



# Unfulfilled: Treating Eating Disorders in Midlife Women

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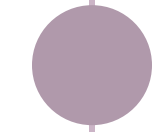




# AGENDA

Participants will be able to identify 3 stressors that maintain eating disorder symptoms among women in midlife.

Participants will be able to describe 2 emotion-focused evidence-based approaches to treat women in midlife with eating disorders.

Participants will be able to implement 3 emotion-focused strategies with midlife clients struggling with eating disorders.





# EATING DISORDERS & UNIQUE STRESSORS FOR WOMEN IN MIDLIFE

- Unique Stressors for Midlife Women
- DSM-5 criteria
- Weight Stigma
- Intersectionality and Co-Occurring Issues

# WHO ARE WE SEEING?

Women seeking treatment for weight & health concerns

Pre-occupation with food & body image, chronic dieting, subclinical eating disorders

Seeking support for depression, anxiety, life stressors (divorce, death of loved ones, identity, menopause)

Current ED pathology (new diagnosis or relapse)

# THE PERFECT STORM...



# EATING DISORDERS & MIDLIFE

Hospitalizations from 1999 to 2009 involving eating disorders of all ages showed the greatest increase – **88%** – **for patients aged 45 to 65** – and 25% of all admissions were > 45 years.

Zhao, Y and Encinosa, W. An Update on hospitalizations for eating disorders, 1999 to 2009  
Healthcare cost and utilization project (HCUP) Statistical Brief #120

The prevalence of eating disorders according to DSM-5 criteria is around 3.5% in older (>40 years) women. **BED and OSFED were the most prevalent.**

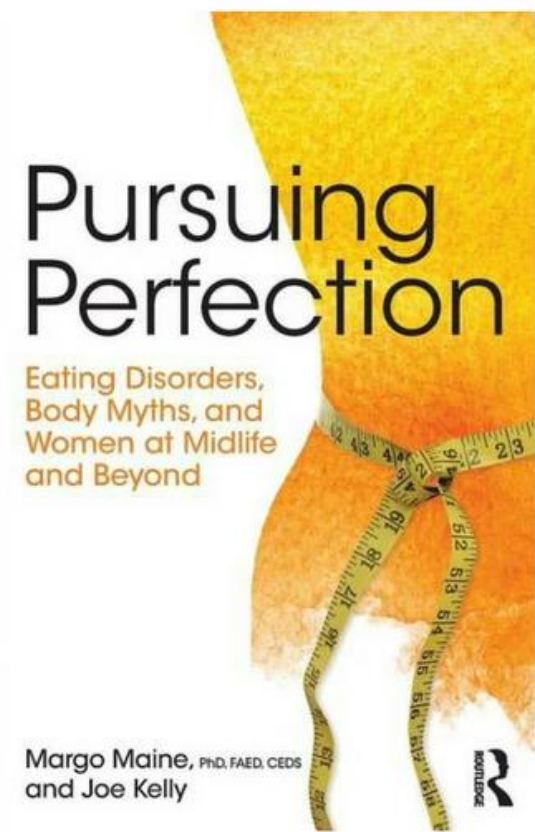
Mangweth-Matzeka, B and Hoek, HW (2017)

A new term has been introduced: “**perimenopausal eating disorder**”  
Due to significantly higher eating disorder prevalence rates in perimenopausal women as compared with pre- and postmenopausal women.

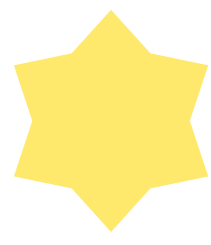
Baker JH and Runfola CD (2016)

# BODY IMAGE, AGING & IDENTITY

## 2012 National Survey - Women over 50



- 79% said weight & shape affected self-esteem
- 41% weigh themselves daily
- 36% spent half their time in the past 5 years dieting
- 13% reported clinical eating disorder symptoms
- 8% reported purging in the past 5 years
- 3.5% reported binge eating
  - Most common current symptom



