



## Review article

# Eating disorders in midlife women: A perimenopausal eating disorder?



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## ABSTRACT

Eating disorders afflict women across the lifespan with peak onset during critical or sensitive developmental periods of reproductive hormone change, such as puberty. A growing body of research supports the role of reproductive hormones, specifically estrogen, in the risk for eating disorders and related symptomatology in adolescence and young adulthood. Like puberty, perimenopause is characterized by estrogen change and may also present a window of vulnerability to eating disorder development. Here, we discuss the evidence that suggests perimenopause indeed may be a vulnerable period for the development or redevelopment of an eating disorder for midlife women. Drawing from what is known about the influence of estrogen on eating disorders at younger ages and from other psychiatric disorders with similar risk trajectories (i.e., perimenopausal depression), we describe a potential mechanism of risk for a perimenopausal eating disorder and how this can be explored in future research. Investigating vulnerability to perimenopausal eating disorders will clarify eating disorder etiology, identify reproductive stage-specific risk profiles, and guide future treatment directions.

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## 1. Introduction

Eating disorders (EDs), which disproportionately affect women, are often thought to be a disease of adolescence, but can occur at any age. Perimenopause has been suggested as a period of vulnerability for ED development in midlife women, as a preliminary report suggests that the prevalence of EDs is higher in women at perimenopause compared with pre- and post-menopause [1]. Compelling evidence that robust hormonal processes, specifically changing estrogen levels, influence the risk for EDs in girls at puberty [2] provides a strong rationale for exploring the role of estrogen in ED risk during perimenopause. Moreover, estrogen influences risk for other psychiatric illnesses with similar developmental trajectories such as major depression. It is reasonable to hypothesize that processes analogous to those observed in puberty and depression confer risk for developing EDs during midlife.

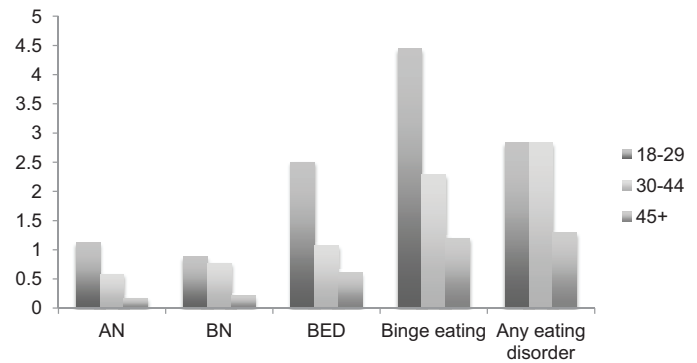
Here, we aim to prompt new research in the often overlooked area of midlife EDs by first providing an overview of the prevalence and challenges of midlife EDs and related symptomatology. Next, we extrapolate knowledge about estrogen's role in EDs and depression to describe a potential mechanism of a perimenopausal ED that can be explored in future research. Finally, we describe the treatment implications of this hypothesized mechanism. Investigating vulnerability to EDs at midlife will clarify etiology, identify reproductive stage-specific risk profiles, and guide treatment directions for midlife EDs.

## 2. Method

We conducted a comprehensive search of PubMed for articles published in the area of midlife EDs as well as the hormonal etiology of EDs and other psychiatric disorders, focusing on perimenopausal depression. Given that our aim was to develop a hypothesis for testing in future research and to present this hypothesis to readers—not to provide a systematic review—a strict search protocol was not used. However, a critical review of each publication was conducted with greater weight in this report given to the research or reviews with higher scientific merit and rigor. The articles referenced herein provide the best snapshot of the aforementioned literature and are the most relevant to our proposed mechanism underlying midlife EDs. An in depth review of the literature in each topic area was beyond the scope of this report.

## 3. Eating disorders

DSM-5 [3] identifies four core EDs: bulimia nervosa (BN), anorexia nervosa (AN), binge-eating disorder (BED), and other specified feeding or ED (known as eating disorder not otherwise specified [EDNOS] in DSM-IV). BN is characterized by recurrent episodes of binge eating, inappropriate compensatory behaviors (e.g., self-induced vomiting, laxative use) aimed at preventing weight gain, and extreme concerns about weight and shape that significantly impact self-esteem. AN is characterized by restriction of food intake leading to a weight that is less than minimally normal or expected, an intense fear of gaining weight, and extreme concerns about weight and shape that significantly impact self-esteem. For some, AN also includes a cyclic pattern of binge eating and/or inappropriate compensatory behaviors. BED involves recurrent episodes of binge eating that occur in the absence of inappropriate compensatory behaviors. Other specified feeding or ED includes clinical presentations that do not fall into one of the above-named diagnoses.



**Fig. 1.** Prevalence of eating disorder diagnoses and binge-eating behaviors across age cohorts.

Note: Adapted from Preti et al. [7]. AN = anorexia nervosa, BN = bulimia nervosa and BED = binge eating disorder.

### 3.1. Midlife eating disorders

AN occurs in approximately 0.5% of the population whereas BN occurs in 1–3% of the population [4]. BED and subthreshold cases of the EDs are more common, estimated to occur in up to 10% of the population [5,6]. Population-based prevalence studies of midlife (ages 45 and over) DSM-IV EDs, although lacking, reveal a lifetime risk for AN of 0.17%, BN of 0.21%, and BED of 0.61% [7]. The point prevalence for EDs in midlife women has been estimated at approximately 4% [8,9]. Fig. 1 presents data from six European countries revealing the prevalence of ED diagnoses across different age cohorts [7]. This figure highlights that, while decreasing with age, diagnoses do not disappear.

Similar to other age groups, community-based studies suggest ED symptoms are more common than threshold diagnoses at midlife [9,10]. Of women in the U.S. over 50 years, Gagne et al. [11] found that 13.3% endorsed at least one current core ED symptom (e.g., low weight, recurrent binge eating, compensatory behaviors). In a younger (42–55 years) multiethnic sample of women, the prevalence of recurrent binge eating (at least two to three times a month) was reported as 11% and extreme restriction or fasting (eating little or nothing for at least a day) to control weight and shape as 13.4% [10]. Body dissatisfaction, which contributes to the development, maintenance, and relapse of EDs [12], is also pervasive into midlife [13]. In contrast, significantly low weight, which is characteristic of AN, is rarer in midlife samples [11]. Collectively, diagnostic and symptom-based studies suggest that EDs characterized primarily by binge eating (e.g., BN, BED) and their subthreshold variants may be more commonly expressed than those characterized by pure restriction and low weight (sub- and full-threshold AN) at midlife (Fig. 1).

#### 3.1.1. Presentation and course

The presentation of midlife EDs varies as a function of chronology and course. Epidemiological and clinical reports suggest three profiles exist: (1) an early-onset, chronic condition without prior recovery; (2) a relapse of a remitted disorder; and (3) a late onset with no prior ED history [14,15]. Although the chronic condition and relapse profiles may be more common, late-onset EDs also occur. In a review of 48 published case studies of adults over age 50 years with EDs, 69% ( $n = 33$ ) of cases had a disease onset late in life and no prior ED diagnosis [16].

Individuals with EDs at midlife may have a worse medical profile than individuals with EDs at younger ages. The medical complications that arise from ED symptoms [17] could be exacerbated at midlife due to the body's lessened ability to resist and rebound from physical insult. For example, comparing young adult and midlife

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