Eating Disorders and Older Adults

More awareness needs to be brought to these diseases and the fact that they can occur (or reoccur) at any age.

By Susan Rowell, MS, CSA
Typically, we think of a person with an eating disorder as being a young female. However, there are older adults, both male and female, with eating disorders. Eating disorders in midlife and later, which usually began in adolescence, are becoming an increasing concern. Why are more older adults being diagnosed with eating disorders, and how or why is an eating disorder triggered in older adults?

Mrs. Smith’s husband of fifty-three years passed away suddenly from complications during knee replacement surgery. After his death, she could no longer afford to live in the senior living community without him, so she moved in with her daughter. She was dealing with grief from the loss of her husband, home, and friends whom she had seen on a daily basis at the senior living community, anxiety about fitting into her daughter’s home and lifestyle, and worries about money. Her daughter would fix her a cup of coffee and a piece of toast in the morning before she left for work, but Mrs. Smith was alone for lunch. She had no appetite, so she would either skip lunch altogether or fix half of a peanut butter and jelly sandwich. Her daughter would fix dinner when she returned home from work, but Mrs. Smith wouldn’t eat much. Her weight started to drop.

Disordered Eating vs. Eating Disorders
Disordered eating can be the beginning of an eating disorder. It often begins with an illness or stressful event, or a desire to become healthier. It typically refers to mild and transient changes in eating patterns. Some examples of disordered eating include:

- Frequent dieting, anxiety associated with specific foods, or meal skipping.
- Chronic weight fluctuations.
- Rigid rituals and routines surrounding food and exercise.
- Feelings of guilt and shame associated with eating.
- Preoccupation with food, weight, and body image that negatively impacts quality of life.
- A feeling of loss of control around food, including compulsive eating habits.
• Using exercise, food restriction, fasting, or purging to “make up for bad foods” consumed.

Disordered eating rarely requires in-depth medical attention, even when it leads to weight loss, weight gain, and/or nutritional problems. If, however, it becomes sustained, distressing, or interferes with everyday activities, it may require professional intervention.

**Types of Eating Disorders**

According to the American Psychiatric Association (APA), there are three main types of eating disorders: anorexia nervosa, bulimia nervosa, and binge eating disorder. There is also a category labeled eating disorder not otherwise specified (EDNOS) for eating disorders that don’t meet the criteria of the APA classifications.

Anorexia nervosa is characterized by a distorted perception of body weight and a significant fear of gaining weight. People with anorexia lack insight into, or have a considerable denial of, their problem. Older anorexics run a higher risk of bone fracture, heart rhythm issues, and infection.

Bulimia nervosa is characterized by people eating a lot of food and then attempting to get rid of that food, and its extra calories, in unhealthy ways. Some examples include purging through self-induced vomiting or the misuse of laxatives. Older women with bulimia, especially those who abuse laxatives, are at higher risk of heart issues and gastrointestinal problems.

Binge-eating disorder is a condition where unusually large amounts of food are frequently consumed, accompanied by a compulsion to overeat. Some indicators of binge-eating disorder include eating very rapidly, eating until uncomfortably full, eating large amounts when not hungry, eating alone due to embarrassment over how much is being eaten, and feeling disgust, guilt, or depression after overeating. To be classified as a disorder, the binge eating episodes must occur, on average, at least two days per week for a period of at least six months.

Unspecified eating disorders make up the third general group. The Diagnostic and Statistical Manual of Mental Disorders (DSM) lists some examples of EDNOS as:

• Meeting all of the criteria for anorexia nervosa except that, despite significant weight loss, the individual’s current weight is within the normal range.

• Meeting all of the criteria for bulimia nervosa except that the binge eating and inappropriate compensatory mechanism occur at a frequency of less than twice a week or for a duration of less than three months.

• Repeatedly chewing and spitting out, but not swallowing, large amounts of food.

There is another eating disorder that isn't formally recognized in the DSM. The term “orthorexia” was coined in 1998 by Steven Bratman, M.D. (Dunn & Bratman, 2016). It refers to people who are obsessed with healthy eating. It can start as an attempt to eat healthier, but people with orthorexia then become fixated on food purity and quality. Their food choices eventually become so restrictive, in both variety and calories, that their health suffers. Ultimately, the obsession with healthy eating can cause the sufferer to ignore activities of interest, impair relationships, and it can become physically dangerous.

**Eating Disorders are Not as Easily Recognized in Older Adults**

The effect of eating disorders on older adults is not well documented. The main reason seems to be that there is a general misconception that eating disorders are youthful disorders. The majority of eating disorder literature focuses on younger people. However, there is evidence to show that eating disorders are not exclusive to people under the age of thirty. This could be because, instead of growing out of an eating disorder, many people live their lives with their condition from adolescence into late adulthood. Then, when the stressors of adult life appear, the disorder can reassert itself. The misconception that people outgrow their eating disorder can be cause for an adverse effect on later-in-life diagnoses.

