Eating disorders in middle aged women: A review

Abstract
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EATING DISORDERS IN MIDDLE AGED WOMEN: A REVIEW

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Katherine Elder, PhD
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Abstract

In regard to eating disorders, most research to date has focused on adolescents and young women. In recent years, there has been an increase in individuals over 40 seeking treatment for eating disorders. A more comprehensive understanding of eating disorders is needed across all age ranges. This review is based on a comprehensive online search for published studies on eating disorders among middle age women. Forty-four studies, published between 1974 and 2012, were found. Predictors and risk factors, clinical features, psychological correlates, comorbid diagnoses, BMI, physical repercussions, and assessment and treatment concerns are considered in respect to eating disorders in middle-aged women. Research findings are mixed and indicate that severity of some related issues may improve or lessen with aging (e.g. body image dissatisfaction) while others may arise or worsen (e.g. aging anxiety, cognitive processing biases). However, it is evident that middle age is associated with different clinical features, risk factors, psychological correlates, comorbid diagnoses, BMI effects, physical repercussions, and assessment and treatment demands.

Keywords: Eating disorders; middle age women; aging; adult development
Eating Disorders in Middle Aged Women: A Review

Historically most research on eating disorders has focused on adolescent and young women. Some studies have indicated both anorexia nervosa (AN) and bulimia nervosa (BN) occur rarely in women age 29 and older (Garfinkel et al., 1995; Hoek et al., 1995). However, other research indicates the risk of having an eating disorder (including eating disorder not otherwise specified [EDNOS]) is a lifelong concern (Fornari, Kent, Kabo, & Goodman, 1994; Gadalla, 2008; Hay, 1998). Morris (as cited in Harris & Cumella, 2006) reported in recent years, eating disorder treatment programs have been recording a steady increase in clients older than 40.

According to the National Institute of Mental Health (NIMH), there is no statistical difference of lifetime prevalence rate between age groups in regard to AN. NIMH reports BN is less likely to occur in individuals over 60, but with no differences between people aged 18-59. The most common eating disorder diagnosis is EDNOS, which may include individuals with prodromal or subclinical AN or BN symptoms and could skew prevalence data on specified eating disorders (Hudson, Hiripi, Pope, & Kessler, 2007).

Typical age of onset for AN is between 14 and 18 (American Psychiatric Association, 2000). Early onset is described as before 15 (Lask et al., 2005) or even before 11 (Casper & Jabine, 1996) and late onset is considered after 18 years (Steinhausen, 2002). Generally, onset of an eating disorder ranges from 10 to 20 years of age. Data suggest middle age eating disorder patients may have had onset of the eating disorder anywhere from preadolescence into their 30s and 40s (Cumella & Kally, 2008). When eating disorders present mid-life, they may represent a new onset, exacerbation of previous symptoms or manifestations of a chronic disorder (Fornari et al., 1994).
Some studies suggest prognosis is better for adolescent onset of an eating disorder rather than for adult onset (Steinhausen, 2002). Other studies demonstrate evidence for a worse outcome for early onset AN (Walford & McCune, 1991). Despite disparate findings, it is believed that age has an influence on psychosocial stressors (Boast, Coke, & Wakeling, 1992) with shorter duration of illness and presentation fostering a better outcome (Russell & Gilbert, 1992).

Some research indicates middle age individuals with eating disorders have more severe pathology than younger individuals. Middle age patients were admitted with lower BMIs, more prior inpatient treatment episodes, longer duration, greater suicidality, and more sexual abuse histories (Cumella & Kally, 2008).

With eating disorders affecting individuals across the life span and with potential for age related complications and pathological differences, a more comprehensive understanding of eating disorders across all age groups is needed. The following review will focus on eating disorders and their effects on middle age women.

**Methods**

A comprehensive computerized search was conducted for all studies published through 2013 of eating disorders in middle age women in the standard electronic database of PsychINFO. A search was conducted using the following search terms: eating disorders, aging, age differences, adult development, and middle age. The reference lists from articles were examined for other pertinent research.

**Results**

**Study Findings**
The search located 44 studies published in an academic journal in English from 1974 to 2012 that discussed women between the ages of 25 and 65 with disordered eating symptomatology.

