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Eating disorder treatment among women forty and older: Increases in prevalence over time and comparisons to young adult patients ☆

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ABSTRACT

Objectives: There is limited information on the prevalence of middle-aged women seeking specialized treatment for an eating disorder and whether middle-aged patients are significantly different from young-adult patients. This two-part study sought to identify changes in the past two decades in the prevalence of middle-aged (MA; 40+ years) and young-adult (YA; 18–39 years) women seeking treatment for an eating disorder (ED) and to identify differences and similarities between both groups.
Methods: For Study 1, all unique female inpatient admissions from 1989 to 2006 were reviewed ($n = 1{,}040$). For Study 2, women admitted to any treatment level from January–May 2007 were compared, based on age at intake admission, on psychological questionnaires and factors relevant to an eating disorder.
Results: In Study 1, the overall percent of MA women who presented for inpatient ED treatment increased significantly from an average of 4.7% (1989–2001) to an average of 11.6% (2002–2006). In Study 2, at intake, MA women were more likely than YA to be married, be older at ED onset and report a longer duration of illness. Self-esteem, depression, anxiety, ED psychopathology, and BMI were not significantly different between groups.
Conclusions: Findings indicate an increase in the prevalence of inpatient admissions among middle-aged women, but few differences between middle-aged and younger-aged women at treatment admission. However, the longer duration of illness among MA warrants in-depth investigation of factors related to resistance to seeking treatment and to existing treatments failing patients, and consideration of tailoring treatment to course of illness.

Introduction

There are limited studies examining the prevalence of middle-aged (MA) women seeking treatment for an eating disorder (ED). Scholtz and colleagues (2010) examined all admitted patients to an ED treatment program within the past decade and found a 1% prevalence of women presenting for treatment at 50 years of age or older [1]. Yet, another ED treatment program reported a 400% increase of patients presenting for treatment at age 40 or older during the same decade [2].

There is also a dearth of research comparing MA to young adult (YA) women seeking treatment. In one study comparing patients 35 years old or older at intake to a residential eating disorders treatment program, those presenting for treatment in midlife had an older age at eating disorder onset, longer duration of ED illness, greater social isolation, lower body shape concerns, and less internalization of the sociocultural ideal at intake assessment than those presenting for treatment in young adulthood. There were no differences in anxiety or depression scores at admission or on ED outcomes at discharge between age groups [3]. In a separate study, issues related to family (e.g., nonsexual trauma, controlling spouse or partner) and health were important factors underlying the predisposition to, and maintenance of, ED among the those patients 40 years of age and older, but not those younger than 40 years [4].

Thus, this two-part study aims to fill two gaps in the literature regarding MA women seeking ED treatment. First, we sought to identify the prevalence of inpatient admissions by year and by age at admission (18–39 years vs. 40 years or older) across an 18-year period for adult females seeking treatment for an ED (Study 1). We hypothesized an increase in admissions among women 40 and older over time. Second, we aimed to identify descriptive and psychological differences at intake across outpatient, partial hospital and inpatient admissions between those aged 18–39 and those 40 years of age and older (Study 2). We hypothesized that MA women seeking treatment would be more psychologically compromised than their YA peers.

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Methods

Design

For both studies, eligible individuals were adult females 18 years of age and older who provided active consent at intake assessment for research-related medical records reviews. Admission criteria were based upon the American Psychiatric Association's (APA) Guidelines for the Treatment of Eating Disorders and included diagnoses of Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorder Not Otherwise Specified (EDNOS) as described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition [5]. This study was reviewed and approved by the Park Nicollet Health Services Institutional Review Board. Participants were not compensated for their participation.

Study 1

From 1989 to 2006, all unique inpatient admissions at the Park Nicollet Melrose Institute, St. Louis Park, MN (USA) were captured by data query of an administrative database containing medical record information for all women aged 18 or older. Data collected were year of admission, age at admission and ED diagnosis. The number of inpatient admissions ranged from a low of 24 in 1993 to a high of 170 in 2006, for a total of 1,040 unique admissions across the 18-year study period. Each patient was only included in the year of her first inpatient admission to this facility; all subsequent admissions were excluded from the data. Most participants were between the ages of 18 and 39, inclusive ($n=$ 950; 91%). Diagnostic presentation for the entire sample, as determined by clinical psychiatric interview, was 41.5% AN, 29.1% BN and 29.3% EDNOS. Please note that patients receiving inpatient treatment for Binge Eating Disorder (BED) are included under EDNOS, although patients with BED are rarely hospitalized at this facility, and the BED diagnosis was not recognized in the early years of this study.

