

Eating disorders: the other side of the obesity epidemic

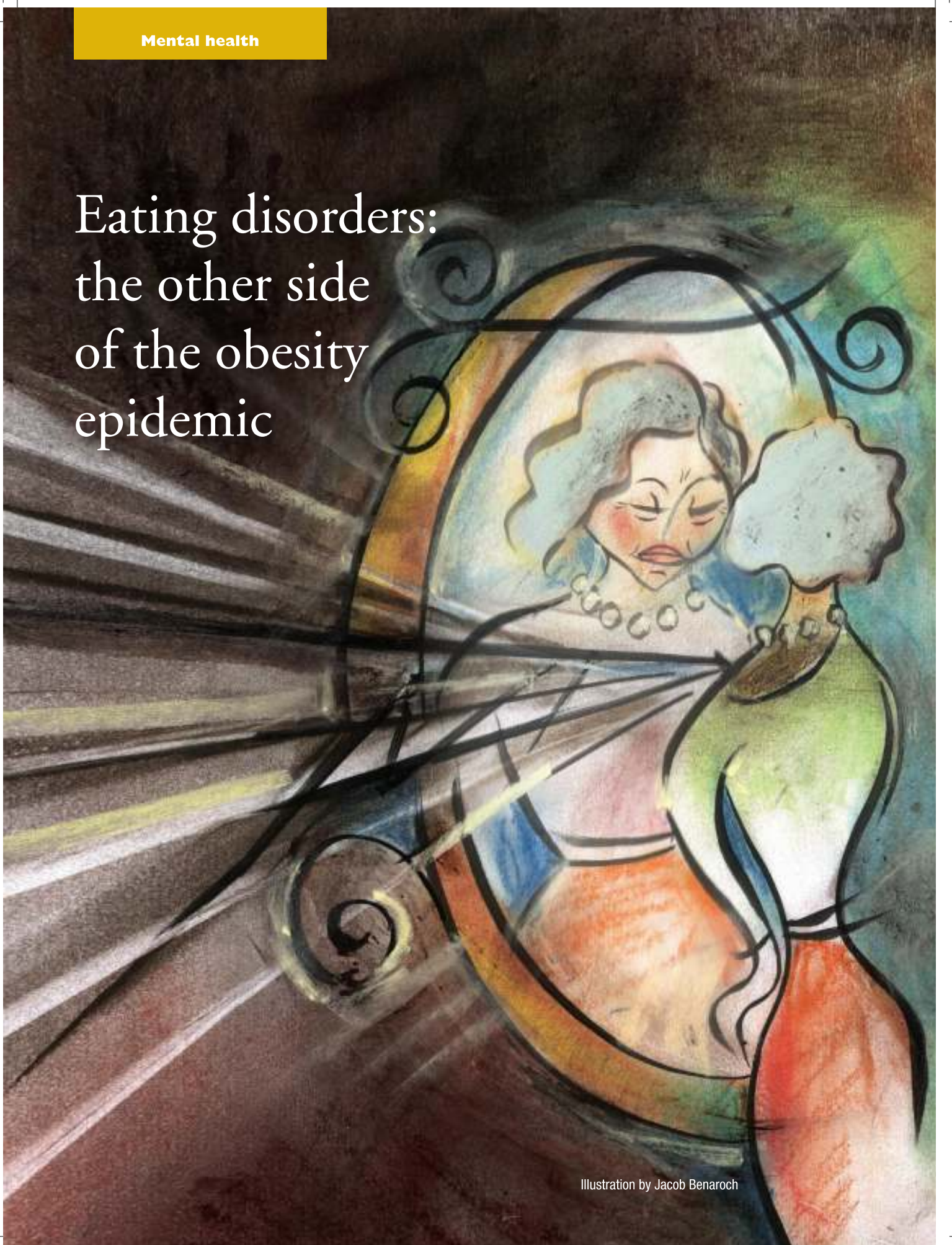


Illustration by Jacob Benaroch

‘Eating disorders, long the bane of younger women, have come of age.’ – Cecilia Ford, PhD

by Marge Coalman, EdD

In recent years, headlines and health news have often focused on the obesity epidemic in developed countries around the world. With the associated risks of diabetes, high cholesterol, high blood pressure, sleep apnea and multiple other factors, obesity *is* a major health risk. However, there is a less visible population—women, in particular—dealing with eating disorders that result in less-than-optimal weight and associated health problems.