**Clinical features.**

Eating disorders have characteristic disturbance in eating behavior coupled with disturbed body image, dietary limitations, refusal to maintain weight (in the case of AN), and potential binging and purging behaviors. Disordered eating may present with a set of clinical features known to correlate to an eating disorder diagnosis, such as obsessive-compulsive traits around food, history of being overweight, self-evaluation unduly influenced by their body size and shape, depressive and anxiety symptoms (Sadock & Sadock, 2005).

In an inpatient sample of 604 participants, significantly more middle age women, when compared with younger individuals, had AN restricting type, AN binge/purge type, and EDNOS and fewer had BN symptoms (Cumella & Kally, 2008; see also Boisvert & Harrell, 2009; Rand & Kuldau, 1992). This may reflect the intractable nature of AN, making it more likely to persist into midlife. It may also reflect a distinct feature of midlife eating disorders. Conversely, in a sample of 1807 female health care professionals, Perez, Hernandez, Clarke, and Joiner (2007) found no significant differences between age groups of women in terms of bulimic symptoms and suggest that bulimic symptomatology may not decrease with age. Abbate-Daga et al., (2007) found there were no significant differences in eating symptomatology between early, intermediate, and late onset AN in their sample of 250 outpatients. While findings are mixed regarding whether eating disorder symptoms persist, worsen, or improve in middle age, eating disorder symptoms are known to occur in adulthood.
In a total sample of 86 college and middle-aged alumnae women, Landa and Bybee (2007) examined two explanations for age-related differences in eating pathology: a reduction in self-image disparity and a reduction in perfectionistic ideals with age. They found self-image disparity and perfectionism were markedly lower among older women compared with younger women. For older women, there was a smaller difference between one’s current and desired self-image, meaning one’s present evaluation of her self-image was more similar to her idyllic self-image. Perfectionistic attitudes and behaviors, overall, decreased with adult development. Specifically the authors noted among older women, the parental measures did not relate to eating problems. The authors suggest the importance of parental expectations in eating pathology may diminish with age. They theorize that with respect to self-image disparity between current and desired state, a current negative self-image plays a large role in eating pathology than does an idyllic desired self-image.

Self-image and perfectionism are qualities often associated with body dissatisfaction. In an empirical review, Slevec and Tiggemann (2011b) found a main factor associated with disordered eating in middle-aged women to be body dissatisfaction, which they believed was mediated by negative affect. Conversely, in community samples, Kenny and Adams (1994) and Johnson and Bedford (2004) found body dissatisfaction, drive for thinness, and image preoccupation decreased significantly in women over 25 years of age. The authors hypothesized these concerns are allayed by life experiences associated with age. Cumella and Kally (2008) also posit middle age individuals with eating disorders may struggle with fewer body image distortions than younger patients. Consistent with this finding, they found middle age patients often need less body image therapy than younger patients, with fewer interventions to reduce
body image distortion. Body image dissatisfaction is a prominent feature of eating disorders overall, but body image may have different and reduced effects in older women.

As with many psychological symptoms, eating disorders may change over time with disorders potentially overlapping. In a sample of 141 inpatient girls and women with AN, Vandereycken and Pierloot (1983) found binge-eaters, specifically those who purge, were older both at admission and at onset of illness and had a longer duration of AN symptoms. The authors’ findings support the hypothesized dynamic nature of eating disorders: over time changes in eating disorder symptoms may occur in the same patient. The older the patient and/or the longer the history of eating disorder pathology, the more likely the individual will show alterations in her eating disorder behavior, either spontaneously or as a result of treatment.

Predictors and risk factors.

Multiple Risk Factors.

Research indicates the etiology of eating disorders is likely a combination of client characteristics, life events and experiences, and biology lending to a multiple risk-factor model (Striegel-Moore & Bulik, 2007). One must be cognizant of the multiple risk-factor model of eating disorders (Cohen, 2002; Fornari et al., 1994; Schwartz, Thompson, & Johnson, 1982) wherein the development of an eating disorder in a person vulnerable to this type of disorder is facilitated by the presence of individual, family, and cultural risk factors and stressors. These include biological, psychological, and social influences.

Precipitating events.

