Eating Disorders in Midlife Women

Seda Ebrahimi, Ph.D.
Founder and Director, Cambridge Eating Disorder Center
Instructor, Department of Psychiatry, Harvard University
THE PREVALENCE OF EATING DISORDERS

- An estimated 8 million Americans suffer from eating disorders
  - 7 Million Women
  - 1 Million Men

- Single best predictor of risk for developing an eating disorder is being female

- Anorexia nervosa and bulimia nervosa are 10 times more common in females

- Binge eating disorder is three times more common in females
PREVALENCE AMONG MIDDLE-AGED WOMEN

- Middle-aged community defined as those aged 35 to 55

- Very little is known about the prevalence of eating disorders among middle-aged women

- A significant number of those struggling with an eating disorder are between the ages of 12 and 25.
IDEAL BODY WEIGHTS ACROSS TIME

- The first runway models weighed 155 lbs. or more
- A half century later, weight was 50 lbs. (or more) leaner; Twiggy was 91 lbs. and 5’6”
- The first Miss America in 1922 weighed 140 lbs. and was 5’7”
- Today the average fashion model weighs 107 pounds at 5’10”; BMI of 15.4
- Today the average American woman weighs 164 lbs. at 5’4”
43 million adult women in the United States are dieting to lose weight.

Another 26 million women in the United States are dieting to maintain their weight.

Body Image dissatisfaction in midlife has increased significantly from 25% in 1972 to 56% in 1997.

75% of American women between the ages of 25-45 report disordered eating and body image dissatisfaction.

67% of American women between the ages of 25-45 were trying to lose weight, even though over half of these dieters were already normal weight.
BODY IMAGE STATISTICS FOR WOMEN OVER 50 YEARS OF AGE

- 79% of women over age 50 reported that weight/Shape affects their self-image
- 42% weigh themselves daily
- 36% spent at least half of the last 5 years dieting
- 13.3% report eating disorder symptoms
- 8% report purging
BODY IMAGE AND ADULT WOMEN

- When asked what bothered them most about their bodies, a group of women between the ages of 61-92 identified weight as their greatest concern.

- A major study found that more than 20% of women age 70 and older were dieting.
A SURVEY STUDY OF ADULT WOMEN HAD THE FOLLOWING FINDINGS:

- 40% are restrained eaters
- 40% are overeaters
- 60% have engaged in pathogenic weight control
- 20% are instinctive eaters
- 90% worry about their weight
- 50% state their eating is devoid of pleasure and makes them feel guilty
BODY IMAGE IN MIDDLE-AGED WOMEN

- Research Findings Suggest:
  - Body dissatisfaction remains stable across the life span
  - Body dissatisfaction is combined with high levels of dieting
  - Body dissatisfaction is comparable in younger and older women
  - Drive for thinness does not decrease with age
  - For women in mid-life, thinness and youth are issues of concern
    - Cosmetic surgery (continued emphasis on appearance)
    - “Aging beautifully” vs. “Appearing not to age at all”
  - Weight is a “normative” discontent for all women regardless of age
  - Body image disturbance is attributed to the development of eating problems
PREVALENCE AMONG MIDDLE-AGED WOMEN

- Two population based studies (Lucas, et al)
  - For AN (7.2-7.7 per 100,000) among women between the ages of 40-59
  - For AN (69.4-73.9 per 100,000) among girls the ages of 15-19

- Bulimia among middle-aged women was the same as women aged 18-25 (.9%)
**GENERAL STATISTICS**

- Binge Eating Disorder is the most common form of eating disorder that affects women in their 30s and 40s.

- 10% of patients diagnosed with an eating disorder are over the age of 40 (Hack, 2006).

- Increase in inpatient admissions of middle-aged women over the past decade ranges from 100-400%.

- Twice as many admissions of 40-49 year old women to the Cornell Eating Disorder Program in 1998 compared to 1988 (Wiseman, et. al., 2001).

- 90% of eating disorders develop before the age of 25.
AGE OF ONSET ISSUE

**DSM-5**

- Anorexia Nervosa: “Commonly begins during adolescence or young adulthood. It rarely begins before puberty or after age 40.”

- Bulimia Nervosa: “Commonly begins in adolescence or young adulthood.”