There are many reasons for eating disorders in today’s older women: body image in a youth-pervasive culture, loneliness, depression, physical illness, lack of information regarding adequate and appropriate nutrition, as well as lingering disorders from earlier years, including sexual abuse, to name some of the most common. In addition to psychiatric and emotional causes, the aging process presents physiological changes that can affect healthy eating. For example, as people age, sensory losses can affect appetite.

This article looks at some of the primary causes of eating disorders, and focuses on what the wellness professional can do to support and assist women with these challenges.

The problem often starts in adolescence

When the literature is reviewed for research on eating disorders, a majority of studies and clinical data summaries are on adolescent girls. The need to fit in, look good, qualify for certain athletic pursuits, and emulate high-profile models, actors and entertainers all factor into the well-studied category of pressure that can, and does, lead to eating disorders.

While some categories (such as specific sports and athletics) are more diverse and include boys, more than 90% of the identified eating-disordered youth are female. The primary disorders in this age group are *anorexia nervosa* and *bulimia nervosa* (see the sidebar on page 56 for definitions). These disorders affect approximately six percent of all adolescent females and an indeterminate number of adult females. Because the criteria for inclusion in these groups are so stringent—for anorexia, being at 85% or less of the expected body weight, loss of menstrual periods for at least three months, and fear of weight gain despite being dangerously thin, for example—a group defined as “eating disorders not otherwise specified” (EDNOS) was developed. This category includes compulsive overeating, deprivation dieting, binge-eating, undereating and food addiction. The population of older women discussed in this article is more often in the EDNOS category.

Anorexia and bulimia can be fatal for young women unless psychiatric interventions are successful. These usually include a long treatment period of behavioral cognitive therapy and nutritional counseling, including possible inpatient care for an extended period of time. Those who survive can relapse, however. And the fundamental behaviors practiced in youth may return at different life stages for the adult.

The media and message

Although body dissatisfaction usually is associated with youth, there is an increasing awareness of the pressures of our culture for women to be “forever young,” regardless of the normal weight changes associated with the life cycle. A 2009 *Johns Hopkins Health Alert* was titled “Eating Disorders: Not Just for the Young.”¹ It cited “our cultural obsession with thinness” as one of the leading contributing factors.

The influence of the media is a key nonmedical cause for disordered eating

Resources

Internet

Health Canada: Canada’s Food Guide
www.hc-sc.gc.ca/fn-an/food-guide-aliment/index-eng.php

Along with a servings tracker and additional resources, this website includes an interactive tool to personalize information from *Canada’s Food Guide*.

US Department of Agriculture: MyPyramid
www.mypyramid.gov

The MyPyramid website offers personalized eating plans and interactive tools based on current Dietary Guidelines for Americans.

Print

“Keys to behavioral change”
Author: Michele Guerra, MS, CHES
Journal on Active Aging, 2(6), 26–33;
November/December 2003

Guerra’s article explores behavioral change, including the stages of change model. International Council on Active Aging® members can access it in the “Articles archives” (Motivation and retention) in the password-protected section at www.icaa.cc.

and excessive exercise in older women. Media models are mostly of one body type—one not achievable to the majority of women of any age—and beauty is dependent on flawless skin (no wrinkles or blemishes) and thinness. Researchers report that women’s magazines have 10.5 times more ads and articles promoting weight loss than men’s magazines. In addition, more than three-quarters of the magazine covers feature at least one

Continued on page 46

Eating disorders: the other side of the obesity epidemic

Continued from page 45

message about how to change a woman's body by diet, exercise or plastic surgery. Even fitness magazines that target a female audience feature supposedly perfect body types with a body fat/body lean ratio unattainable to most. This advertising supports the billion-dollar industries of diet products, plastic surgery, clothing, jewelry, cosmetics, exercise equipment, and more.

The onslaught of visual and verbal messaging has given rise to a group of middle-aged and older women with disordered eating. In many cases, it has triggered relapses in women who, in their younger years, were treated for eating disorders. The life-threatening eating disorders of anorexia and bulimia may come back and be undetected by an individual's family members, friends and others. Many researchers feel that, like alcoholism, the illness does not go away, but goes into remission and can resurface under later life stresses, such as divorce, empty-nest adjustment, and the stress and demands of balancing career and family.