Some precipitating events that can trigger eating disorder behaviors in middle-aged women are likely different than those observed in younger women. An increase in occurrence of distinct precipitating events (Abbate-Daga et al., 2007; Fornari et al., 1994; Halmi, 1974; Harris
& Cumella, 2006; Russell & Gilbert, 1992), which were usually some form of loss, have been show to differentiate late onset and typical onset groups. Loss of an important person, idea, appearance, and way of life could precede an eating disorder. The prominent loss precipitant suggests a different genesis to the onset typically observed in adolescence.

**Loss.**

Loss can be enacted in a number of respects, each of which may precede an eating disorder in a number of theoretical ways. In two case reports of middle-aged women, Inagaki et al. (2002) reported late onset cases of AN develop out of sadness over a loss (such as divorce, bereavement, and fear of future) that enacts existential anxiety, not out of a fear of aging or losing attractiveness and sexuality.

Death of a parent may indicate the loss of safety and dependence. The loss of a child may lead to despair and a passive desire to die through self-starvation. When children leave the home, filling the void can be difficult if the primary identity has been mother. Death of a peer or sibling can increase thoughts of personal mortality. Divorce can raise issues of dependency, fears of being alone, low self-esteem, and the possibility of having to revisit dating. Women who develop an eating disorder after such losses may have developed eating disorders to escape maturity, passively die, fill the void, seek youth, and increase ideal image (Harris & Cumella, 2006).

**Depression and stress.**

Research indicates precipitating events often trigger eating disorders and Mynors-Wallice, Treasure, and Chee (1992) examined the differences between late and early onset of AN in regard to life events in a sample of 12 inpatient cases. They found late onset cases of AN are more likely to occur during chronic stress than early onset cases. Also, AN of late onset is more
likely to be complicated by concurrent depression than in young onset cases (Mynors-Wallice et al., 1992; Russell & Gilbert, 1992). However, it has been argued that long-term depression could also be a product of eating disorder duration rather than an etiological feature of midlife eating disorders (Cumella & Kally, 2008).

**Aging and physical appearance.**

Findings are mixed regarding the association between physical appearance and eating disorders. Some studies indicated no relationship between aging and physical appearance and eating disorders in middle age women (Inagaki et al., 2002). Others have found physical aging to be correlated with eating disorders in middle age (Midlarsky & Nitzburg, 2008; Slevec & Tiggemann, 2011a). Signs of aging can be difficult for some women to manage, especially if their primary identity and self-esteem come from their appearance. With aging, one may also fear losing their partner’s attention. Divorce can enhance a woman’s focus on her appearance and lead to desire to lose weight or achieve what she believes to be an ideal body by severe measures. Also, a traumatic illness can impair a woman’s body image and acceptance leading to desire to reshape the body or reclaim a young exterior (Harris & Cumella, 2006). Appearance investment and aging anxiety were positively related to body dissatisfaction and disordered eating in middle-aged women. In a study of 101 middle-aged women from a community sample, it was found middle age women might engage in maladaptive eating not just to achieve a thin body but also to appear more youthful (Slevec & Tiggemann, 2011a).

Slevec and Tiggemann (2011b) found many factors associated with body dissatisfaction and disordered eating in middle-aged women are similar to those found in young women. However, during midlife women also experience normal age-related changes to appearance, such as increased weight gain, menopause, and the aging of physical features.
**Sociocultural.**

Midlarsky and Nitzburg (2008) found that pathology in their sample of 290 middle age women that eating is related to sociocultural pressures to be thin, body dissatisfaction, and perfectionism. They found, in the presence of these variables, neither depression nor aging-related concerns was significantly related to disordered eating. The authors propose that middle-aged women may generally have internalized the message that “thin is beautiful,” more so than the message that “thin equals young” as did Slevec and Tiggemann (2011a).

Boisvert and Harrell (2009) stated that disordered eating is rising partially from unrealistic beauty ideals from repetitive social messages and subsequent internalization of the thin ideal. This could contribute to body dissatisfaction because of the discrepancy between the actual body and the thin ideal. Additionally, the Western cultural ideals of beauty and thinness may differentially impact non-White women.

Slevec and Tiggemann (2011a) found that media exposure through television was positively correlated with disordered eating as well as body dissatisfaction in middle-aged women. Media exposure was not associated with body dissatisfaction directly, but rather via a number of mediating cognitive processes, specifically thin-ideal internalization, social comparison, appearance investment, and aging anxiety. The feeling of failure to measure up to the midlife figures portrayed on television may be particularly harmful to middle-aged women. The authors found sociocultural theory provides a useful framework for disordered eating in middle-aged women.

