



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"

BODY IMAGE STATISTICS

- 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 perimenopausal 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

- Bulik, C.M., *Midlife Eating Disorders* (2013) New York: Walker and Company.
- Gura, T., *Lying in Weight* (2007) New York: Harper Collins Publishers.
- Geller, J., *How and When? The Ingredients of Change. Restoring Our Bodies, Reclaiming Our Lives: Guidance and Reflections on Recovery from Eating Disorders*, ed. Aimee Lie. Boston and London: Trampeter, 2011, 13-15
- Franko, Debra L., Spurrell, Emily B. (2000). *Detection and Management of Eating Disorders During Pregnancy*. *Obstetrics and Gynecology*, 95;6 (1), 942-946.
- American Psychiatric Association. *Diagnostic Statistical Manual of Mental Disorders, Fifth Edition, DSM-5* (2013). Washington, D.C., American Psychiatric Association.

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!

SEDA EBRAHIMI, 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