Self-acceptance—or not

Psychological profiles and self-reported data show that women susceptible to eating disorders struggle with low self-esteem, distorted body image and feelings of worthlessness. Most report that to be happy, they must be thin. These women may or may not be in a nurturing relationship, but their lack of self-worth is a hindrance to enjoying a healthy one. Rather than acceptance, “dis-ease” often characterizes the relationship they have with themselves.

All the women interviewed for this article cited a need to control something in their lives as a reason for their disordered eating. Weight and appetite were easier options than those factors they felt were outside their ability to control. They all further reported controlling individuals who continued to influence them.

Continued on page 48

Touchmark's observation of resident changes in the dining experience

Most retirement providers schedule at least annual and in many companies (Touchmark is one) quarterly care conferences for residents living in care settings (skilled nursing, assisted living, memory care). Conferences to look at all areas of the resident's well-being are also scheduled at a significant change of condition. This process does not include the resident in independent living who may be experiencing age-related changes that affect ability to eat. There is a companywide effort in Touchmark communities to be sure changes are noted in a timely manner by all employees and volunteers who interact with the residents in a variety of settings—in the common areas, residents' homes, and dining rooms; on transportation vehicles; and at scheduled outings and events. Changes in mobility, participation in preferred activities, socialization, appearance, and demeanor are important indicators of the resident's well-being.

One area of particular focus is the changing eating patterns and preferences that individuals demonstrate in all of the various locations. Since healthful eating is a major focus of the wellness programming, it is important to notice changes in an unobtrusive but thorough way to determine if sensory, psychological or physiological changes might be impacting the dining experience for a resident.

- A resident observation and report form (R.O.A.R.) is available to all staff members to note changes in all of these areas, including dining. Housekeepers, caregivers, servers, maintenance staff, life enrichment team members, front

desk concierges—every employee has access to the form and is trained to complete it when a behavior or change is noticed that could signal a need for an intervention to support the resident to success. The forms are turned in to the appropriate manager for follow-up. This proactive approach often identifies changes before negative outcomes occur.

- Wellness questionnaires—the life enrichment/wellness director evaluates each new resident's talents, interests and preferences, and partners with the person to assure a good fit into appropriate programs and services. When a change in condition affects the resident's ability to participate at the previous level, another interview is scheduled.
- The wellness nurse is available to the independent residents on a regularly scheduled basis. The impact of medications on eating may not be well understood by the resident. When possible, recommendations are made to offset any adverse effects of medication that would cause disordered eating.
- Dining is one of the most social areas in Touchmark communities and the activity that most residents go to daily—sometimes three times a day. Participation in the dining program assures that the resident is provided a balanced diet and an opportunity to have a social experience with friends and neighbors. All residents are invited to provide feedback and support on the dining experience with simple evaluation forms.

For further information on the Full Life Wellness Program, visit the company website at www.touchmark.com

Eating disorders: the other side of the obesity epidemic

Continued from page 46

While each individual is unique and generalizations are not uniformly applicable, the composite profile of women with eating disorders gives the health professional the opportunity to understand the underlying forces that contribute to the whole person and provide a supportive, nurturing relationship of nonjudgmental acceptance.

Exercise in excess

As Amanda V. states in the profile on page 50, “Exercise is more socially acceptable than throwing up.” For disordered eaters, exercise addiction is not associated with the production of “feel-good” endorphins or the other benefits elite athletes cite for rigorous exercise regimens. These women may work out three hours or more per day. They may visit a gym multiple times or prolong their visits and/or sports activities.

Exercising to excess is viewed as a way to enhance metabolism (burning of calories at rest and throughout the day) and reach an ideal in body type/weight. At best, this pattern will achieve increased aerobic capacity and possibly strength. At worst, it will lead to overuse injuries and serious conflicts with work, family and other normal activities of daily living.

Interestingly, a number of highly visible women in this category may be fitness professionals whose self-image and professional expectation include a self-imposed image of fitness, performance and body type. Access to fitness equipment and classes is made easier for these individuals through their work environment.

Suggested solutions

In working with women with eating disorders in the above categories, the wellness professional has a unique role in providing support and assistance. Here are some suggested strategies:

- Develop a trusting relationship with the client that encourages honesty and self-discovery.