**Existential anxiety and maturity fears.**

Developmental milestones or phase-of-life events may be stressors for women vulnerable to eating disorders at any age, triggering an eating disorder as a maladaptive reaction. Kenny
and Adams (1994) found maturity fears, associated with development of eating disorders, decreased significantly with increasing age.

However, Gupta (1990) demonstrated in two case reports patients developed AN of late onset when the physical and psychosocial changes associated with aging precipitated a “delayed adolescent crisis” for them. They were “forced to separate and individuate from their parents, a task that they had deferred since adolescence” (p. 224). Death or illness of a parent may bring up a fear of maturity or independence wherein one may unconsciously create physical illness such as an eating disorder to remain dependent (Harris & Cumella, 2006).

Zerbe (2002) noted that another commonly observed issue in middle age is envy and rivalry with younger generations. Zerbe recommended, “One must come to grips with the fact that one’s own time is limited while the lives of others seem just to be beginning” (p. 15).

To avoid the crisis of sexual maturation and demands of adulthood, women at middle age may use eating problems to avoid confronting life transitions or to cope with a fear of the future (Inagaki et al., 2002). The midlife transition often means coming to grips with actual losses and also recognizing the meaning of those losses to the self. Aspects of the self must be grieved so one’s life can continue (Zerbe, 2002).

Fox and Leung (2008) noted it is possible that AN may serve as a maladaptive attempt to regain control and meaning in life in that the disordered behaviors provide an exaggerated sense of control and inflated sense of uniqueness. Macleod (1981) (as cited in Fox & Leung, 2008) suggests that the denial of food can be itself an existential crisis of identity.

*Objectification theory.*

Disordered eating development has been linked to models incorporating constructs of objectification theory (i.e., sexual objectification, self-objectification, body shame, poor
interoceptive awareness; Fredrickson & Roberts, 1997). In a community sample of 659 women, Augustus-Horvath and Tylka (2009) found that, when compared with younger women, women ages 25 and older reported similar levels of body shame, poor interoceptive awareness, and disordered eating but lower levels of perceived sexual objectification and body surveillance. The authors found older women’s experiences with these constructs may differ as they depart from early stages of life, but objectification theory can be extended to women ages 25 and older.

**Abuse history and bullying.**

A history of sexual and physical abuse may be significant risk factors in the development of eating disorders, weight problems, (Kenardy & Ball, 1998; Cohen, 2002) and body dissatisfaction (Slevec & Tiggemann, 2011b) in middle-aged women. There is some evidence to indicate middle-age women with eating disorders have higher rates of sexual abuse than younger women with eating disorders (Cumella & Kally, 2008). Kenardy and Ball (1998) found in their community sample of 469 women that past sexual abuse was more predictive of disordered eating than current physical or sexual abuse.

Fosse and Holen (2006) suggest there is a relationship between BN and bullying and between BN and father overprotection. They hypothesize overprotective fathers may focus too much on their daughters’ weight and physical appearance, which may result in poor self-esteem. Poor self-esteem may contribute to bullying by peers at a young age. Their study of 107 female outpatients also indicated that early childhood experiences such as bullying and overprotection are linked to more chronic or late onset BN.

**Body Mass Index (BMI).**

In two case studies, Gadalla (2008) found older women who had eating disorder symptomatology had higher average BMI than older women who did not endorse eating disorder
symptomatology. The women with higher BMI exhibited higher frequencies of dieting behaviors and preoccupation with food content and calorie intake. Slevec and Tiggemann (2011b) found one of the main factors associated with body dissatisfaction and disordered eating in middle age women is BMI. They suggested that body dissatisfaction mediates the relationship between BMI and disordered eating. Middle-aged women reported lower body satisfaction than did younger women (Boisvert & Harrell, 2009).