# JEAN (SHE/THEY)

**48-year-old lesbian female**

**Presented with panic attacks,  
PTSD & restrict/binge behaviors**

History of severe restriction and  
diet cycling

PTSD (“behaviors don’t work  
anymore”)

Desire to lose weight

Perimenopause (weight gain,  
fatigue, brain fog, irregular  
menses)

## **Treatment Themes**

Isolation & feelings of  
loneliness

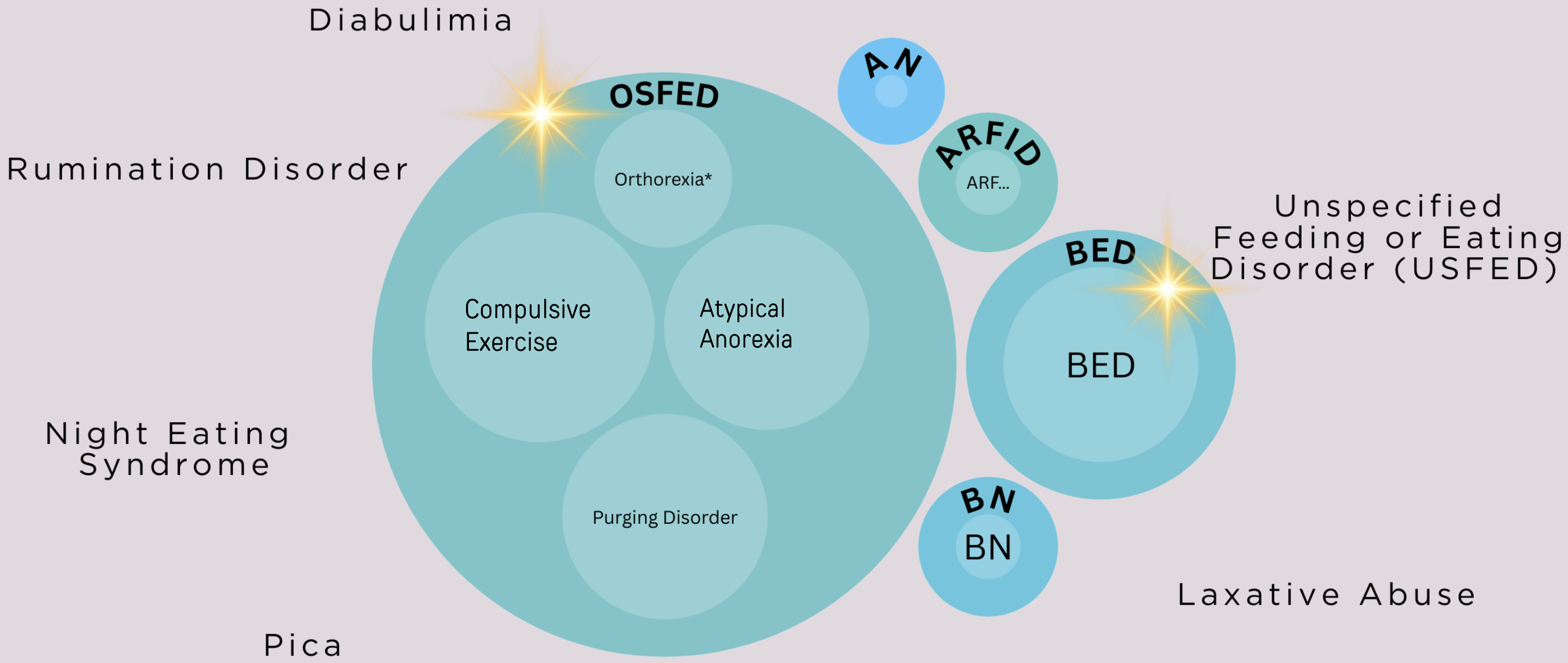
Lack of purpose

Caregiver for mother (assisted  
living community)

Body distrust & shame

Function of ED behaviors





# INTERSECTIONALITY & ED RISK FACTORS

## BIPOC

- Tend to be misdiagnosed
- Under treated
- Less likely to seek out ED recourses
- Mental health stigma

