

# Eating Disorders – A normative discontent or serious illness?

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Do older people especially women, worry about their body image once they've reached an age when they had experienced life for many decades and hopefully gained much from the mere fact of living life, observing and listening to the world around them? On the other hand, perhaps the values so often promoted by the media in our Western culture (youthfulness and beauty = happiness) have had a negative effect on their thinking over this period and have actively promoted disordered thoughts and expectations around body image and eating for all ages and sexes. Another important factor is that New Zealand is fast becoming a mix of different cultures and ethnic groups who do not espouse Western culture and will bring their own values related to body image and eating into the mix. For health professionals and others who have daily interaction with older adults, it will pay to keep in mind that unusual and unhealthy attitudes to food and/or body image may exist or be developing. Once the problem or underlying causes of the dysfunction have been identified then appropriate strategies for treatment should be easier to implement.

There are 3 categories of eating disorders classified by the Diagnostic and Statistical Manual of Mental Disorders<sup>i</sup> – anorexia nervosa (AN), bulimia nervosa (BN) and an eating disorders not otherwise specified (NOS), including binge eating disorder. To serve as a reminder, the diagnostic criteria for AN relevant to older adults include low body weight (refusal to maintain above a minimally normal weight), intense fear of gaining weight or becoming fat even though underweight, or a disturbance in the way in which one's body weight is experienced. For BN these are recurrent episodes of binge eating and inappropriate compensatory weight loss behaviours such as self-induced vomiting, laxative misuse, diuretics, enemas, fasting or excessive exercise. In addition, self evaluation is unduly influenced by body shape and weight. The diagnostic criteria for eating disorders (NOS) include those seen in AN and BN as well as other inappropriate behaviours such as repeatedly chewing and spitting out, but not swallowing large amounts of food and employing inappropriate behaviours after eating small amounts of food. Tardive anorexia (appearing after adolescence or in later years) and late onset bulimia can also be seen described in the literature but there is disagreement as to what is considered the age of onset for these conditions.

Thoughts and beliefs around food, eating and body image are clearly a very important part of the spectrum of disordered eating behaviours. Clear discrepancies between what is perceived to be ideal and what actually is an ideal body weight are repeatedly seen. Some researchers have proposed that psychological and physical changes associated with aging and menopause

may parallel changes associated with puberty and menarche. Lewis and Cachelin<sup>ii</sup> attempted to elucidate this further by surveying and comparing middle aged (50-65y) and older women (66+y) across all weight ranges for their body size, eating and weight related attitudes and behaviours and also fear of aging. The older group scored similarly to the younger group in body dissatisfaction and choosing thin figures as ideal and attractive to men. These findings suggest that body image, size preferences and desire for thinness affect older women to the same degree as middle aged women. They also found a positive relationship between fearing aging and disordered eating.

The topic of disordered eating in older adults is not widely studied. Research evidence that is reported is conflicting as to whether the frequency amongst the population decreases with age or remains the same. There is some interesting speculation in the literature around why eating disorders appear or reappear in older age. One suggestion is that valuing slenderness and youthfulness in Western society may lead older women to be increasingly dissatisfied with their appearance. Another idea hypothesizes that eating disorders are an unconscious reaction to society's views or presumed views of older women's place in society leading to envy, loss and preoccupation with body image. Other proposed causes put forward are a person's loss of control and power in her/his life. The eating disorder subsequently provides a sense of regaining control and drawing the family's attention to her/his feelings of discontent. These outlooks or thoughts are extremely important when considered in the context of people living in residential care.

In a review article of Eating Disorders in the Elderly<sup>iii</sup> Lapid et al listed cases of eating disorders in individuals over the age of 50 years. The following precipitating events were identified: fall & hip surgery, widowed, bereaved, family member moved, domestic crisis, health problems of husband, re-marriage of ex-husband, retirement, marriage of daughter, prisoner during WW2, stressful life events, cholecystectomy, stomach operation, immigration, marital dissatisfaction, stress from child rearing, pneumonia, residential move and facial surgery. Widowhood and bereavement were the most common precipitating factors. This long list of events, most of which are not directly health issues, shows how social circumstances may have a huge impact on an older person's attitudes. The researchers noted that a combination of behavioural and pharmacological therapies was most successful in treating the eating disorders. They also noted that true late onset eating disorders do occur in the elderly.

An American online survey used self-administered questions to examine age differences in disordered eating, eating-related cognitions and dissatisfaction with appearance in a community based sample of adults across the life span<sup>iv</sup>. Self-reported perceptions and behaviours used to classify people were taken from an Eating Disorders Diagnostic Scale and

eating cognitions taken from a Intuitive Eating Scale (both well researched tools for these purposes). A high rate of suspected anorexia, bulimia and binge eating was found. The authors were alarmed to find similar results across all age groups from adolescence, emerging adults, midlife and older adults. In addition, the authors found a strikingly high percentage of men exhibiting symptoms of eating disorders.