Rø, Reas, and Rosenvinge (2012) investigated the effects of age and BMI on eating disorder symptoms in a community sample of 3000 females and found two trends, symptoms decreased with age yet increased with BMI. Further analysis indicated that BMI had a far greater impact than age in the variance of symptomatology. Tao and Zhong (2010) also found that in comparison to age, BMI had a stronger impact on the psychological and behavioral traits related to the eating disorders among a community sample of 236 middle-aged Chinese women. In comparison to the older group (50-59), the younger group (30-39) and middle-aged group (40-49) expressed the desire to lose weight with a lower BMI. The authors assumed that relatively young Chinese women suffered from more pressure to be thin than older women. One can infer that while age is a factor, increased BMI is more closely related to eating disorder pathology.

At the time of initial evaluation of 604 inpatient participants, BMI had a large influence on classification for peak-onset (onset between age 15 and 24) and late-onset (onset after age 25) AN in that BMI decreased as age of onset increased (Cumella & Kally, 2008; see also Boast et al., 1992; Casper & Jabine, 1996; Kimura, Tonoike, Muroya, Yoshida, & Ozaki, 2007). In a sample of 149 psychiatric patients, Kimura et al. (2007) found that clinical features of late-onset AN are similar to those of peak-onset AN except for BMI at the time of initial evaluation. The authors presuppose this may be related to the common psychopathology of late-onset and peak-
onset AN. Greater weight loss and increasing age and delay in seeking help has been linked to worse outcome (Steinhausen, 2002). Possible explanations provided by Boast et al. (1992) include lower weight individuals have more malignant illness or that the older group had a more prolonged illness dating from the onset of eating pathology.

**Psychological functioning.**

Developmentally, one would assume a middle age individual with an eating disorder might have different emotional and psychological processing than would a younger individual with and eating disorder. Additionally, the functioning of one’s mind may be affected by decreased nutrition and semi-starvation. Patrick, Stahl, and Sundaram (2011) demonstrated in their community sample of 567 adults, that unhealthy eating-related cognitions exert effects on disordered eating, which increases psychological distress. Moreover, decreased satisfaction with appearance exerted direct effects on psychological distress. For middle-aged women with eating disorders, decreased nutrition and decreased satisfaction with appearance together likely have an increased influence on psychological distress. The increase in psychological distress would negatively effect healthy psychological functioning.

In a sample of 90 individuals, outpatients and control subjects, Shott et al. (2012) found cognitive set-shifting, flexibility, or inefficiencies may be an important aspect of AN at late age, and could point towards developmental brain changes that could affect individuals with AN at different ages. Shott and colleagues were not sure whether set-shifting inefficiencies are a result of illness duration, develop during late adolescence or young adulthood, or whether youth with AN have protective factors that compensate for such cognitive difficulties.

Zonnevylle-Bender et al. (2004) demonstrated adolescents and adults with eating disorders do not differ significantly in regard to emotional functioning. In 71 patients admitted
for eating disorders either in- or out-patient, the authors measured emotional functioning by use of the construct alexithymia. Alexithymia includes difficulty identifying feelings, difficulty describing feelings, a limited imaginative capacity, and an externally oriented style of thinking (Taylor, Parker, & Bagby, 1999). Both groups had high alexithymia scores and performed worse on tasks measuring alexithymia indicating poorer emotional processing ability.

Heebink, Sunday, and Halmi (1995) found few psychological differences between 250 inpatient adolescents and adults with eating disorders. The authors suggest that eating disorder symptomatology and associated affective states are fairly consistent through life or that certain developmental processes have little effect on an eating disorder during illness.

Boast et al. (1992) found within their sample of 185 patients with AN, individuals with late-onset and typical onset had similar profiles of psychosocial stressors and high rates of reported disturbance in relationships. Both groups shared much of the psychopathology and behaviors associated with weight loss.

Abbate-Daga et al. (2007) found that age, irrespective of age of onset, appeared to have an independent effect on the personality dimensions of cooperativeness and self-directedness on the Temperament and Character Inventory (TCI; Cloninger, Przybeck, & Svrakic, 1994). According to the TCI, cooperativeness reflects the degree to which the self is viewed as a part of society and self-directedness indicates the degree to which the self is viewed as autonomous and integrated. Abbate-Daga et al. noted that self-directedness and cooperation decrease with age in women with AN, yet in non-anorexic subjects, self-directedness and cooperation typically increase (Cloninger et al., 1994). The authors hypothesized that being anorexic may at times benefit adjustment or self-esteem and the feelings of belonging to a social group at a younger age, but with age, patients become more aware of their character limitations.
In a sample of 80 non-clinical female participants, Seddon and Waller (2000) found that women with bulimic attitudes show both attentional bias toward and cognitive avoidance of emotional information, with the processing style varying with age. The older group showed attentional bias toward negative emotion cues that was stronger among women with more bulimic attitudes. The authors hypothesized that the change in strategy might be linked to environmental changes, such as the presence of unresolvable emotional issues during the development of relationships. Or, the change may be related to the duration of the eating problem, and the gradual failure of avoidance as negative affective states become more prominent.

