6.183	0.013*
• No	26 (48.1%)	5 (19.2%)		
• Yes	28 (51.9%)	21 (80.8%)		
Doubt			35.427	<0.001**
• No	44 (81.5%)	3 (11.5%)		
• Yes	10 (19.5%)	23 (88.5%)		
Hoarding			Fisher	>0.999
• No	46 (85.2%)	22 (84.6%)		
• Yes	8 (14.8%)	4 (15.4%)		

t independent sample t test   χ²Chi square test   ¥Chi square for trend test   *p<0.05 is statistically significant §Mann Whitney test   **p≤0.001 is statistically highly significant

Table (5) Relation between eating attitude and quality-of-life scores of OCD patients:

	Low (≤30)	Abnormally high(>30)	Z	p
	Median (IQR)	**Median (IQR)**		
Overall perception of health	4(3 – 4)	2(1 – 2)	-7.636	<0.001**
Perception of general health	4(3 – 4)	1(1 – 2)	-7.345	<0.001**
Physical health	63(56 – 69)	19(11.25 – 31)	-7.346	<0.001**
Psychological health	56(56 – 63)	19(11.25 – 25)	-7.423	<0.001**
Social health	69(56 – 69)	25(6 – 44)	-7.172	<0.001**
Environmental domain	63(56 – 75)	25(19 – 32.75)	-6.74	<0.001**
Total score	50.8(46.2 – 52.6)	16.8(12.4 – 27.6)	-7.224	<0.001**
Poor (≤51)	27 (50%)	26 (100%)	19.623	<0.001**
Good (>51)	27 (50%)	0 (0%)		

Z Mann Whitney test   **p≤0.001 is statistically highly significant   IQR interquartile range

Table (6) Relation between quality-of-life scores and OCD domains, severity, and EAT-40:

	Poor QoL	Good QoL	χ^2	p
	N=53 (%)	**N=27 (%)**		
Severity :				
Subclinical	1 (1.9%)	8 (29.6%)	25.927	**<0.001****
Mild	7 (13.2%)	9 (33.3%)		
Moderate	18 (34%)	9 (33.3%)		
Severe	14 (26.4%)	1 (3.7%)		
Extreme	13 (24.5%)	0 (0%)		
YBS [median (IQR)]	25(17 – 31)	15(7 – 17)	-5.017[§]	<0.001**
Autogenic				
Aggression				
No	42 (79.2%)	15 (55.6%)	4.091	**0.027***
Yes	11 (20.8%)	12 (44.4%)		
Religious				
No	36 (67.9%)	14 (51.9%)	1.972	0.16
Yes	17 (32.1%)	13 (48.1%)		
Sexual				
No	32 (60.4%)	25 (92.6%)	9.063	**0.003***
Yes	21 (39.6%)	2 (7.4%)		
Reactive				
Contamination				
No	19 (35.8%)	12 (44.4%)	0.557	0.456
Yes	34 (64.2%)	15 (55.6%)		
Doubt				
No	26 (49.1%)	21 (77.8%)	6.089	**0.014***
Yes	27 (50.9%)	6 (22.2%)		
Hoarding				
No	48 (90.6%)	20 (74.1%)	3.816	0.051
Yes	5 (9.4%)	7 (25.9%)		
EAT-40				
Normal	12 (70.6%)	63 (100%)	Fisher	<0.001**
Abnormally high	5 (29.4%)	0 (0%)		

t independent sample t test χ^2Chi square test   ¥Chi square for trend test *p<0.05 is statistically significant §Mann Whitney test **p≤0.001 is statistically highly significant

Table (7) Multivariate regression analysis of factors associated with abnormally high eating attitude scores:

	β	p	AOR	95% C.I	
				Lower	Upper
factors associated with abnormally high eating attitude scores					
Total score of Yale brown scale	1.182	0.086	3.260	0.848	12.540
factors associated with poor QoL among OCD patients					
Aggression	-1.501	0.025*	0.223	0.06	0.825
Total score of Yale brown scale	0.228	<0.001**	1.256	1.12	1.41

AOR adjusted odds ratio CI Confidence interval

DISCUSSION

The presence of disturbed eating attitudes in OCD patients can have a profound impact on their QoL and overall well-being [19]. Individuals with comorbid OCD and eating disorders often report increased anxiety levels, depression and functional abnormality compared to those with OCD alone. The preoccupation with food, weight and body image can consume significant time and energy, interfering with daily activities, social relationships and occupational functioning. As a result, addressing disturbed eating attitudes in the context of OCD treatment is crucial for improving QoL outcomes and enhancing overall recovery [20].

