The Ageless Disease of Eating Disorders: Truths, Similarities and Differences in Older Adults

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Why Awareness Matters

- 30 Million People struggle with a clinically significant eating disorder at some point in their lifetime
- Only 1 in 10 individuals with eating disorders receive treatment.
  - Only 35% of people that receive treatment for eating disorders get treatment at a specialized facility for eating disorders.
- Eating disorders have the highest mortality rate of any mental illness

Key Facts to Remember

- Not a Choice
- Biogenetic Illness- eating disorders are highly heritable, but genetics ≠/≠ fate
- Nobody’s Fault: No blaming, no shaming, no judgment
- Eating Disorders Do Not Discriminate
- You Cannot Assess Health Based on Appearance
- Serves a Life Purpose
Objectives

- Overview of eating disorders and risk factors
  - Special considerations for older adults
- How Eating Disorders present in older adults
  - Persistent eating disorders
  - Relapse from eating disorder treated earlier in life
  - Long history of disordered behaviors/traits that develop into an ED later in life
  - New onset of ED
- How physical and nutritional risk may differ in older adults
  - Nutrition Assessment

Eating Disorders 101: Know Your Basics

- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge Eating Disorder (BED)
- Avoidant/Restrictive Food Intake Disorder (ARFID)
- Other Specified Feeding or Eating Disorder (OSFED)
- Unspecified Eating Disorder

Why Does an Eating Disorder Occur?

- Physiological Adaptation to Starvation
- Genetic Predisposition
- Temperament
- Environmentally triggered
- Media/Society
- Family Dynamics (history of dieting, inappropriate boundaries)
- Co-morbidity of Depression / Anxiety or other Mood/Personality Disorder
What is the Function of an Eating Disorder?

A Coping Mechanism
- Escape
- Protection
- Communication
- Emotional Regulation
- Feeling in control of their life
- The precipitating event may not be what maintains the disorder

Eating Disorders: The Numbers
- In Women:
  - 0.9% Diagnosed with AN in lifetime
  - 1.5% Bulimia
  - 2.8% Binge Eating Disorder
  - 1.5% Other Specified Feeding and Eating Disorders (OSFED)
- Majority of the onset is adolescence through early adulthood

Eating Disorders do not Discriminate
- 10-20% are males
- All races, Socio-economic statuses
- Not a “young rich white girl disease”
Risk Factors

- Being Female
- Genetic Predisposition
  - Character Traits
  - Low self esteem
- Intrusive Body Dissatisfaction
- Social Pressures/"standards"
- Co-morbid conditions
- Environmental Triggers
  - Precipitating events

Precipitating Events

- Life Event
  - Divorce
  - Death of loved one
- Trauma
- Other life transition
- Weight Loss

Common way of thinking regarding eating disorder symptomology
**Eating Behaviors Spectrum**

<table>
<thead>
<tr>
<th>Eating Behavior</th>
<th>Life Enhancing</th>
<th>Life Interfering</th>
<th>Life Distracting</th>
<th>Life Disrupting</th>
<th>Life Threatening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Complications</td>
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<tr>
<td>Outpatient</td>
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<tr>
<td>Intensive Outpatient</td>
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<tr>
<td>Partial Hospitalization</td>
<td>Medically Stable</td>
<td>&gt; 85% IBW</td>
<td>&gt; 80% IBW</td>
<td>&gt; 75% IBW</td>
<td>Needs some structure to gain weight</td>
</tr>
<tr>
<td>Residential</td>
<td>No IV/NG feedings needed, multiple daily lab not needed</td>
<td>&lt; 85% IBW</td>
<td>Needs supervision at all meals or will engage in symptoms</td>
<td></td>
<td>Structure required to prevent compulsive overexercising</td>
</tr>
<tr>
<td>Inpatient</td>
<td>HR&lt;60 bpm, BG&lt;60mg/dL, K&lt;3 meq/L, Temp&lt;97.0, Dehydration, orthostatic BP changes</td>
<td>&lt;75% IBW, acute weight decline with food refusal</td>
<td>Needs supervision at and after all meals, or needs tube feeding</td>
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</tbody>
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**Eating Disorders in Older Adults**

- Much is unknown
  - Older diagnostic criteria (DSM-IV) excluded post-menopausal women
  - Highest mortality of all mental illnesses
- 4% Prevalence in midlife (45 and older)
- 1 in 10 diagnosed with an ED is over 40
- Higher percentage of patient admissions to inpatient treatment centers are over 40 y.o.

