

Article 2

Disordered Eating Across the Lifespan of Women

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Abstract

Disordered eating (DE) and body dissatisfaction are common among diverse women across the lifespan and similar in prevalence and nature to findings from studies of adolescents and young adults. Given the historic focus on adolescents and young adults, clinicians may lack awareness and knowledge of DE among all ages of women. This is vital given that treatment seeking is increasing for women beyond emerging adulthood. Early detection and intervention are important given the prevalence and progressive nature of DE. The prevalence, trends, patterns, and predictors of DE are discussed along with clinical considerations regarding the unique intersection of age and gender as it relates to DE and body dissatisfaction.

Keywords: disordered eating, dieting, body dissatisfaction, lifespan, mental health

There is growing evidence that disordered eating (DE) and body dissatisfaction are common among all ages of women and can adversely impact their wellness across the lifespan (Pike, Dunne, & Addai, 2013). *Disordered eating* is defined as endorsing unhealthy eating-related behaviors without meeting criteria for an eating disorder (Reba-Harrelson et al., 2009). Some scholars (e.g., Slevec & Tiggemann, 2011b), however, have included diagnosable eating disorders (ED) as part of the range of disordered eating.

Disordered eating *behaviors* may include restrictive, chronic, and extreme dieting (e.g., fasting, purging, diet pills, laxative abuse), and excessive exercise (Gagne et al., 2012; Hill, Masuda, & Latzman, 2013). Disordered eating *cognitions* may include weight concerns, body dissatisfaction, and beliefs about eating and weight, such as forbidden foods (Hill et al., 2013). DE cognitions can be fueled by the Western beauty ideal of

thinness and can initiate efforts (e.g., dieting) to conform to this ideal (Smolak & Chun-Kennedy, 2013). A range of DE attitudes and behaviors can bring about significant psychological distress similar to a fully diagnosable eating disorder (Mangweth-Matzek et al., 2014), and DE is associated with increased risk for depression, anxiety, medical complications, and death (Patrick, Stahl, & Sundaram, 2011).

Women and girls are particularly vulnerable to these concerns as their status and value are directly related to their physical attractiveness, whereas men are valued more for attributes such as money and intelligence (Ferraro et al., 2008). Further, women encounter physical changes associated with pregnancy, menopause, and aging (Becker, Diedrichs, Jankowski, & Werchan, 2013), which can promote body dissatisfaction and DE. Historically, researchers focused on eating and body concerns of female adolescents and young adults, as eating disorders (EDs) have been found most prevalent among this age range (Favaro, Caregato, Tenconi, Bosello, & Santonastaso, 2009). More recent evidence supports that DE and body dissatisfaction affect women across the lifespan; therefore, counselors must have knowledge of these concerns.

The purpose of this article is to offer an overview of the prevalence, trends, patterns, and predictors of DE and body dissatisfaction for women across the lifespan, as well as clinical considerations regarding the unique intersection of age and gender. For this paper, DE will include diagnosable EDs to fully capture the state of eating- and body image-related concerns among adult women; however, the distinction will be made when possible.

Prevalence

There are many challenges for determining the true prevalence of DE across the lifespan. Criteria for DE are less defined than EDs, and evidence for prevalence rates delineated by age is sparse. Further, prevalence rates differ across studies depending on which edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* was used, and most studies were completed prior to the arrival of the *DSM-V* (American Psychiatric Association, 2013). The *DSM-V* includes new categories (e.g., Binge Eating Disorder) and eliminates others (e.g., Eating Disorders Not Otherwise Specified).

Based on the studies examined (Table 1), it seems women across the lifespan can exhibit DE at rates similar to or greater than the rates of the overall U.S. population of women (Mangweth-Matzek et al., 2014; Reba-Harrelson et al., 2009; Wade, Bergin, Tiggemann, Bulik, & Fairburn, 2006). Further, ED occurs across racial/ethnic groups and across ages within these groups (Pike et al., 2013; Reba-Harrelson et al., 2009).

In terms of prevalence related to life events, such as pregnancy or menopause, there is little research. Prevalence of EDs during pregnancy has historically been low (Mathieu, 2009); however, Easter and colleagues (2013) found that among a community sample of 739 pregnant women (*M age* = 30.5) in their first trimester, 7.5% met diagnostic criteria for an ED, 23.4% reported weight and shape concerns, 8.8% endorsed binge eating, and 2.3% endorsed regularly engaging in compensatory behaviors (e.g., fasting, excessive exercise, and laxative misuse). In sum, although prevalence rates for DE, specifically by age, are not well defined, based on available studies, DE can impact women across the lifespan, and pregnant women should not be overlooked when assessing for it.