The impact of stress and the way individuals deal with stressful situations are important factors in eating disorders. Woolsey discusses this topic in her book chapter on the Biology of Eating Disorders<sup>v</sup> and how the hypothalamic-pituitary-adrenal axis of the brain can become chronically dominant in response to stress. This dysfunction is proposed as one of the primary biological origins of alterations in eating behaviour observed in AN, BN and binge eating disorder (BED). Another important biological effect on the nervous system is that of the reward mechanism triggered by food restriction or bingeing where increased levels of opiates such as endorphin are released.

Body dissatisfaction appears to be so prevalent in Western society that it has been described by some researchers as a “normative discontent”. An important question is whether the effect that a negative body image has on a person’s self esteem might lessen with age. A review by Peat et al<sup>vi</sup> has put forward the argument that whilst body dissatisfaction and importance of body image did not differ across the age groups, the impact of these factors on a person’s self esteem may lessen with age. They postulated that this might be caused by women perceiving their bodies to be less important than when they were younger which might be a protective mechanism against negative outcomes.

Another attempt to quantify the extent of body image dissatisfaction amongst older women was carried out in Austria using a questionnaire for 60-70 year old community living women<sup>vii</sup>. The authors chose this age group as these women were in their first decade of retirement. They found that of those with a BMI <25 (55% of study sample), over a third (34.7%) said they felt moderately fat, 5% felt very fat and 15.4% disagreed with the statement “I really like my body.” Sixty-five percent of this BMI <25 group thought that appearance was very important and nearly 50% agreed with the statement that “self esteem depends on weight and shape”. Amongst the whole cohort 4% were classified as having an eating disorder and 4% to have single symptoms of eating disorders such as binge eating, use of laxatives or diuretics and vomiting. The authors commented that the weight history of the participants was consistent with other data which has shown that weight increases for women through their decades of life but starts to decrease into older age (reported BMI was lowest at 35y and highest at 53y).

My intention in writing this article, is to bring awareness to the area of eating disorders in older adults. A high percentage of deaths from AN occur in the elderly. Hewitt and colleagues<sup>viii</sup> found that the death rate climbed from 10% in the 55-64y age group, 12% in the 65-74y age

group and 28% in the 85+y age group. In my clinical practice I have come across a number of people, mostly women, whom appear to fit a diagnosis of having an eating disorder. For example women who have gradually narrowed the range of foods that they consider to “agree” with them so that they are eating a very limited and unbalanced range of foods? Or perhaps women, having recently suffered loss of a long term spouse, start restricting their food intake and having unusual, perhaps obsessive thoughts about the effects of food on their body. As a consequence, family members may be frequently requested to bring in special foods to the residential facility. The preparation and/or cooking of these may not be the way the resident is used to and thus everyone from cook to family to resident is disappointed. It makes good sense that counselling is recommended as a foundation of eating disorder treatment.

My thanks go to Monique Le Heron, Nutritionist for assisting with sourcing material used for this article.

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<sup>i</sup> American Psychiatric Association 2000. *Diagnostic and Statistical Manual of Psychiatric Disorders 5<sup>th</sup> ed.* Washington DC.

<sup>ii</sup> Lewis DM, Cachelin FM 2001. Body image, body dissatisfaction and eating attitudes in midlife and elderly women. *Eating Disorder 9*: 29-39

<sup>iii</sup> Lapid MI et al 2010. Eating Disorders in the elderly. *International Psychogeriatrics 22*:4 523-36

<sup>iv</sup> Patrick JH, Stahl ST 2009. Understanding Disordered Eating at Midlife and Late Life. *Journal of General Psychology 136*(1), 5-20.

<sup>v</sup> Woolsey MM 2001. Eating Disorders, a Clinical Guide to Counselling and Treatment. Chapter 2. *American Dietetic Association, Chicago Illinois.*

<sup>vi</sup> Peat CM et al 2008. Body Image and Eating Disorders in Older Adults: A Review. *Journal of General Psychology 135*(4) 343-58.

<sup>vii</sup> Mangweth-Matzek et al 2006. Never Too Old for Eating Disorders or Body Satisfaction: A Community Study of Elderly Women. *International Journal of Eating Disorders 39*:7 583-6

<sup>viii</sup> Hewitt PL et al 2006. Death from anorexia nervosa: age span and sex differences. *Aging and Mental Health 5* 41-6.