Fox and Leung (2008) suggest that individuals who are vulnerable to anorectic thoughts and behaviors may be more prone to existential anxiety. Factors that predispose someone to developing a maladaptive coping strategy such as AN may also predispose him or her to suffer more existential anxiety.

Cumella and Kally (2008) found that among midlife patients, Eating Disorder Inventory-2 (EDI-2) admission scores were significantly lower usually indicating less severe pathology than for younger patients. Lower EDI-2 scores often suggest less eating disorder severity, however, lower EDI-2 scores are typical of severe eating disorder inpatients with long illness durations. Garner (as sited in Cumella & Kally, 2008) suggests that this is likely due to denial about the eating disorder, which suppresses self-reported symptoms. Middle age patients’ MMPI-2 scores, support that denial was likely use to diminish awareness of psychological symptoms. Compared to younger individuals with eating disorders, middle age individuals appear to be less aware of their emotional needs, rely more on denial and repression, and are less inclined toward impulsive behavior (Cumella & Kally, 2008). Zerbe (2002) noted that just as
adolescents and young adults tend to deny or minimize the extent of an eating disorder, so the older adult refrains from acknowledging her difficulties, often out of shame or guilt.

**Comorbid psychological diagnoses.**

Casper and Jabine (1996) found in their clinical sample of 75 girls and women, all women with chronic AN, even some who had recovered, qualified for one or more psychological diagnoses. Women with a later age of onset reported high levels of previous psychiatric illness, particularly episodes of depression. Boast et al. (1992) suggest the increase in psychological diagnoses is due to patients having lived longer. Boast et al. and Cumella and Kally (2008) report high rates of suicide among individuals with late onset AN. The higher incidence of self-harming behaviors in chronic patients might be indicative of more severe psychopathology or of concomitant personality disorder (Russell & Gilbert, 1992).

In regard to distinguishing psychological diagnoses and disorders typically associated with eating disorders between younger women and middle-aged women, Cumella and Kally (2008) found significant differences in depressive disorder not otherwise specified, major depressive disorder, bipolar disorder, cannabis abuse/dependence, and opioid abuse/dependence. In further analysis, the authors found the duration of depressive symptoms, rather than severity may be the primary difference between midlife and younger eating disorder patients. Heebink et al. (1995) found that older patients, specifically with AN restricting type, had more depression and anxiety than younger patients. In regard to substance abuse, there was a trend for midlife patients to use more sedative drugs (Cumella & Kally).

Psychological disorders correlated with eating disorders in middle age include depression (Mynors-Wallice et al., 1992), bipolar disorder (Cumella & Kally, 2008), anxiety (Gadalla, 2008; Zonnevyle-Bender et al., 2004; Halmi, 1974), substance use (Fornari et al., 1994), and
schizophrenia (Muñoz & Ryan, 1997). Additionally, the comorbidity of eating disorders and personality disorders is high (Abbate-Daga et al., 2007). In a community sample of 658 individuals, Johnson, Cohen, Kasen, and Brook (2006) found individuals with personality disorders by young adulthood are at an elevated risk for eating disorders at middle adulthood. Borderline and histrionic personality disorder symptoms were associated with recurrent binging and purging, antisocial and schizotypal symptoms were associated with recurrent binging and obesity, and depressive personality disorder symptoms were associated with recurrent binging and dietary restriction.

**Physical complications and mortality.**

It is essential to rule out possible medical causes of eating disorder symptoms, since such symptoms may mimic a variety of illnesses, such as malignancies, thyroid disease, blood abnormalities, and diabetes (Devlin et al. as cited in Harris & Cumella, 2006). Psychosomatic complaints may be greater in older individuals (Halmi et al., 1974), which may complicate differentiating between medical disorders and psychological disorders.