“We have heard of cases where physicians have told patients that they should have ‘grown out of’ eating disorders. Or that they are ‘too old’ to be suffering from anorexia, bulimia, or binge eating disorder,” said Professor Cynthia M. Bulik, the founding director of the University of North Carolina Center of Excellence for Eating Disorders (McIntosh, 2015).

Different life events/stressors can precipitate disordered eating and eating disorders in older adults vs. children/young adults. For older adults, there can be many triggers including:

• an empty nest
• divorce
• loss of parents
• widowhood
• retirement
• chronic illness/disability
• death of an adult child
• growing old/facing mortality
• lack of enthusiasm for life
• attempts to get attention from family members
• protesting against living conditions (such as a skilled nursing facility)
• economic hardship
• medical problems

“I think eating disorders are still primarily a disease of the youth, as most midlife women with eating disorders developed the problem prior to the age of eighteen,” stated Holly Grishkat, Ph.D. and site director of the Renfrew Center, an eating disorder treatment facility, at its Radnor, Pennsylvania, location (Schaeffer, 2019). “Many of those women are just now reaching out for treatment. So while it may look like they are emerging later in life, most eating disordered women have been suffering since adolescence. The difference is that we are now working with women who have had the disorder for ten, twenty, and thirty years rather than the adolescents who may have a much shorter experience with these disorders. After thirty years, the eating disorder has become almost a personality characteristic for these women, as many of them define themselves by the eating disorder.”

Eating disorders in older adults aren’t merely a manifestation of a person’s stubbornness and refusal to eat, but a serious and potentially lethal mental disorder. Almost 50 percent of people with eating disorders suffer from depression, and eating disorders have the highest mortality rate of any mental illness. Yet the link is often not made. “Many family members or helping professionals may attribute weight loss, malnutrition, or unexpected symptoms such as vomiting or diarrhea to a ‘normal’ aging process or some other medical condition, rather than a mental health disorder,” said Laurie Cooper, site director at the Renfrew Center located in Nashville, Tennessee (McIntosh, 2015).

What makes it even more challenging to diagnose an older adult with an eating disorder in comparison to their younger counterparts is the fact that some of the symptoms of disordered eating are similar to those associated with the aging process. For example, older adults are more likely to be taking prescription drugs, and some medications cause nausea and diarrhea. Or, older adults may have functional problems that impair their ability to obtain healthy and adequate food.

Additionally, as we age our sense of taste and smell become altered. This could be secondary to medications that are prescribed, but an inability to enjoy food the way we did when we were younger can lead to disordered eating. Cognitive and memory impairment can also be a factor. People with cognitive decline may think that they’ve already eaten when they actually haven’t.

**How to Diagnose an Eating Disorder in Older Adults**

A layperson should not attempt to diagnose an eating disorder, but there are some indications when someone is at increased risk. “Yes” answers to any of the following questions merit a mention to a health professional:

• Did the person have an eating disorder when he or she was younger?
• Does the person have alterations in taste and smell, especially secondary to medications?
• Are there incompletely treated psychological problems?
• Is there cognitive and memory impairment?
• Is the person seeking undue attention?
• Has the person experienced the loss of a loved one?
• Does the person have feelings of isolation and loneliness that can escalate to depression?
• Is the person refusing to eat as a form of control?
• Is the person refusing to eat as a protest against caregivers or relatives?
• Is the person consciously or subconsciously attempting suicide?

Clinicians should conscientiously seek common treatable causes of weight loss in older adults and...
distinguish if one of the four basic causes of weight loss (anorexia, dysphagia, socioeconomic factors, and weight loss despite normal intake) could be at fault. Some things to do that can help with this determination include:

- Performing a comprehensive dietary history.
- Checking saliva production.
- Checking to see if dentures fit well or poorly, and for missing teeth.
- Checking for dysphagia and other swallowing disorders.
- Checking for gastrointestinal tract problems (these occur in 50 to 75 percent of older adults).
- Determining if weight loss is unintentional (it can be caused by a psychotic disorder such as depression, or by cancer, or a benign gastrointestinal disorder).

Some social challenges that are specific to seniors and may lead to an eating disorder include the inability to shop for groceries, an inability to prepare/cook nutritious meals, an inability to feed oneself, poverty, social isolation, and abuse. Specifically for senior men, festering anger is often an underlying issue that can lead to disordered eating. Older anorexics run a higher risk of serious bone fracture, heart rhythm issues, and infection. Older women with bulimia, especially those who abuse laxatives, are at a higher risk of heart issues and gastrointestinal problems. Typically, older adults are more likely to use laxatives for purging rather than self-induced vomiting.