Table 1

ED Prevalence Rates Among Women (Post Emerging Adult) Using DSM-IV

Source	Sample	AN	BN	EDNOS
APA (2000)*	U.S. women	0.5%	1.0-3.0%	--
Mangweth-Matzek et al. (2014)	Austrian community women ages 40–60 (<i>N</i> = 715)	0.0%	1.4%	3.2%
Reba-Harrelson et al. (2009)	U.S. community women ages 25–45 (<i>N</i> = 4,023)	0.3%	8.4%	31.1%**
Wade et al. (2006)	Australian community women ages 28–39 (<i>N</i> = 1,002)	1.9%***	2.9%	5.3%

Note: AN = Anorexia Nervosa; BN = Bulimia Nervosa; EDNOS = Eating Disorders Not Otherwise Specified; *DSM-IV-TR; **Not including partial AN; ***Purging type

Trends

Based on the literature, there are two noteworthy trends regarding DE across the lifespan. First, there has been a steep rise in the number of midlife and older clients admitted for treatment of EDs over the past decade (e.g., Ackard, Richter, Frisch, Mangham, & Cronemeyer, 2013; Deam, 2012). Deam (2012) reported that across 11 locations of a well-known U.S. ED treatment program, admissions of women 35 and over increased 42% in the past decade. Ackard et al. (2013) reviewed 1,040 discrete admissions at a single U.S. ED clinic and found that inpatient treatment for an ED among women 40 and older increased from 4.7% during 1989–2001 to 11.6% during 2002 to 2006. Additionally, these middle-aged women reported later age of ED onset (21.4 vs. 17.0) and longer duration of illness (26.5 vs. 8.1 years) than women ages 18 to 39. Zhao and Encinosa (2011) found that between 1999–2009, ED hospitalizations increased 88% for patients aged 45 to 65, which was the greatest increase among all age groups reviewed (under 12 to over 65). Thus, treatment seeking among women of varying ages is growing, although little is known about the source of this trend.

The second trend is related to age of onset and progression of DE among older women. Scholtz, Hill, and Lacey (2010) found that among women 50 years and older, the mean age of ED onset was 15, yet the age when first seeking services was much older (*M age* = 31, range 14–57). Further, late onset EDs are considered rare; however, Lapid and colleagues (2010) reviewed 48 published cases of EDs among people 50 years and older and found that 69% were late onset (mostly anorexia nervosa). In sum, despite early onset of EDs, women may wait years to seek treatment or may struggle later in life, and EDs can present later in life and have a longer duration.

Patterns of Disordered Eating

Dieting, extreme weight loss behaviors, and body dissatisfaction are common among youth and young adults (Liechty & Lee, 2013). More recently, researchers have examined patterns of DE and body dissatisfaction among adults across the lifespan. Body dissatisfaction and dieting are discussed as they are central to DE and antecedents of EDs (Hill et al., 2013; Shisslak, Crago, & Estes, 1995).

Dieting and extreme weight loss behaviors. Dieting (restricting food to lose weight) can result in low self-esteem, poor body image, weight cycling (Gillen, Markey, & Markey, 2012), weight gain, obesity, and EDs (Neumark-Sztainer, Wall, Larson, Eisenberg, & Loth, 2011). Although dieting alone is not sufficient to cause EDs, it is one of the most common indicators of the development of an ED (Smolak, & Chun-Kennedy, 2013). In fact, in a review of several one to two year longitudinal studies, Shisslak et al. (1995) reported that 35% of normal dieters progressed to pathological dieting, 20-30% of pathological dieters progressed to a partial or full ED, and 15% of those with partial syndromes progressed to a full syndrome ED. This is a concern given how common dieting is overall. Based on a Gallup poll of 1,013 U.S. adults age 18 and older, 54% reported current weight loss efforts, with 35% of women and 41% of minorities endorsing “serious” weight loss efforts (Wilke, 2014).