Chest pain is a common complaint among individuals with AN. Increased age and low body weight have been found to lead to a higher incidence of chest pain indicative of coronary heart disease in individuals with AN (Birmingham, Stigant, & Goldner, 1999). All individuals with AN should be well screened for risk factors of coronary heart disease, especially older individuals.

People with AN are 18 times more likely to die early than the general same aged population (Hudson et al., 2007). In a review of over 10 million death records, Hewitt, Coren, and Steel (2001) found mortality is greater among older individuals, but because there are more causes of death in older women, the relative risk is greater for younger women. Hewitt et al.’s
findings suggest that mortality risk from present AN may be lower than previously assumed, though not for indirect morality risk of a past disorder, and mortality risk is not confined to younger individuals.

Cohen (2002) warns that many older people will not be pressured by family members or friends to seek treatment. Because the patient, family, and friends may not recognize the problem as an eating disorder, it may go misdiagnosed. Older patients with eating disorders and psychological comorbidities are at serious risk for cardiovascular disease, osteoporosis, kidney disease, brain damage, and death if eating disorders go undiagnosed or untreated.

Middle age women may have subclinical eating disorders that have gone undiagnosed and untreated for years. Therefore, these women may be experiencing significant effects of sustained malnourishment, such as orthostatic hypotension; bradycardia; electroencephalogram changes; and gastric, hematological, renal, and metabolic abnormalities. Middle age women with eating disorders are more likely to over exercise and use stimulants to lose weight than middle age women without eating disorders. Complications of excessive exercise and poor nutrition may include stress fractures and osteoporosis (Harris & Cumella, 2006).

**Assessment and treatment considerations.**

Physicians and health practitioners should be alert to the possible diagnosis of eating disorders when older adults present with weight loss and weight preoccupation (Rand & Kulda, 1992). All women should be screened for symptoms of disordered eating and associated psychiatric comorbidity.

It is important to note that although similar factors may operate in women of all age groups, their salience may vary by age. Therefore, treatment may need to differ depending on
age and unique presentation of each individual. A thorough understanding of one’s history is fundamental and essential in conceptualization and subsequent treatment planning.

Given that cognitive inflexibility contributes to poorer treatment prognosis (Roberts, Tchanturia, & Treasure, 2010) and set-shifting inefficiencies appear to develop over time, then it becomes even more important to identify and treat eating disorders at a younger age before the development of set-shifting inefficiencies (Shott et al., 2012) and increased malnourishment affect other cognitive functions. Consideration of cognitive factors among middle age women with eating disorders is important, as interventions to reduce this problem may be necessary.

Because middle-aged women with eating disorders may have a high degree of denial of symptoms and emotional disengagement, treatment for midlife patients may need to be tailored for greater denial and alexithymia related to treatment resistance issues (Cumella & Kally, 2008). Additionally, older patients are more likely to process negative emotional material, assimilating negative rather than positive emotional material (Seddon & Waller, 2000) in all aspects of their life, including treatment. Again, approaches that counter these types of cognitive processing biases may be particularly important among individuals with chronic eating disorders.

As depressive symptoms are often comorbid with eating disorders, it is suggested that depression be assessed and targeted if necessary. Treatment recommendations may need to include additional work to address entrenched depression and more aggressive antidepressant medications are warranted for some patients (Cumella & Kally, 2008; Mynors-Wallice et al., 1992).

Often times, adolescent and adult treatment centers differ in regard to therapeutic approach. Child and adolescent treatment is often based around family interventions. Adult treatment tends to be based around individual therapy, and the patient is encouraged to take
personal responsibility for change (Winston, Paul, & Juanola-Borrat, 2012). While some treatment centers have groups who serve all ages, other groups pertaining to aging with eating disorders may prove beneficial to target specific age related factors. AN has been related to existential concerns that can be incorporated into existing cognitive-behavioral constructions of treatment (Fox & Leung, 2008) with special attention to longstanding eating disorders as they can become integral to one’s identity and therapy can be a threat to this identity (Cohen, 2002).