A loss of 5 to 10 percent of body weight in the previous one to twelve months may indicate a serious problem in an older patient. This degree of weight loss shouldn't be considered a normal consequence of the aging process. “Eating disorders are never about weight, food, numbers, etc., but they are a way of coping with something else that the person finds extremely difficult to express, feel, or control,” states Grishkat (Schaeffer 2019).

**Interventions to Try**

Eating treatment centers focus their treatment around young people. If you look up an eating treatment center website, you’ll see many pictures of young people, but none of older adults. This lack of treatment options for midlife and older adults can be a deterrent to treatment. Being in a group of young teens who are trying to cope with their specific life events (puberty, transitions from high school to college, peer pressure, etc.) doesn’t meet the needs of older adults and the life transitions that they’re experiencing. Many older adults feel that they should be the role model for the younger generation, not be dealing with the same issues.

However, there are some things that professionals can try in order to assist older adults with eating disorders. One of them is working with these people to overcome or navigate their psychological issues. This approach is more effective than dealing with weight loss or food choices. Counseling can help to deal with perceived losses, anger, a lack of purpose, family conflicts, and self-esteem issues. Medication could potentially be helpful, such as prescribing a pill that will increase appetite and address depression. However, no prescription is specifically indicated or recommended for the treatment of weight loss in seniors, and few have been studied in this population.

Additional interventions include providing recommendations for shopping and cooking, encouraging people to be social and dine with others, and participating in a rehabilitation or exercise program to increase endurance, mobility, strength, and balance. However, some people with eating disorders use excessive exercise as a way to hasten their weight loss.

Attempting to force-feed, or being aggressive with, an older adult can actually aggravate or worsen television, and social media all depict what the perfect man and woman ‘should’ look like. There are some differences between the sexes, however. Women with an eating disorder typically vomit and abuse laxatives, but men will more often exercise compulsively (Weltzin et al., 2005).

Gay and bisexual men have a higher reported prevalence of eating disorders than heterosexual men (Feldman & Meyer, 2007). This perceived higher prevalence could be related to a higher likelihood of gay and bisexual men to seek treatment. Eating disorder treatment for men is complex because, as mentioned previously, eating disorders are typically understood to be more prevalent in females. Men may be embarrassed and reluctant to come forward for treatment, and many treatment centers don’t have a specific area for male patients.

**Men and Eating Disorders**

While most of the studies about eating disorders center around women, more and more men are being diagnosed with the problem. For decades women have been inundated with images of the perfect woman. Now men are feeling the same pressure. Magazines,
the condition and can more likely accelerate, rather than prevent, death. The eating disorder is the result of a mental disorder, and the mental aspect must be addressed in order for its physical manifestation, the eating disorder, to abate.

Where to Learn More and Find Help
Help is almost always needed to treat eating disorders and there are eating disorder treatment centers across the country. The National Eating Disorders Association (NEDA) is one place to go for more education and guidance. The association has a list of treatment centers and can be found at: https://www.nationaleatingdisorders.org/. You can also go to https://www.eatingdisorderhope.com/treatment-centers for a list of treatment centers near you.

Locally, there are many professionals a person can turn to for help with eating disorders. A psychiatrist or therapist is a good starting point. Additionally, dietitians, speech therapists, social workers, and physicians can all field questions and point people in the right direction. However, these professionals most likely won’t be experts regarding disordered eating and eating disorders and, as mentioned earlier, eating disorders in older adults are less recognized by these professionals.

Mrs. Smith, mentioned earlier in this article, found help when her daughter took her to the doctor and her weight loss was detected. The doctor started her on an anti-depressant and spoke to both of them about changing her environment. Mrs. Smith’s daughter found ways for her mother to get to the local senior center, where she could socialize with others and share a meal instead of sitting at home alone for most of the day. Her mood, and weight, started to improve.

Exposure and Awareness
Eating disorders in older adults need more exposure. More awareness needs to be brought to these diseases and the fact that they can occur (or reoccur) at any age. Anyone can help with that goal. The National Eating Disorders Association (NEDA) suggests that educating yourself and others about disordered eating and eating disorders, and spreading the facts surrounding them, is one way to raise awareness. You can also become involved in various charities that focus on providing information, research, and treatment for these diseases. •CSA

Susan Rowell, MS, CSA, has worked in the senior living industry since 1987. She has been a Caregiver, a Life Engagement Director, and a Licensed Nursing Home Administrator. She is currently the Community Relations Director at Quail Park of Lynnwood in Washington state. She has published books, articles, and a blog about issues that affect seniors and older adults. She can be reached at ageboldly@gmail.com.

REFERENCES