Adapted from: Am J Psychiatry 157:1 January 2000 supplement

McKinley and Nittberg 2006; Heel et al., 2010; Mergenthal-Mather et al., 2008; Heek 2006
Body Image, Dieting Issues

- 69 million women dieting at any given time
  - Lose or maintain weight
- Body dissatisfaction stable across lifespan
  - Increases with increased BMI until age 60

Weight and Shape concerns over 50

- Online survey (n=1849)
- 71.2% trying to lose weight
  - ~50% of those over age 75
- 35.6% spent at least 50% of the past 5 years dieting
- 3.5% binge eating
- 7.8% purging in the past 5 years
- 13.3% report at least one core eating disorder behavior

Challenges for Older Adults when Seeking Help

- Shame and embarrassment
  - Needing help
  - Not getting over “teenage disease”
  - Stigma of therapy
- Less known as a diagnosis decades ago
  - Did not seek help.
  - Long term struggles
- Perceived or real barriers to entering treatment
  - Family
  - Financial responsibility
  - Not making self a priority

www.nationaleatingdisorders.org
Differing Factors in Older Adults

- Normal physical changes due to aging
  - Metabolic rate decline
  - Weight gain
- Perimenopausal hormone changes
  - Estrogen from adipose tissue to protect bones, manage menopausal symptoms
- Medical weight loss recommendations

Considerations in Older adults Seeking Treatment

- More or less motivation for treatment due to sense/ awareness of loss due to ED
- Significant Stressors and losses of adulthood
- Body image issues still present
  - Enduring and ingrained
**Persistent / Chronic Eating Disorders**
- Long-term struggles with clinical eating disorder
- Severe and Enduring Anorexia Nervosa (SE-AN)
- May or may not have sought treatment
- Ingrained behaviors
- Physiologic adaptations
  - Normal lab values
- Higher Mortality Rate
  - 20% after 20 years

**Relapsing Eating Disorders**
- Diagnosed at early age
- Treatment/ recovery earlier in life
  - Precipitating event as older
  - Sub threshold behaviors may or may not have existed

**Example: Phyllis (Relapsing ED/Chronic(?))**
- 54 y.o. WF
- History of eating disorders
  - Treatment in 1987 for AN
  - Binge/purge behaviors for 10 years after treatment (age 28-38)
- Onset of restriction after recollection of past trauma at age 40
Food Preoccupation developing into Eating Disorder

- Extended or recent history of chronic dieting, body dissatisfaction
- Likely temperament traits and/or co-morbid mental illness present
- Precipitating factor triggers full-blown eating disorder

Example: Betty (subclinical behaviors emerging into ED)

- 61 y.o. WF
- Presenting with new onset of Clinical BED
  - History of dieting, body dissatisfaction
  - Recent life triggers had food sought for comfort and control

Late Onset Eating Disorder

- Other mental or physical issues may initiate weight changes which trigger disorder
- Perpetuated by eating disorder
- Perimenopausal trigger?
- Subgroup of women sensitive to estrogen fluctuations
  - Binge eating behaviors
  - Sleep disruptions
Example: Alexandra (new onset)

- 64 y.o. WF
  - Ten year breast cancer survivor
  - Mother died at client’s current age
  - History of anxiety, depression
    - Recent depressive episode led to weight loss
    - Also reporting numerous undocumented food allergies (beef, gluten, dairy, nuts).
  - 5’6” reported UBW of 135#
    - Current weight 99# (BMI of 16)

Food Recall: “Susan”