- Determine where the client is in Prochaska’s behavior change model. She will need to be in the action stage to benefit from an action plan that she develops with your support. (See the box on page 45 for a resource about behavioral change.)
- Encourage open and honest communication, with confidentiality assured.
- Refrain from judging the individual—especially her ability to tell the truth.
- Provide education and awareness.
- Provide a reasonable exercise plan based on the client’s identified risk factors.
- Develop a healthy eating plan and tools to implement and track food choices and consumption. (Turn to page 45 for resource information.)
- Provide a safety net for failed attempts at lifestyle change.
- Encourage and support the client working with her physician and other health professionals for thorough assessment and treatment of identified concerns.
- Look for and support other aspects of the client’s personality that help her to

Continued on page 50

Profile of someone who did not survive: Mary Jane

Mary Jane is an 82-year-old health and fitness club member in a retirement community who is 30–40 lbs. below her optimal weight. She has a history of being both compulsive with exercise (three hours-plus a day) and noncompliant with family members, fitness staff, and physicians who have tried to interact with her about her nutrition and exercise practices. When I interviewed her, she was defensive and painfully aware of how others viewed her lifestyle choices.

“I am not anorexic, and if that is the reason for this interview, it is over.” This was her opening comment to me when we met. I realized from talking with the fitness team beforehand that this was a deal breaker and approached Mary Jane from a different perspective. My request was that she tell me her story and why she felt so discriminated against because of her weight and exercise routines.

“I don’t understand why people who are fat never get asked, ‘Why are you so fat?’ when I, who am thin (and always have been), get asked all the time, ‘Why are you so thin?’ I am fine!” Mary Jane said.

In fact, I had a lot of information about Mary Jane from her doctors and other fitness professionals. I knew that her total caloric intake on an average day was less than 800 calories and her output in exercise was at least 2,000 calories. She was starving herself, and the outcome would be fatal.

As she told me her story, it became painfully clear that Mary Jane’s view in the mirror was distorted, and she saw herself as overweight and ugly. Her life routine was completely dominated by food deprivation and exercise addiction. Further conversations led to an insight about her social support network, which was nonexistent.

“Tell me about your friends,” I asked. “I don’t have any,” Mary Jane replied. I knew that numerous interventions to provide social support to her had failed.

Mary Jane died earlier this year of “failure to thrive,” a diagnosis usually associated with infants who do not bond with their mothers early on. In spite of the many interventions that were attempted, we were unable to stop her cycle of unhealthy lifestyle choices.

Eating disorders: the other side of the obesity epidemic

Continued from page 48

identify strengths, talents, interests and skills.

- Be a friend.

It is important to understand the limits of the wellness professional in dealing with individuals with bulimia and anorexia. In general, the wellness professional will not be a psychiatrist or cognitive behavioral therapist. On the other hand, the well-trained wellness professional (personal trainer, group exercise instructor, life coach, etc.) does have a role in helping the client to identify these serious disorders. Also, the professional can—and often does—develop a supportive relationship that allows the client to disclose information (possibly a diagnosis, if a diagnosis has been made) and preferences for support.

Changes associated with aging

Another group of older women who are prevalent in fitness/wellness centers and retirement communities serving adults over 60 are those who have eating challenges resulting from the aging process. As sensory changes occur in taste buds, vision, smell and appetite, these individuals may not feel motivated to eat healthful choices and portions throughout the day.

Coupled with sensory loss may be the loss of a spouse, adult child or other life losses that trigger depression, loneliness and disengagement. If food no longer smells or tastes good, there is no one to share it with and/or limitations prevent obtaining and preparing it, malnourishment may result. Most depressive disorders do manifest in significant weight loss or occasionally weight gain. Memory problems present a whole other group of concerns that needs to be addressed. With memory problems, many older adults simply forget to eat. In one type of memory problem, frontal lobe disorder, individuals are so active that they walk off calories at a much higher rate than they consume them.

Quite often, the changes associated with aging also make a change in physical activity a necessity. The combination of changes in physical activity and dietary intake can put older women at risk for significant weight loss or gain, sarcopenia (loss of muscle mass), and decreased bone density, mobility and overall strength. In traditional retirement settings, the life enrichment specialist and/or resident relations counselor, in combination with the dietitian, will be the appropriate wellness professionals to identify changes and meet with the resident for further information and follow-up. Therapists and physicians also will be notified and involved, if appropriate.

Suggested solutions

- In care settings (assisted living, skilled nursing, memory care), all team members should be tracking the activities and well-being of residents—for example, monthly weight, participation in activities, dietary changes, and change-of-condition. (The sidebar on page 46 explains how Touchmark gathers observations.)
- For independent retirees, a wellness nurse or life enrichment team member is the likely reporter of changes that affect nutrition and other indicators of well-being.
- Interventions need to be developed by the interdisciplinary team in concert with the resident.
- Involvement of the resident and often the family is critical to success.

