INSIDE OUT
Institute for Eating Disorders

Eating Disorders and Older Populations

(Aziz, Rafferty & Jurewicz., 2018).

Eating disorders (EDs) can affect older people. There are three categories:

1) those with an ED from a younger age,
2) those who had received treatment at an early age but the ED has recurred or
3) those who develop it later in life

Older persons are most affected by Anorexia Nervosa compared to other EDs, with around 50% of the onset reported to be after 40 years of age (Mulchadani et al., 2021). However, it can be difficult to identify an ED because some symptoms are associated to ageing.

Signs of an ED in an Older Person

To identify an ED, do the following:

- Refer to the DSM-5, use the SCOFF or IOS

Other signs to consider:

- Laxative or diuretic use
- increase/ decrease of at least 5-10% of body weight in a short time period
- Desire to eat alone or avoiding meals
- Physical signs: excessive hair loss, dental damage, heart or digestion problems
- Anxiety or depression (comorbidity with ED symptoms)
- Purging after a meal

Triggers for an ED in an Older Person

Stressors like loss and grieving can trigger an ED in the older population, for example:

- Death of a child or their children leaving home
- Ageing or death of a parent
- Divorce or widowhood
- Chronic illness and signs of their own ageing

This is because EDs are about perceived control and the use of dieting and weight control at an earlier age as a coping strategy can promote this behaviour later in life. Other triggers that can cause restriction include body dissatisfaction due to aging such as: decreased ability to burn calories, decreased mobility and bodily changes associated with ageing.

Other Issues associated with Disordered Eating in the Older Adults

Although it is important not to miss an eating disorder in an older person there are a number of other causes of weight loss in the older population.

- Medical Problems:
    - Multiple medications that affect appetite
    - Gastrointestinal, cardiovascular and pulmonary problems
    - Poorly fitting dentures, missing teeth, dysphagia
- Mental problems
    - Depression (Zayed & Garry, 2017)
        - Associative relation between depression and ED
        - Dieting or oral control behaviours increases risk of depressive symptoms
    - Dementia
        - Forgetting to eat or prepare food or difficulty remembering food
- Social factors like decreased ability to obtain and prepare food physically and financially

What to do with dementia-related disordered eating?

- Provide regular snacks or small meals instead of set meal times
- Showing pictures of food to stimulate recognition of food
- In earlier stages, preserve autonomy by helping to shop but not cooking for them
- Provide sufficient funding for food
- Monitor kitchen use or weight loss or mentions of hunger and grocery shopping

Treatment for ED in Older Adults

Psychological Interventions as a First-Line Treatment

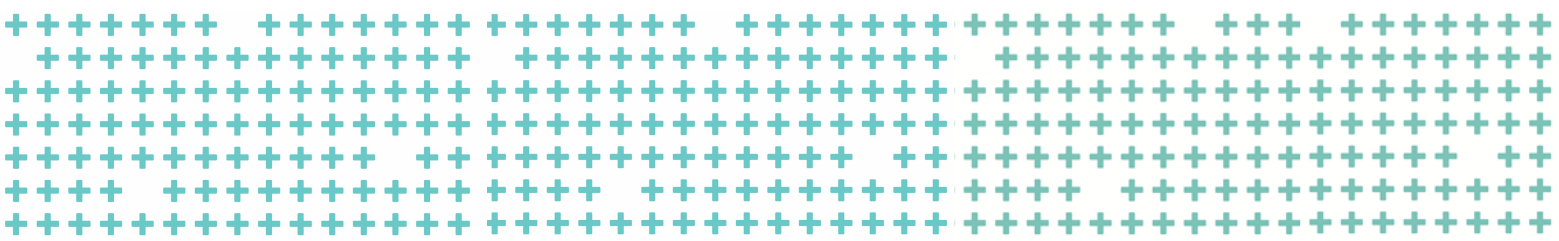
- Supportive counselling to cope with relational conflict, perceived losses, anger, decreased self esteem, and purposelessness.
- If depression and ED is present, treat with medication and psychotherapy
- Hearing and vision assisted cognitive behavioural therapy (CBT) to maximise learning
- Include discussions around normal age-related bodily changes

Multi-dimensional approach recommended (Mulchadani et al., 2021)

- Pharmacological, psychological and nutritional support
- Low-dose olanzapine specifically for anorexia nervosa
- Psychotherapy (family or individual based) for bulimia nervosa and anorexia nervosa
- Providing medical and psychiatric indicators for hospital admission

Care-planning, Physical Care, Familial Support and Day Programmes

- Ask questions around values and how ED behaviours have affected these values to motivate change
- Look after physical health by involving dieticians when considering to remove dietary restrictions (i.e salt and cholesterol).
- Psychoeducation for families surrounding ED (usually spouse or adult children)
- Day programmes can increase appetite by re-accustoming an individual to eating with others, increasing social activity and promoting physical rehabilitation.



Barriers to Treatment for Older Adults

- Lack of Awareness

Healthcare professionals may be less aware that older adults are experiencing an eating disorder and therefore may not address the issue with them.

- Shame

Older adults have reported shame and embarrassment about having a disorder associated with young people (Maine, 2016)

- Age of Treatment Group

Older adults may fear being part of a treatment group which is primarily comprised of adolescents and young adults. It may compound shame and sense of “being different”.

- Co-Morbidities

A number of other long-standing and related issues may also need to addressed, including addiction, PTSD, OCD, depression and anxiety as well as the consequences of long-term eating disorder behaviours such as excessive exercise, restriction and purging (Maine, 2016).

- Relationship to the ED

Particularly if an individual has had an ED for most of their life, it may be hard to consider the possibility of recovery. This can be because they may have attempted to get better multiple times without being able to, increasing a sense of hopelessness. In addition, recovery for older adults may also involve the challenge of developing their identity outside of the eating disorder as well as learning new coping skills.

Prognosis

As with younger adults, the prognosis varies. Some will recover, some will improve and some will continue along a chronic course. Treatment should begin as soon as possible.