- 4:40 am = 1.5 oz. Haddock, 2/3 C Sweet potato
- 7:45 am = 2 oz. Haddock with 1 1/3 cups veggie/rice mixture
- 10:30 am = 2 oz. Haddock, 2/3 c sweet potato
- 1:00 pm = 5 oz. Haddock, ½ avocado, 8 rice crackers (60 cal; 13 carbs, 1 pro), 1 ½ cups veggie/rice, 1 cup “rice water”
- 3:30 pm = “snack” few bites sweet potato with fish (not specified amounts)
- 6:30 pm dinner = 6 oz. Haddock, ½ avocado, 1 ½ corn tortillas (per 2-110 cal; 22 carbs; 2 pro), 1 ½ cup veggie/rice, 1 cup “rice water”
- 9:30 PM snack = 1 oz. Haddock, 1/3 cup sweet potato

Onset of Eating Disorders in Older Men

- Similar profiles as noted above
- Higher prevalence of BED than in women
- Increased risks of falls
  - Overexercising behaviors

Reas and Steedal, 2015
NUTRITION CONSIDERATIONS

How may You see a patient with an Eating Disorder?

- Fainting episodes, dizziness
- Low potassium
- Anemia
- Low Blood Sugar
- Constipation/ GI Issues
- Suicidal Ideation

Red Flags of potential eating disorders

- Rapid weight loss
- Hair loss
- Lanugo
- Poor capillary refill
- Muscle wasting
- Swollen glands
- Calluses on knuckles
- Tooth enamel erosion
Nutrition Risk Factors in Eating Disorders

**Acute:**
- Malnutrition
- Orthostasis
- Electrolyte Imbalances
- Dehydration

**Long term:**
- Osteoporosis
- Muscular (including cardiac) atrophy
- Dental problems
- Depressed immunity
- Kidney failure

Body less resilient

Screening Questions

- Are you satisfied with your eating patterns?
- **Do you eat differently when alone than when with other people?**
- Does your weight affect the way you feel about yourself?
- Do you believe yourself to be fat when others say you are thin?
- Do you worry you have lost control over how much you eat?

Proper assessment of eating Disorders

- Increased medical rule-outs
  - Thyroid issues
  - Diabetes
  - Infection
  - Cancer
  - Pulmonary Disease
  - GI Issues
  - Depression
  - NOTE ANY OF THESE MAY BE PRECIPITATING FACTOR
Nutrition Interventions versus Weight Loss

- Mortality not directly related to weight loss
  - Mortality increased due to weight fluctuations
  - Decreased lean body mass in weight regain
  - Most Co-morbidity risk not affected by weight loss
  - Greater satisfaction with one’s weight shows better health in all weight ranges
  - Behaviors not BMI predict health

Lee et al. 2020; Blake et al. 2013; Barry et al., 2014

Indications supporting Hospitalization (one or more of the following)

- < 75% median body mass index for age and sex
- Dehydration
- Electrolyte disturbance (hypokalemia, hyponatremia, and hypophosphatemia)
- EKG abnormalities (e.g., prolonged QTc or severe bradycardia)
- Physiological instability
  - Severe bradycardia (heart rate <50 beats/minute at daytime; <45 beats/minute at night)
  - Hypotension (<90/45 mm Hg)
  - Hypothermia (body temperature <96F, 35.6C)
  - Orthostatic increase in pulse (>20 beats per minute) or decrease in blood pressure (>20 mm Hg systolic or >10 mm Hg diastolic)


Goals of Different Levels of Care

- **Inpatient Hospitalization (IP):** Medical stabilization
- **Residential Treatment Center (RTC):** Weight restoration, symptom management, skill building
  - More intensive therapeutic opportunities
  - Help prepare self and environment for step-down
- **Partial Hospitalization Program (PHP):** Work on independence with strong therapeutic support
  - Sleep on own, meal(s) on own
- **Intensive Outpatient Program (IOP):** Begin real life with consistent support throughout the week
Take Home Messages

- Eating Disorders are prevalent in all ages and demographics
- Precipitating versus Perpetuating Factors
- Ask questions – don’t assume
- Behaviors versus weight when making health improvement recommendations
- Seek help from other providers
  - Eating Disorders are a collaborative treatment effort

Thank You!

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- Blake CE et al. Adults with Greater Body Satisfaction Report more Positive Health Behaviors and Have Better Health Status Regardless of BMI. J Obesity. 2013; (Article ID 291371)
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