Support, encouragement and directed treatment

A high percentage of older women with eating disorders are single, having had challenges with personal relationships for a sustained period of time. Further, all of the women interviewed for this article reported struggles with primary people in their family or circle of primary influencers—siblings, best friends, coaches—and a few interviewees identified sexual abuse

Continued on page 54

Profile of a survivor: Amanda V.

Amanda is a 39-year-old fitness professional who has been pursuing a fitness career since her high-school years. She works as a personal trainer and exercise instructor for spinning, pilates and strength-training classes. She is also a mother, daughter, sister, wife and community volunteer. Amanda describes herself as a recovering sexual abuse victim who dealt with eating and exercise disorders for over 20 years.

“I have been in the fitness world for over 25 years,” states Amanda. “In my teen years, I [and the people around me] knew something was wrong, but no one talked about it. By the time I was in my early 20s, I knew I had an eating disorder.”

In her college years, Amanda was working and going to school full time, while exercising six hours a day. This meant she had “about 15 minutes to sleep.” Her obsession with calories led to endless calculations in her head as well as challenging social situations. “I realized I was thinking about this all the time. I was tired—so tired—and angry.”

Amanda’s relationships with boyfriends deteriorated, and she began to withdraw sexually without knowing why. By the time she met her husband, she had begun to physically harm herself.

A friend and colleague working with Amanda felt that her behavior, posture and stature were consistent with sexual abuse victims, and when they explored the topic together, Amanda agreed. When she realized that suppressed sexual abuse was the underlying cause of her eating and exercise disorders, there were other family members affected and confronted. And Amanda spent more than three years in individual and group therapy.

Today, Amanda is a loving wife and mother of two healthy children—and one of the lucky ones who made it back.

Eating disorders: the other side of the obesity epidemic

Continued from page 50

Profile of a survivor in progress: Suzanne H.

Suzanne is a 52-year-old married woman with three grown children, and a grandmother of three. By her report, she is approximately 40 lbs. under her optimal body weight. Suzanne weighs herself every day (as she has for years), and exercises at her fitness club at least five days a week. Most observers would describe Suzanne as emaciated, although she has good skin tone and color. She describes herself as being in “good health,” other than being underweight.

“I was the oldest child in my family, with three younger brothers,” says Suzanne. Her family owned a mercantile business, and Suzanne began working there when she was a teenager “because my mother got mad at me and said I had to Her standard for me was that I had to be perfect at all times.” Suzanne also alluded to, but did not amplify on, an experience of sexual abuse by a male family member when her family was visiting relatives.

Suzanne attended Catholic schools from grade school through college in California. As it turned out, so did her husband. Following their marriage, they returned to the area where they grew up, and he joined his family business. Their first child was born nine months after the marriage.

Suzanne was able to maintain a normal weight through high school and college, but has been underweight most of her adult life. She describes her mother as controlling, critical and mean. “She

said I had a nasty mouth. I was a heavy kid, and she said my legs looked like telephone poles. She measured our ankles—hers and mine. I spent a lot of time with my cousin, who was thin, and I began to lose a lot of weight.”

A self-described perfectionist, Suzanne portrays her husband as “possessive with a controlling personality. I married my mother,” she says. When her husband told her at age 36 that she “had to exercise,” she began running. Asked if she was bulimic, Suzanne noted that she could not tolerate vomiting; instead, she would pocket food in her mouth during family meals and spit it out without being noticed.

According to Suzanne, she has tried therapy three times but says, “It didn’t work.” The third round was biweekly sessions that lasted more than two years. When she went back again, the therapist would not take her and said she needed inpatient therapy, which she did not do. A prescription for the antidepressant Prozac did not help.

Suzanne believes her eating disorder and excessive exercise are byproducts of her need to have some control over her life. She is committed to being a good mother and grandmother and not emulating her mother’s behavior. “Love for your children should be unconditional,” she stresses. When asked what she wanted to say to readers of this article, Suzanne replied, “If someone had caught me when I was younger, I’d be 20 lbs. heavier.”

from a parent or relative as the source of the problem behavior. Families and friends may not be fully aware of the complex issues and problems that a loved one with an eating disorder faces. Yet almost all will be aware there is a significant problem and try to persuade the loved one to seek solutions.