Study 2

To further understand the subset of MA women presenting for treatment, data were abstracted from medical charts of all women aged 18 or older (range 18 to 64 years) who completed an intake assessment for any level of treatment between January 1, 2007 and May 31, 2007 ($n=164$) at the Park Nicollet Melrose Institute, St. Louis Park, MN (USA). Most were Caucasian ($n=141$, 86.0%) and reported their marital status as single ($n=115$; 70.1%). The vast majority of women were between the ages of 18 and 39, inclusive ($n=134$, 81.7%). Over one-half received outpatient ($n=86$; 53.1%) and the remainder received inpatient ($n=73$; 45.1%) or partial hospitalization ($n=3$, 1.8%) treatment. Diagnostic presentation for the entire sample was 20.7% AN, 23.8% BN and 55.5% EDNOS. The Park Nicollet Melrose Institute provides a separate program for the treatment of Binge Eating Disorder, therefore these patients were excluded from study sample 2.

Materials

The following information was collected at intake and later abstracted from the medical chart: race, date of birth, marital status, date of admission to the treatment facility, age at admission, treatment milieu (inpatient, partial hospital, intensive outpatient, outpatient), ED diagnosis (AN, BN, EDNOS), self-reported age at onset of ED, and anthropometrically measured height and weight as used to calculate BMI.

In addition, the following psychological measures, described below, were collected at intake: Eating Disorders Examination—Questionnaire, Body Image Assessment, Beck Depression Inventory II, Rosenberg Self-Esteem Survey, and State-Trait Anxiety Inventory.

The Eating Disorders Examination—Questionnaire (EDE-Q; [6]) is a 41-item self-report questionnaire that asks specific questions pertaining to the presence and frequency of ED behaviors, thoughts, and feelings about body over the past 28 days. The EDE-Q is derived from the interview version of the Eating Disorders Examination and has four subscales: Restraint, Eating Concern, Weight Concern, and Shape Concern. Mean scale scores (and standard deviations) among young Australian adult women are: 1.30 (1.40) for Restraint, 0.76 (1.06) for Eating Concern, 1.79 (1.51) for Weight Concern, and 2.23 (1.65) for Shape Concern [7]; mean scores (and standard deviations) among undergraduate women in the United States are similar: 1.29 (1.41) for Restraint, 0.87 (1.13) for Eating Concern, 1.89 (1.60) for Weight Concern, and 2.29 (1.68) for Shape Concern [8]. Higher scores indicate greater pathology across the four subscales. The EDE-Q has been found to have good concurrent validity and criterion validity among community samples [9] and good internal consistency [9,10].

The Body Image Assessment (BIA) instrument assesses perception of current and ideal body shape with established reliability and validity [11]. Participants select one female body silhouette perceived to represent their current body size (CBS), and one silhouette for ideal body size (IBS); figures range from 1 (thinnest) to 9 (heaviest).

The Beck Depression Inventory-2 (BDI-II; [12]) is a 21-item self-report instrument designed to measure depression severity using a 4-point Likert scale (responses from 0 to 3). Total scores range from 0 to 63, and a higher score indicates a higher level of depression. Clinical severity categories are: 0–13 minimal, 14–19 mild, 20–28 moderate, and 29–63 severe [12]. Psychometric properties that assess the reliability and validity of the BDI-II for measuring depression have been found to be strong among adolescent [13] and adult populations [14].

Participants also completed the Rosenberg Self-Esteem Scale (RSES; [15]), a 10-item questionnaire that assesses overall self-esteem and self-worth; scores range from 10 to 40, and higher scores indicate greater self-esteem. Reliability and validity estimates have been published elsewhere [16] and the measure demonstrates adequate psychometric properties.

The State-Trait Anxiety Inventory (STAI; [17]) is a 40-item self-report assessment that includes separate measures of state and trait anxiety. The total score ranges from 20 to 80 for each scale (trait versus state anxiety), and higher scores indicate greater anxiety. Clinical severity categories, based on score, are: 20–30 low, 31–40 low average, 41–48 average, 49–60 high average, 61–70 high, and 71–80 very high [17]. Psychometric properties of the STAI are sound, with test–retest among male and female high school and college students ranging from .65 to .86 for trait anxiety and .16 to .62 for state anxiety. This low level of stability for the state-anxiety scale is expected since responses to the items on this scale are thought to reflect the influence of whatever transient situational factors exist at the time of testing [17]. The validity correlations are .80 with the Taylor Manifest Anxiety Scale, .75 with the IPAT Anxiety Scale, and .52 with the Multiple Affect Adjective Check List [17].

Data analysis

The results were stratified into two groups by age at intake assessment (18–39, inclusive, versus 40 years or older). Demographic data including race, marital status, initial assessment treatment recommendation and ED diagnosis were analyzed using the Chi-Square Test while a 2-sample t-test with Satterthwaite's approximation for unequal variances was used to test for differences in age at onset, duration of illness and BMI between groups. Differences between questionnaire scores at intake assessment were evaluated using multivariate analyses of variance (MANOVA) adjusting for age of eating disorder onset, duration of illness and BMI. The significance level was set at $p<.05$. Statistical analyses were conducted with SAS version 9.3.

Results

Study 1—Prevalence of eating disorder admissions by admission age from 1989 to 2006

Inspection of prevalence rates, stratified by year (1989–2006) and age (18–39 years versus 40 years or older), shows that the rates of MA women presenting for