As regards demographic data, we found that there were no statistically substantial variations between OCD patients (case group) and healthy individuals (control group) concerning age, with a mean age of 28.44 years (±8.48) in the case group and 28.46 years (±8.5) in the control group (p = 0.985). Comparatively, the findings from Steiger et al. [21] study in Canada revealed similarities in demographic characteristics between their sample and ours. They reported a mean age of 24.2 years in their sample, which is lower than the mean age observed in our study. Additionally, Steiger et al. [21] found a predominance of female participants (100% of the sample), contrasting our study's more balanced gender distribution. However, they observed a higher prevalence of a history of any eating disorder (ED) in their sample (15.4%) compared to our study, where none of the participants in either group reported comorbid physical disease or substance abuse.

Our study showed a significant association between OCD and disturbed eating attitudes, as evidenced by markedly higher EAT-40 scores in OCD patients compared to healthy controls. About 33% of the case group versus 6.3% within the control group had higher scores of EAT-40. The substantial difference in median total EAT-40 scores underscores the pronounced disparity in eating attitudes between the two groups. Moreover, specific domains of dietary behavior, oral control, food preoccupation and body image demonstrated significantly elevated scores in OCD patients, indicating not only a general propensity towards disturbed eating attitudes but also specific behaviors and attitudes related to diet and body image. This high ratio in the case group could be explained by the sample's high symptom severity and free of drug use. These findings are consistent with existing literature documenting a link between OCD and disordered eating behaviors. OCD is featured by compulsive behaviors and intrusive thoughts, which may extend to food-related concerns and behaviors, leading to disturbances in eating attitudes. The higher EAT-40 scores in the case group may reflect the impact of obsessive thoughts and compulsive rituals on eating behaviors and body image perceptions [22]. Similarly, Gezer and Yalvac [23] found that students with increased levels of abnormal eating behavior also had increased obsession levels compared to students with lower levels of abnormal eating behavior. In conclusion, a relationship was found between eating behavior and obsession. Contrastingly, Mandelli et al. [24] reported lower rates of comorbidity, with 18% of cases with ED having a lifetime comorbidity with OCD and 15% having a current comorbidity. Moreover, Drakes et al. [25] estimated lower rates of OCD comorbidity at roughly 13.9% for the lifetime measurement window.

Regarding degrees and subtypes of OCD, our findings according to total Yales Brown scores, 33.8%, 20%, 18.8% and 16.3% of patients had moderate, mild, severe and extreme OCD in line with the study conducted by Ezz-Eldin Prince Ali [26] highlights several significant findings regarding obsessive-compulsive disorder (OCD) severity and symptomatology. Most respondents, comprising

54%, reported a moderate severity level, while 26% indicated a severe level. Interestingly, 10% of respondents reported experiencing both mild and extreme levels of seriousness, underscoring the variability in symptom presentation among individuals with OCD. The domain of contamination emerged as the most predominant among respondents, with 40% of them reporting OCD symptoms related to contamination. However, the results contradict those reported by Saleem and Gul [27]. In their investigation, nearly half of the sample population displayed severe levels of OCD severity, contradicting the prevalence of moderate severity observed in our study. This incongruity underscores the variability in reported severity levels across different studies, highlighting the intricate nature of OCD symptomatology and its ramifications on quality of life.

Additionally, we observed a significant association between disturbed eating attitudes and urban residence, employment status, and body mass index, highlighting the influence of urban living, occupational stress, and body weight perception on eating disturbances among OCD cases.

Regarding the current findings, there was a remarkable association between eating attitude and OCD severity (severity is associated with higher scores of EAT-40), which suggests a complex interplay between these factors. Higher OCD severity, as indicated by elevated scores on the Yale-Brown scale, was correlated with increased EAT-40 scores, indicating more disturbed eating attitudes. Consistent with our results, the findings from Lee et al. [28] reported a substantial association between ED and OCD symptom severity. The remarkable positive association observed between the severity of ED symptoms and OCD symptoms as a whole implies that individuals with more severe symptoms in one disorder tend to exhibit more severe symptoms in the other. This suggests an overall more severe clinical profile in cases with comorbid ED and OCD. Lee et al. [28] explained this correlation by suggesting a synergistic effect of ED and OCD symptoms, wherein the simultaneous presence of both disorders exacerbates overall clinical severity beyond what would be observed with only one disorder.