Other aspects of psychotherapeutic treatment for middle age women with eating disorders may focus on rebuilding an identity based on life experiences, successes, and personality attributes, rather than on appearance. If helpful, therapists can aid clients in understanding the grief process and developing an acceptance of aging and may use spirituality to promote a sense of meaning in relation to maturity (Harris & Cumella, 2006; Robert & Gilbert, 1992).

Assessing for historical sexual and physical abuse in middle-aged women and addressing trauma using evidence-based methods is deemed critical as abuse has been shown to be an associated risk factor and potential factor for increased duration of illness (Cumella & Kally, 2008). Middle age individual’s treatment needs in body image distortion may be lower than those of more traditional age, such that mixed age body image groups may prove less ineffective for middle age women (Cumella & Kally, 2008; Russell & Gilbert, 1992). However, Slevec and Tiggemann (2011a) still recommend treatment strategies aimed at challenging and minimizing thin ideal, social comparisons, appearance investment, and aging anxiety processes that may reduce some of the negative impact of media exposure in middle age women.

From a psychodynamic perspective, Zerbe (2002) asserts that therapists who treat middle-aged clients with eating disorders should pay attention to issues such as narcissistic preoccupation with the body, unresolved losses, need for control and autonomy, unconscious
envy and competition, devaluation of women who are older, unconscious identification and transferential enactments.

**Discussion and Conclusion**

With respect to eating disorders, age is deemed to impose differential effects. Research findings are mixed and indicate that severity of some related issues may improve or lessen with aging (e.g. body image dissatisfaction) while others may arise or worsen (e.g. aging anxiety, cognitive processing biases). However, it is evident that middle age is associated with different clinical features, risk factors, psychological correlates, comorbid diagnoses, BMI effects, physical repercussions, and assessment and treatment demands. Further research is needed to elucidate differences in regard to age in respect to nomothetic and idiographic features of eating disorders.

 Possibly most pertinent to understanding eating disorders among middle age women is the identification of women who have experienced a chronic course of the disease suggesting greater physical endangerment and potential for long-standing symptomatology. These two factors increase risk of harm and decrease prognosis for change. Comorbid diagnoses, most commonly depression and anxiety, may need particular attention while ensuring weight restoration and physical health. Assessing for recent psychological loss of any respect may also be particularly important for establishing a treatment plan for middle age women with eating disorders.

 The studies included in this review represent numerous ethnic groups including Chinese, Norwegian, British, Australian, Canadian, and American populations. There is evidence that eating disorders manifest differently cross-culturally. In order to understand eating disorders of middle-aged women well, the disorders must be examined in a cross-cultural paradigm without
holding the Western or US ideal of beauty as applicable to all. Age, appearance, nourishment, and psychological pain have differing meanings across the globe, and these should be further examined for associative patterns in regard to eating disorders.

Further studies would assist in separating the effects of weight and BMI from those of menopause (Slevec & Tiggemann, 2011b). Amenorrhea is less useful in middle-aged women as they may not menstruate for a number of reasons; however, amenorrhea is a criterion for AN. Separate from diagnostic integrity, the conceptualization of eating disorder pathology is likely different post-menopause for most women.

Future research should attempt to identify factors that may protect middle-aged women against the development of eating disorders. As eating disorders may present for the first time in middle age and have the potential for more deleterious physical effects, appreciating precipitating events is key for this age group.

Potential generational differences will continually present new effects on the conceptualization and treatment of psychological disorders. As the baby boomer generation ages, further information is necessary for proper treatment for this group. Midlarsky and Nitzburg (2008) found current cohorts may have even higher expectations regarding their own physical attractiveness than past cohorts, likely adding to disordered eating pathology. Thus, as the baby boomers age the need for increased research and clinical attention will be become more important, as will the updated conceptualization needed for future generations in their wake.

The preceding review has limitations that affect its overall findings. Among studies there were a multitude of methodologies, different definitions of pathology, different groupings for classification of middle age, little differentiation between late onset and chronicity, small sample sizes, and few ethnic minorities represented in American studies. Despite these limitations, this
review summarized some of the key findings regarding the etiology, risk factors, clinical features, effects, and treatment considerations for middle age women with eating disorders. While age likely has a considerable impact in understanding and treating an eating disorder, appreciating the age in the larger context of the person’s life and experiences is likely the most important tool in conceptualization and treatment.
References


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