In terms of dieting by age, Reba-Harrelson and colleagues (2009) found that among women ages 25 to 45, frequent dieting was common with 67.2% reporting “currently dieting,” and extreme or unhealthy weight loss measures were widely endorsed including vomiting (7.1%), laxatives (9.0%), diuretics (11.6%), diet pills (40.2%), excessive exercise (20.5%), restricted eating (17.9%), and smoking to control weight (14.7%). Nearly one third of the women endorsed purging behaviors such as the use of laxatives, diet pills, and vomiting (Reba-Harrelson et al., 2009). Gagne and colleagues (2012) found similarly high incidences of dieting and unhealthy weight loss measures among a large sample of women 50 years and older ($N = 1,849$). Olson, Visek, McDonnell, & DiPietro (2012) also found high levels of dieting among midlife women, with an average of 10.3 weight loss attempts, and one or more weight cycles (loss/regain) of at least 20 pounds. In sum, frequent dieting and extreme weight loss behaviors are prevalent among adults, and this is a concern given the potential health consequences (Gillen et al., 2012), particularly among women as they age.

Body dissatisfaction and weight and shape concerns. Body dissatisfaction, a discrepancy between one’s current and ideal body (Esnaola, Rodriguez, & Goni, 2010), is a DE cognition associated with binge eating, low self-esteem, depression, unhealthy weight control measures (Becker et al., 2013), and DE (Slevec & Tiggeman, 2011b). In contrast, positive body image contributes to health behaviors and quality of life (Runfola, Von Holle, Peat, et al., 2013), and body appreciation is positively associated with self-esteem, life satisfaction, proactive coping, and optimism and negatively associated with body image disturbance and DE (Avalos & Tylka, 2006).

Because of its role in DE, body image concerns are some of the most studied factors among women over 25 years of age. Runfola, Von Holle, Trace, et al. (2013) conducted one of the largest ($N = 5,868$) studies examining differences in prevalence of body dissatisfaction among U.S. women based on age (25–89). They found that most participants (91%) were dissatisfied with their current appearance and body dissatisfaction did not decline with age (after adjusting for BMI), with middle-aged women (ages 35–55) reporting the highest degree of body dissatisfaction among all *age* groups.

Similarly, among a Finnish sample of 7,548 women and 3,920 men, increased age was associated with decreasing body satisfaction, and more so for women (Algars et al., 2009). Additionally, among 1,849 women age 50 and older, the majority of respondents endorsed that weight and shape concerns adversely impacted their lives (61.8%) and their

self-perception (79.1%) and that they felt “less,” or “much less” satisfied with their stomach (83.9%), shape (73.3%), skin (70.1%), weight (71.1%), arms (65.8%), face (54.1%), thighs (57.4%), and overall appearance (66.4%) compared to when they were younger (Gagne et al., 2012). Thus, body dissatisfaction does not appear to diminish with age, and new concerns (e.g., skin and face changes) emerge with age.

A culture’s beauty ideal is often implicated in women’s dissatisfaction with their bodies. The Western female beauty ideal involves an ultra-thin shape (Pike et al., 2013) and a youthful appearance (Becker et al., 2013). Messages from family, peers, and media are often identified as important means for transmitting ideal body expectations, and internalization of these ideals are well known factors for body dissatisfaction and DE among young women (Smolak & Chun-Kennedy, 2013). Although young, beautiful images are abundant in the media, midlife and older women are increasingly portrayed in the media as both thin and youthful in appearance (Hefner et al., 2014). Being older does not preclude women from being susceptible to cultural expectations of thinness and beauty (Pike et al., 2013). Ironically, as women age, they face a dilemma between looking thinner and looking younger. A 4-point higher BMI was associated with an older appearance for those younger than 40 and a younger appearance after age 40, and an 8-point higher BMI had the same impact when comparing those under and over age 55, among 186 pairs of identical twins (Guyuron et al., 2009).

Highlighting this dilemma, researchers (Becker et al., 2013) explored *old talk* and *fat talk*, and their relationship to body image factors and ED symptoms among an international sample of 914 women (*M age* = 36.80, *range* = 18–87). *Fat talk* and *old talk* involve speech that endorses the *thin-beauty-ideal* and the *young-thin-beauty-ideal*, respectively. Occasional fat talk was common (81%) and did not decline until after age 61, and old talk was also common (66%) and increased with participant age, eventually matching or exceeding fat talk. Both types of talk were significantly correlated with body image disturbance and ED pathology, and the relationship strengthened with participant age for old talk (Becker et al., 2013). Thus, body image concerns exist among diverse women across the lifespan, particularly when defined more broadly to include many aspects of the body, including age-related changes.