Life coaches and lifestyle change professionals have very effective tools for screening, assessing and programming for individuals with an identified eating disorder. Some of the key features of this work include the process of using a diary, mutual goal setting, unconditional support and unlimited access to the specialist. Similar strategies can be applied by a wellness professional who has certification in other areas, such as personal training and exercise instruction. Over the course of the professional relationship, education, specific exercise prescription and stress reduction strategies can be incorporated into the plan. The wellness professional may also share nutritional information and resources with the client, or refer the individual to a dietitian for nutritional counseling, if appropriate.

In retirement settings, the wellness professional may be a life enrichment specialist with training and experience in assessment, motivation and counseling. This professional, in combination with the nursing staff, is usually very aware of the changing physical and emotional attributes of older women and can work with the dietary manager and other leaders in the community to address needs—especially in sensory and cognitive function—as they manifest.

All wellness professionals need to be sensitive to the family’s concerns and observations regarding a loved one. The goal is not to replace the role of the family, but to supplement and support family members’ concerns while helping them accept and understand the specific needs of the individual with an eating disorder.

Stopping the cycle


The women interviewed for this article shared their struggle with eating disorders and excessive exercise. They described themselves as obsessed with food to the point that it took over their lives—above

Continued on page 56

Eating disorders: the other side of the obesity epidemic

Continued from page 54

all other priorities and competing interests. Their obsession became their full-time focus. Some realized it was a lifetime commitment on their part to overcome their eating disorder.

Adult females with an eating disorder can be identified. These individuals can be helped with top-of-the-mind skill training for wellness professionals in any setting. Stopping the cycle of disordered eating and excessive exercise can be the most important intervention these women will ever receive to support lifestyle change and to overcome the damage from these unhealthy behaviors. 

Marge Coalman, EdD, is the vice president of wellness and programs for Touchmark, a Beaverton, Oregon-based lifestyles company that owns and operates homes for people 55-plus in eight states and Canada. A community locator map and information about the Touchmark mission are available at www.touchmark.com.

touchmark.com. An International Council on Active Aging Advisory Board Member, Coalman is also the owner and principal of Coalman Consulting Inc., a quality senior housing consulting business in Portland.

Author's note

In each interview I conducted (with the exception of Mary Jane, profiled on page 48), the interviewee expressed appreciation for my concern. Each wanted to know what she could say or do to help others find relief and solutions for the overwhelming problems associated with their choices and behaviors. Peers recovering from eating disorders can be important in the network of resources made available to a client.

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Definitions and symptoms of eating disorders

Anorexia Nervosa

- emaciation (extremely thin from lack of nutrition)
- relentless pursuit of thinness; unwilling to maintain a normal or healthy weight
- distorted body image; intense fear of gaining weight
- lack of menstruation among girls and women
- repeatedly weighing him/herself
- portioning food carefully, eating only small amounts of only certain foods
- excessive exercise, self-induced vomiting, misuse of laxatives, diuretics, or enemas

Other symptoms that may develop over time:

- thinning bones
- brittle hair and nails
- dry, yellowish skin
- growth of fine hair over the body

- mild anemia and muscle weakness and loss
- severe constipation
- low blood pressure, slowed breathing and pulse
- feeling cold all the time
- lethargy

Bulimia Nervosa

- frequently eating large amounts of food (binge-eating)
- feeling a lack of control over the eating
- compensating for binge-eating with self-induced vomiting, misuse of laxatives and diuretics, fasting, and excessive exercise
- bingeing and purging in secret; feelings of shame and disgust
- intensely unhappy with body size and shape despite normal height and weight

Other symptoms include:

- chronically inflamed and sore throat
- swollen glands in neck and below jaw

- worn tooth enamel from exposure to stomach acids
- gastroesophageal reflux disorder
- intestinal distress from laxative abuse
- kidney problems from diuretic abuse
- severe dehydration from purging

Eating Disorders Not Otherwise Specified (EDNOS)

- binge-eating
- deprivation dieting
- undereating
- food addiction
- use of laxatives, diuretics and enemas
- any of these disorders combined with exercise addiction

The above information about anorexia and bulimia is reprinted from the article "Symptoms and warning signs" in the Spring 2008 issue of NIH MedlinePlus, a publication of the US National Institutes of Health and Friends of the National Library of Medicine.