Consistent with previous findings, Olatunji et al. [29] reported that alterations in OCD symptom severity also predicted ED severity alterations. This suggests a bidirectional relationship between OCD and ED, where changes in symptoms of one disorder influence the severity of symptoms in the other. Such

findings highlight the interconnected nature of these disorders and underscore the importance of considering comorbidity in assessing and treating individuals presenting with either condition.

Respecting the present results, we reported significantly lower QoL scores in OCD cases than controls across all domains. This discrepancy underscores the profound impact of OCD on overall well-being. Additionally, our correlation analysis revealed a significant negative relationship between OCD severity, as measured by Yale-Brown scale scores, and all domains of QoL among OCD patients. This suggests that as OCD symptoms intensify, there is a corresponding decline in overall quality of life across multiple dimensions. The results of Ezz-Eldin Prince Ali [26] corroborate our findings, indicating that OCD patients experience remarkable impairment in the psychological domain of QoL, characterized by negative mood, anxiety, and dissatisfaction with oneself. Additionally, Subramaniam et al. [30] findings highlight lower QoL scores across various domains among OCD patients, indicating a consensus among studies regarding the detrimental impact of OCD on QoL.

In this study, we observed higher scores in various domains of EAT-40 among individuals with sexual domains in OCD compared to those without. This could be attributed to several factors. Firstly, sexual OCD often involves intrusive thoughts or obsessions related to sexuality, which can lead to heightened anxiety and distress. These psychological symptoms may manifest in disordered eating behaviors, such as dietary restrictions or preoccupation with food, as individuals attempt to cope with their obsessive thoughts. Additionally, the compulsive behaviors associated with sexual OCD, such as rituals or repetitive behaviors aimed at reducing anxiety, may interfere with normal eating patterns and contribute to disordered eating attitudes [31].

Our study findings reveal a significant and consistent association between disturbed eating attitudes, as assessed by EAT-40, and various domains of QoL, alongside total QoL scores. Notably, individuals exhibiting elevated EAT-40 scores demonstrated markedly poorer QoL across all domains than those with lower scores, indicating a pronounced impact of disturbed eating attitudes on overall well-being. Additionally, we found a remarkable variation in QoL between individuals with average scores on EAT-40 in the case group and the control group. Poor QoL was more prevalent in the case group (50%) than in the control group (16%). Moreover, all individuals with high EAT-40 scores had poor QoL.

Our results align with those of Sfeir et al. [32], who similarly identified a direct correlation between Disturbed eating attitudes and orthorexia nervosa (ON), with discernible impairment observed mainly in the physical and environmental domains of QoL. Notably, this association persisted independently of other known risk factors, underscoring the significance of eating attitudes in influencing overall well-being, particularly regarding physical health and environmental factors.

Furthermore, our findings are supported by Ab Hamid et al. [33], whose study highlighted a correlation between eating attitudes and lower scores, specifically in the social and environmental domains of QoL. This suggests that disturbed eating attitudes may detrimentally affect social interactions and environmental aspects of well-being, contributing to overall QoL impairment. Additionally, Varga et al. [34] demonstrated that individuals with eating disorders often resort to social withdrawal as a means to avoid criticism and judgment. This retreat from social interactions can precipitate a decline in physical and social activity levels, further exacerbating the negative impact on overall well-being.

CONCLUSION

In conclusion, our study sheds light on the intricate relationships among OCD domains, demographic factors, eating attitudes and QoL. While certain OCD domains, such as aggression and doubt, demonstrated significant associations with demographic factors and Disturbed eating attitudes, others, like hoarding, showed no direct influence on eating attitudes. Overall, individuals with OCD exhibited significantly lower QoL scores, particularly among those with elevated Disturbed eating attitude scores, highlighting the pervasive impact of OCD symptoms on overall well-being. These results underscore the importance of comprehensive evaluation and tailored interventions addressing both OCD symptoms and associated Disturbed eating attitudes to improve the QoL of individuals affected by OCD.

 Conflict of interest : no potential conflict of interest was reported by the authors.

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