Positive body image. Researchers have sought to understand the effect of positive body image such as body satisfaction (Runfola et al., 2013a) and body appreciation (Tiggemann & McCourt, 2013). Among women ages 50 and over (*N* = 1,789) who reported body size satisfaction, 12.2% had a lower BMI and reported fewer ED symptoms, dieting behaviors, and weight and appearance dissatisfaction and exercised more than dissatisfied women (Runfola et al., 2013a). Women satisfied with their body, however, still reported that weight and shape were important to their self-evaluation, and they equally engaged in weight monitoring, appearance-altering behaviors, and extreme weight loss behaviors similar to their dissatisfied counterparts. Thus, body satisfaction was largely a function of effective body weight and appearance maintenance than passive acceptance of shape and weight.

Among a community sample of Australian women ages 18 to 75 years (*Mean age* = 39.9), Tiggemann and McCourt (2013) found a significant positive relationship between age and body appreciation (acceptance, appreciation, respect, and attention given to one’s body). Body appreciation had a moderate positive correlation with body satisfaction across all age groups, although the association was weaker among older

women. The authors concluded that body appreciation is more than an indicator of lower body dissatisfaction, but also reflective of a positive attitude toward one's body. Although studies are limited, there is some evidence that positive body image is associated with lower body dissatisfaction and DE.

Predictors and Correlates

A number of commonly identified biological (e.g., BMI), psychological (e.g., negative affect), and sociocultural factors (e.g., media, family, and peer pressure) that have been associated with DE and body dissatisfaction among younger women have similarly been identified among midlife women; however, some unique factors such as aging anxiety were also identified for the latter group (see Slevec & Tiggemann, 2011b). Further, Mangweth-Matzek and colleagues (2013) found that perimenopausal and surgically induced menopausal women had greater eating and body image pathology than premenopausal women (Austrian sample). Hirschberg (2012) noted that sex hormones regulate appetite and energy output during menopause, pregnancy, and lactation, and may play a role in bulimic behavior.

In terms of sociocultural factors, Hefner and colleagues (2014) found exposure to “aging beauty” media (i.e., actresses over age 40 who appear younger, thinner, and sexier than average) was associated with greater reported DE, greater body dissatisfaction, and stricter food choices when around others. Similarly, Slevec and Tiggemann (2011a) found that television exposure was positively related to body dissatisfaction and DE among middle-aged women, however, both television and magazine exposure were positively related to internalization of the cultural thin ideal, social comparison, appearance investment, and aging anxiety, which were positive correlates of body dissatisfaction and DE.

Further, body dissatisfaction was found to be closely related to four aspects of perceived sociocultural pressure: the influence of advertising, verbal messages (e.g., conversations about weight), social models (actors, fashion models), and social situations (e.g., social pressure when eating with others) among 627 adolescent, young, midlife, and older adults (Esnaola et al., 2010). In this study, gender was a better predictor of body dissatisfaction and perceived sociocultural influences than age. Thus, women across the lifespan are impacted by the same predictors as younger women, with some additional age-related concerns such as skin changes, aging anxiety, and menopause.

Clinical Considerations

Based on the current review, a number of clinical implications related to assessment and intervention should be considered. One caveat, however, is that assessment and treatment of fully diagnosable EDs is complex and requires expertise. Therefore, the following are general clinical considerations for subthreshold disordered eating. If an ED is suspected, counselors can use the *DSM-V* in an interview format as well as a brief (five question) ED assessment, the Eating Disorder Screen for Primary Care (ESP; Cotton, Ball, & Robinson, 2003), to help rule out an ED or determine if more specific assessment or referral is needed.

Assessment of disordered eating. For decades, researchers focused on fully diagnosable EDs among adolescents and young adults, particularly White, affluent girls. Although there is now evidence that women of varying ages and races experience DE,

counselors may inadvertently overlook DE among all demographics. As a remedy, counselors may consider including assessment of eating habits and exercise as part of a holistic wellness assessment for every client. The Five Factor Wellness Inventory (Myers, & Sweeney, 2005) is a holistic, strength-based wellness assessment that includes assessment of physical wellness including nutrition and exercise.

