Anorexia, Bulimia, and Binge Eating Disorders in Older Adults

Rita Khoury, MD

Assistant Professor of Clinical Psychiatry

Adult and Geriatric Psychiatrist

American University of Beirut, Faculty of Medicine and the Medical Center, Beirut, Lebanon

Adjunct, St Louis University School of Medicine, Department of Psychiatry and Behavioral Neuroscience, Missouri, United States

Email: rk224@aub.edu.lb

Highlights

1- Eating disorders (anorexia nervosa, bulimia nervosa, and binge eating disorder) are often underdiagnosed in older adults, and anorexia nervosa is the most common of all three.

2- Eating disorders presenting in older adults can be either a relapse of a chronic young-onset disorder or a late-onset disorder due to unique precipitating factors such as grief, social isolation, menopause, or retirement.

3- Eating disorders in older adults are associated with increased physical and psychiatric comorbidities (malnutrition, cardiac arrythmia, refeeding syndrome, depression, anxiety, suicidality, and substance misuse), as well as a mortality risk of 21%.

4- There are no specific treatment guidelines developed for older adults, due to scarcity of data; they include a combination of hospitalization, outpatient therapy and medication. Aggressive treatment of psychiatric comorbidities is essential.

Text

1. Introduction

Malnutrition can be defined as a state resulting from lack of intake or uptake of nutrition, leading to altered body composition and body cell mass, diminished physical and mental functioning and impaired clinical outcome from disease. Malnutrition in older adults is multifactorial; in addition to physiological changes related to age, the acronym “nine d’s” summarizes a list of possible pathologies underlying malnutrition: dementia, dysgeusia, dysphagia, diarrhea, depression, disease (acute, chronic), poor dentition, dysfunction (functional disability), and drugs. Malnutrition has a severe socioeconomic and medical impact as it is closely correlated with frailty, sarcopenia, dementia, recurrent falls, and worse health outcomes (1). While dementia and

depression associated with unintentional weight loss are more commonly identified in older adults, other psychiatric etiologies such as eating disorders (anorexia, bulimia and binge eating disorders) are often underdiagnosed, as they are typically known to occur in adolescents and young adults. Research has shown that the drive for thinness and body dissatisfaction may persist in the elderly, which closely correlate with the fear of aging. A typical peak of symptoms is reported in the postmenopausal period in women (2). In a sample of community-dwelling Austrian women aged 60-70 years, the prevalence of eating disorders (EDs) according to the Diagnostic and Statistical Manual 4th edition (DSM-IV criteria) was 3.6% (3). Per the DSM-5 criteria, a similar prevalence (3.25%) has been found in a sample of 342 Portuguese women aged 65–94 years old (4). Although they share similar clinical presentation with women, older men rarely report suffering from EDs (prevalence rate of 0.02%) (5, 6), due to both age and gender bias. EDs in seniors can be either a relapse or a continuation of a young-onset ED or present as a late-onset ED, occurring de novo after the age of 40 (7); hence, gathering a thorough history, including collateral information from siblings, and offspring is critical.

2. Anorexia Nervosa (AN):

AN is a chronic and relapsing disorder characterized by restriction of energy intake leading to significant weight loss, fear of gaining weight, and disturbance of body image (table 1). It is the most common ED in the elderly and is associated with 21% mortality risk (8). A longitudinal study with 21-year follow-up after AN-associated hospitalizations showed that 10% continued to meet all diagnostic criteria. AN may also emerge de novo in the elderly, a condition known as late-onset anorexia nervosa or “anorexia tardive”. Anorexia tardive is believed to share important similarities with early onset AN; the common clinical features include age of menarche, weight at onset and upon presentation to a healthcare professional, and percentage of women partaking in high levels of physical activity or vomiting to lose weight. Differences between anorexia-tardive and young-onset AN include precipitating factors and psychiatric comorbidities: bereavement, domestic problems, and reduced social involvement are commonly associated with anorexia tardive; also, depression is a very common comorbidity, in addition to greater suicide rates, and substance misuse to lose weight (9). Nutritional rehabilitation can be challenging in these frail individuals, and particular attention for complications of refeeding syndrome is warranted (10).

3. Bulimia Nervosa (BN):

BN is characterized by binge eating (eating large amount of food with a sense of lack of control) and compensatory behaviors, such as self-induced emesis, laxative or diuretic use, or compulsive exercise to prevent weight gain (table 1). Like AN, BN can be either a relapsing form of a chronic early-onset disorder or a late-onset disorder. 10% of men and women over the age of 50 who had an eating disorder were diagnosed with bulimia nervosa, according to a 2010 meta-analysis (8). Although less common than AN, BN causes severe health risks, due to the medical complications of purging in vulnerable older adults. Those include arrhythmias, dehydration, and electrolyte abnormalities. Observational studies have shown that BN shares common features across all age groups notably demographics (race, gender, and marital status), fasting, self-induced vomiting, and laxative use (9).