- Binge Eating Disorder: “Typically begins in adolescence or young adulthood but can begin in later adulthood.”
AGE OF ONSET ISSUE

- In general, different studies have used different range of ages (from 25-60 years) to identify later onset eating disorders

- Two-thirds of middle-aged eating disorder cases have onset in adolescence and early adulthood (chronic course of illness).

- In one-third of these cases, onset is in mid-life (Cumella & Reilly, 2008)
FOUR COMMON PATIENT PROFILES

- Chronic cases (ages of onset adolescence or young adulthood); have continued to struggle

- Diagnosed at an early age, recovered and then relapsed later in life

- Late onset eating disorders
  - Tardive anorexia

- Preoccupation with food and weight for years, but develop full blown eating disorder later in life

Data regarding eating disorders in mid-life is sparse
RISK FACTORS FOR MIDDLE-AGED WOMEN

- Transitional times can be triggering to patients struggling with an eating disorder

- Relationships:
  - Divorce/separation
  - Infidelity
  - Marriage
  - Death of a spouse or loved one
  - Separation and individuation from aging parents
RISK FACTORS FOR MIDDLE-AGED WOMEN

- Developmental milestones in a women’s life
  - Pregnancy/Childbirth
  - Fertility/Infertility
  - Menopause (exit from reproductive life)
    - Increased eating disorder prevalence among peri-menopausal women compared to pre-menopausal and post-menopausal women

- Issues with adult children
  - Empty nest
  - Issues regarding health and well-being of adult children
RISK FACTORS FOR MIDDLE-AGED WOMEN

■ Aging Body
  ■ Unexpected Illness
  ■ Fear of aging is correlated with drive for thinness
  ■ Physically less resilient

■ Career or Financial Issues
  ■ Change in job
  ■ Unemployment
  ■ General Financial Concerns
  ■ Retirement
  ■ Work-Family Balance
  ■ Competing with younger women
**SIMILARITIES WITH YOUNGER WOMEN**

- Very similar with regard to comorbidities
  - Depression
  - Anxiety
  - Self-harming behaviors
  - 20-50% of women with eating disorders have a history of trauma
Differences with Younger Women

- Different with regard to drug/alcohol abuse (more common in adults than adolescents)

- Higher likelihood of residual issues such as GI concerns, GERD, Osteoporosis, etc.

- Less resilient physically
  - With anorexia, 10% mortality rate at 10 years
  - 20% at 20 years of symptom duration

- Increased cognitive impairment secondary to eating disorder in older patients
DIFFERENCES WITH YOUNGER WOMEN

- Shame and embarrassment for having a “teenager’s problem”
- More years of struggling with obsessional thinking about food and weight
- Greater difficulty admitting the need for help and asking for help
- Motivation for treatment (Spouse, children, financial)
- Increased awareness of what they have lost because of their eating disorder
- More increased anxiety about appearance due to aging process
- Multiple stresses and losses that are part of adult development
- More obstacles to treatment
DIFFERENCES WITH YOUNGER WOMEN

- Before adolescence, a girl’s body has approximately 12% body fat.

- During adolescence, the percent of body fat increases to 17% (enough for ovulation and menstruation).

- Mid-life women have 22% body fat.

- Women gain fat first in the hips, thighs, and breasts.

- During transition through menopause, there is an average weight gain of 8-12 lbs, metabolism slows 15-20%.
**IMPACT & ACCESS**

- The disorder affects spouses, children and other family members
- Patient’s work suffers (missed days, decreased productivity)

**Access:**
- Costs associated with the illness
- Cost of receiving treatment

- Frequent emphasis on younger patients-invisible
FERTILITY AND EATING DISORDERS

- Fertility problems among underweight or severely disturbed eating behaviors

- Among infertile women with amenorrhea or oligomenorrhea, 58% had eating disorders

- 7.6% of infertility clinic women suffer from anorexia nervosa or bulimia nervosa

- Percentage reaches 16.7% of infertility patients when all eating disorder (EDNOS) are included
FERTILITY AND EATING DISORDERS

- Eating Disorders increase the risk of infertility (treat the Eating Disorder first).

- Typically menses will resume within 6 months of reaching and maintaining at least 90% ideal body weight.