In addition, because DE does not have formal criteria, Gottlieb (2014) suggested that counselors assess the degree to which body dissatisfaction and weight loss concerns and efforts affect daily functioning including coping skills, cognitive functioning (i.e., distracted by weight-related thoughts), social life (e.g., not participating due to weight and shape concerns), and anxiety. It will also be useful to use *DSM-V* criteria for EDs, noting when clients present with many of the same concerns but are subthreshold for a diagnosis. Further, because high rates of women among community samples have been found to engage in purging behavior, such as the use of laxatives, diet pills, and vomiting (Reba-Harrelson et al., 2009), it is important that counselors inquire about these habits among clients who endorse extreme weight loss behaviors.

Assessment of body dissatisfaction. Because body dissatisfaction precedes dieting and both are antecedent to DE (Hill et al., 2013), body dissatisfaction is another important area to assess. A high percentage of women experience body dissatisfaction (Runfola, Von Holle, Trace, et al., 2013) regardless of age. Most assessments of body concerns focus on weight and shape and, therefore, may not be sensitive to the nature of appearance dissatisfaction across the lifespan. As women age, they not only endorse weight and shape concerns, but also dissatisfaction with changes in their skin and overall appearance (Gagne et al., 2012). It is also possible that for older women, body dissatisfaction may encompass changes in bodily functions such as joint dysfunction or loss of bladder control. Therefore, when interviewing midlife and older women, it is important to assess *all* physical changes that may be of concern.

Interventions. Women across the lifespan are susceptible to cultural expectations of thinness and beauty (Ferraro et al., 2008). Two hallmark signs of a woman's internalization of the beauty ideal are the drive for thinness and body dissatisfaction, and the latter is negatively associated with a woman's self-concept and self-esteem, regardless of age (Gadalla, 2008). In addition, older women may experience greater distress over the beauty ideal because youth is strongly associated with beauty in Western culture (Ferraro et al., 2008). When there is a high level of body dissatisfaction and a high importance on physical appearance, this can lead to low self-esteem, social isolation, and unhappiness (Craighead, 2006). Further, as women age, they not only have body and shape concerns but may also encounter aging anxiety (Slevec & Tiggemann, 2011b).

A strengths-based approach to addressing these concerns is through engaging clients in developing greater self-compassion. Self-compassion involves self kindness versus self-judgment, a sense of common humanity versus isolation, and mindfulness versus over-identification when encountering difficult thoughts and emotions about one's self (Neff, 2003). Self-compassion has been positively associated with greater psychological well-being, happiness, and life satisfaction, lower anxiety, depression, and stress (Neff & Germer, 2013), and is typically promoted through mindfulness and self-compassion exercises. Additionally, counselors can work with clients to explore the normative nature of thinness and sources of those beliefs (e.g., media, family) and use

cognitive restructuring of beliefs that fuel the drive for thinness. Additionally, exploring aging anxiety and meaning associated with changing life roles may also be of value.

For problematic eating behaviors, general interventions might include mindfulness meditation, which has shown promise with treating DE and is generally shown to decrease stress and increase self-acceptance, self-compassion, and self-esteem (Baer, Fischer, & Huss, 2005; Kristeller & Hallett, 1999). Similarly, clients may benefit from Mindfulness-Based Eating Awareness Training (Kristeller, Wolever, & Sheets, 2012), in which clients learn to increase their attunement to the present moment and improve their relationship to food and their body. In addition, programs such as Health at Every Size (Bacon, Stern, Van Loan, & Keim, 2005) and Intuitive Eating (Tribole & Resch, 2003) are strengths-based programs that teach alternatives to dieting and emphasize self-acceptance, body appreciation, and self-connection. These can be recommended reading and the basis for working with clients.

Finally, the ideal is prevention and early intervention. Because the same factors that predict DE among younger women are also relevant to older women (Slevec & Tiggemann, 2011b), working to enhance protective factors across the lifespan of girls and women is key. Individual protective factors may include increasing self-esteem, positive body image, and coping skills. Sociocultural protective factors may include critical processing of media images (i.e., media literacy) with attention to unrealistic age-related media images and messages.

Conclusion

Overall, evidence is growing that DE is a concern for women across the lifespan and patterns of DE cognitions and behaviors, including dieting, body dissatisfaction, and extreme weight loss behaviors, among adults are similar to those found among adolescents and young adults. Sociocultural factors found to influence DE among younger women have also been found relevant among midlife and older women; therefore, counselors must advocate for the education and prevention of these concerns as well as tailor interventions so that they are relevant to women of all ages. Communication between clinicians and researchers is important to growing our understanding of DE across the lifespan of diverse women so that counselors can contribute to women's wellness.

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