4. Binge Eating Disorder (BED):

BED is characterized by binge eating episodes accompanied by marked distress in the absence of compensatory behaviors to lose weight (table 1). BED is associated with increased risk of type II diabetes and obesity, which are conditions to be aware of in older adults. Older individuals (aged > 40 years) suffering from BED have higher BMIs and report more medical problems, skip meals less often, exercise less often, and have less frequent binge eating episodes, when compared to their younger counterparts (<25 years old) (9). Much like other eating disorders, older BED patients have a higher mortality risk and a poorer prognosis compared to the younger patients (11).

5. Conclusion:

EDs need to be considered in the differential diagnosis for unexplained weight changes in older adults, regardless of gender. Early identification of these disorders and appropriate management can be lifesaving. There are no specific treatment guidelines developed for EDs in older adults, as research is limited mostly to case reports or case series, as shown by a recent systematic review (12). Management is based on a multidisciplinary approach including a combination of hospitalization, psychotherapy, and medications. Around 79.5% of treated cases reported improvement, while 20.5% relapsed or died due to complications.

References

1. Agarwal E, Miller M, Yaxley A, Isenring E. Malnutrition in the elderly: a narrative review. Maturitas. 2013;76(4):296-302.
2. Khalil J, Boutros S, Kheir N, Kassem M, Salameh P, Sacre H, et al. Eating disorders and their relationship with menopausal phases among a sample of middle-aged Lebanese women. BMC Women's Health. 2022;22(1):153.
3. Mangweth-Matzek B, Rupp CI, Hausmann A, Assmayr K, Mariacher E, Kemmler G, et al. Never too old for eating disorders or body dissatisfaction: a community study of elderly women. The International journal of eating disorders. 2006;39(7):583-6.
4. Conceição EM, Gomes FVS, Vaz AR, Pinto-Bastos A, Machado PPP. Prevalence of eating disorders and picking/nibbling in elderly women. The International journal of eating disorders. 2017;50(7):793-800.
5. Striegel-Moore RH, Garvin V, Dohm FA, Rosenheck RA. Eating disorders in a national sample of hospitalized female and male veterans: detection rates and psychiatric comorbidity. The International journal of eating disorders. 1999;25(4):405-14.
6. Reas DL, Stedal K. Eating disorders in men aged midlife and beyond. Maturitas. 2015;81(2):248-55.
7. Luca A, Luca M, Calandra C. Eating Disorders in Late-life. Aging and disease. 2015;6(1):48-55.
8. Lapid MI, Prom MC, Burton MC, McAlpine DE, Sutor B, Rummans TA. Eating disorders in the elderly. International psychogeriatrics. 2010;22(4):523-36.
9. Bulut EA, Khoury R, Lee H, Grossberg GT. Eating disturbances in the elderly: A geriatric-psychiatric perspective. Nutrition and Healthy Aging. 2019;5:185-98.
10. Zayed M, Garry JP. Geriatric Anorexia Nervosa. Journal of the American Board of Family Medicine : JABFM. 2017;30(5):666-9.
11. Ackard DM, Richter S, Egan A, Cronemeyer C. Poor outcome and death among youth, young adults, and midlife adults with eating disorders: an investigation of risk factors by age at assessment. The International journal of eating disorders. 2014;47(7):825-35.
12. Mulchandani M, Shetty N, Conrad A, Muir P, Mah B. Treatment of eating disorders in older people: a systematic review. Systematic Reviews. 2021;10(1):275.

Table 1: DSM-5 Criteria for Eating Disorders, American Psychiatric Association, 2013.

Anorexia Nervosa	Bulimia Nervosa	Binge Eating Disorder
Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health.	Recurrent episodes of binge eating*.	Recurrent episodes of binge eating*.
Intense fear of gaining weight or becoming fat, even though underweight.	Recurrent inappropriate compensatory behavior to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other	The binge eating episodes are associated with three (or more) of the following: Eating much more rapidly than normal. Eating until feeling uncomfortably full.

	medications, fasting, or excessive exercise.	Eating large amounts of food when not feeling physically hungry. Eating alone because of feeling embarrassed by how much one is eating. Feeling disgusted with oneself, depressed, or very guilty afterward.
Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.	The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for three months.	Marked distress regarding binge eating is present.
Restricting type: the patient has not engaged in binge-eating or purging in the past 3 months.	Self-evaluation is unduly influenced by body shape and weight.	The binge eating occurs, on average, at least once a week for 3 months
Binge-eating/purging type: the patient has regularly engaged in binge-eating* or purging in the past 3 months.	The disturbance does not occur exclusively during episodes of anorexia nervosa	The binge eating is not associated with the recurrent use of inappropriate compensatory behaviors (e.g., purging) as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

*An episode of binge eating is characterized by both of the following: 1- Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances. 2- A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).