- Menstruation and return of fertility can be delayed in up to 30% of women with anorexia nervosa who reach their ideal body weight.
PREGNANCY AND EATING DISORDERS

- 1 in 14 pregnant women have an eating disorder
- Increased anxiety about weight gain
- Increased desire to restrict food intake
- Fear of losing control of weight gain
- Decrease in disordered eating behaviors
- Depression, Anxiety
- Prescription medications
- Alcohol/Substance Abuse
- Problem of disclosure of eating disorders to medical provider
EATING DISORDERS AND POST-DELIVERY

- Increased risk of post-partum depression

- It is estimated that 2 in 3 women with AN will experience post-partum depression

- 3x the risk for patients with Bulimia or Binge Eating Disorder

- Post-delivery body
  - Pressure to lose pregnancy weight “instantly” - pregorexia
  - This unrealistic expectation can fuel eating disorder behaviors in women without a history of eating disorder

- Relapse of the eating disorder
  - A large percent will relapse within the first six months of postpartum
RELAPSE DURING POST-PARTUM PERIOD

- Increased risk of relapse due to:
  - Drive for thinness
  - Perfectionism, OCD
  - Increased anxiety
  - Depression
  - Increased stress
EATING DISORDER AND POTENTIAL ATTACHMENT ISSUES

- Weak maternal-fetal attachment
  - Unplanned pregnancy

- Bonding
  - Women with higher rates of body image dissatisfaction less likely to breastfeed
  - Women with bulimia nervosa report less desire to breastfeed
  - Differences with attunement to baby’s hunger cues can contribute to over/under feeding
  - Worry about the size and weight of the child
EATING DISORDERS AND MOTHERHOOD

■ Impact on Infant Feeding:
  ■ Breastfeeding requires higher caloric intake
  ■ Starvation causes a new mother to stop lactating and may stop breastfeeding earlier
  ■ Some bulimic women may use breastfeeding as a form of purging (lactation burns up to 500 extra calories per-day)

■ Post-Partum Depression can impact attachment

■ Use of laxatives, diet pills, diuretics to lose weight can affect breastfeeding
EATING DISORDERS AND MOTHERHOOD

- More controlling of their children’s nutritional needs
- May underestimate their children’s nutritional needs
  - Meal coaching in their environment
- Neglecting/rejecting children while engaging in binge/purge episodes
- Ruminating on food, weight, exercise and shape related thoughts
- Stressful mealtimes
- Fearful of transferring their eating disorder to their children
- Feeding a toddler becomes more difficult
- Closely monitor infant/child growth
- Perfection and mother’s need to control can contribute to failure in recognizing child’s cues for autonomy, inhibiting child’s ability to self regulate
RECOMMENDATIONS:

- More research on midlife eating disorders
- Developmentally appropriate treatment
- Separate treatment units in residential setting
- Feasible treatment options (outpatient, IOP, PHP)
- Women with active eating disorders should be advised to postpone pregnancy
- More training for gynecologists and obstetricians regarding eating disorders
- More training of all mental health professionals
RECOMMENDATIONS:

- Establish good rapport to encourage honesty and disclosure
- Watch carefully for postpartum depression and/or eating disorder relapse
- Extra support to mothers with eating disorders (create healthy home environments)
- New mom support networks
- If unable to care for children, a referral to child protective services may be needed (mandated reporters)
- Optimism about recovery regardless of how long she has suffered
EATING DISORDER SCREENING FOR MEDICAL AND MENTAL HEALTH PROFESSIONALS

- Are you satisfied with your weight?
- Has there been any weight fluctuations in the past few years?
- Are you trying to change your weight? If yes, how?
- What is your desired weight?
- Do you worry about food, eating and weight?
REFERENCES


TREATMENT AT CAMBRIDGE EATING DISORDER CENTER

- Specialized Multidisciplinary Eating Disorder Treatment Including:
  - Individual therapy
  - Family therapy
  - Group therapy
  - Nutritional Support/education
  - CBT/DBT/FBT
  - Medication management
  - Expressive arts therapy
  - Yoga

- Levels of Care include:
  - Residential
  - Partial Hospitalization
  - Intensive Outpatient
  - Outpatient
  - Transitional Living

- Teaching Facility:
  - Harvard University Psychiatry
  - Massachusetts General Hospital
THANK YOU!

SEDAR EBRABI, PH.D.

Director of the Cambridge Eating Disorder Center
Instructor, Department of Psychiatry, Harvard University

Cambridge Eating Disorder Center (CEDC)
3 Bow Street | Cambridge, MA 02138

617-547-2255 ext. 222
seda@cedcmail.com

www.eatingdisordercenter.org