## Cultural/Societal Factors

- Historical and intergenerational trauma
- Bullying
- Glorification of masculinity
- Acculturation status
- Food insecurity
- Social media influence

## ED RISK FACTORS

## Female Identity

- Body Objectification
- Internalization of dominant culture thin ideal
- Cultural differences

- Diet cycling
- Fad diets (keto, intermittent fasting)
- Fat phobia and size discrimination
- Norms that value thin bodies and appearance

## Diet Culture & Weight Stigma

- LGBTQIA+ increased risk
- Risk factors include social exclusion, family rejections, peer victimization

## LGBTQIA+

Grabe et al., 2008; NEDA, 2023

# MIDLIFE MOOD DISORDERS

Lifetime prevalence of mood disorders 2x greater in women than men

16% of women in midlife report a mood disorder

Women 2-4x more likely to experience depressive episode during menopausal transition

Absence of estrogen implicated in regulation of mood & behavior

Navarro-Pardo, Holland & Cano (2018)

# PERIMENOPAUSE AND MENTAL HEALTH

## Severe mental illness and the perimenopause

Sophie Behrman,<sup>1</sup>  Clair Crockett<sup>2</sup>

BJPsych Bulletin (2023) Page 1 of 7, doi:10.1192/bjb.2023.89

<sup>1</sup>Oxford Health NHS Foundation Trust, UK; <sup>2</sup>Newson Health Menopause and Wellbeing Centre, UK

Correspondence to Sophie Behrman ([sophie.behrman@psych.ox.ac.uk](mailto:sophie.behrman@psych.ox.ac.uk))

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Hormonal fluctuations in the perimenopause are associated with an array of physical and psychological symptoms. Those with pre-existing mental disorders may experience changes to their symptoms and response to treatment during the perimenopausal and postmenopausal periods and may also be at risk of poorer longer-term physical health outcomes in menopause. The transition towards menopause may be compounded by the oestradiol-suppressing effect of many psychotropics on the hypothalamopituitary–gonadal axis. A collaborative approach between primary care and secondary mental health services is an opportunity for proactive discussion of symptoms and support with management of the perimenopause. This may involve lifestyle measures and/or hormone replacement therapy, which can both lead to improvements in well-being and mental and physical health.

**Keywords** Comorbidity; neuroendocrinology; organic syndromes; primary care; patients.

Fluctuating hormones and decline in estrogen increase risk for:

**New-onset psych symptoms** (anxiety, low mood, brain fog) and **first episodes of mental illness** (depressive and psychotic episodes)

# SYSTEMIC ISSUES



Eating Disorders  
Mental Health Issues  
Chronic Avoidance

**Midlife women** - aging is to be feared,  
fertility/infertility, sexually unattractive, lack of  
fulfillment & purpose, “fix” perimenopause/menopause

Diet Culture  
Thin Ideal  
Wellness Culture & Healthism  
Anti-Fat Bias  
Weight Stigma & Discrimination



Marginalization &  
Oppression  
Poverty & Food Insecurity  
Provider Bias  
Provider Lack of Education  
Healthcare Inequities

Perceived  
Weight-Based  
Stigma





Low self-esteem  
Poor psychosocial  
functioning  
Binge eating  
Psychological distress



Internalized  
Weight Stigma



Emotion regulation  
issues  
Negative affect  
Somatic symptoms  
Non-sustaining  
coping behaviors (i.e.  
self-harm, substance  
use)



# EMOTIONAL AVOIDANCE & EATING DISORDERS

- Emotional Avoidance
- Body Image & Body Avoidance
- Perfectionism & Shame
- Language of “fat”

# EATING DISORDERS & EMOTIONAL AVOIDANCE

Individuals with Emotional Disorders

Experience negative affect more intensely & frequently

View emotional experiences as unwanted & intolerable

Use non-sustainable strategies to dampen or avoid emotions

**Negative Reinforcement**



# MAINTAINING FACTORS

Effects  
of  
altered  
nutrition

Cognitive  
rigidity/  
pro-ED  
beliefs

Systems

Relational  
response  
to ED  
behaviors

Temperament:  
harm avoidant,  
perfectionistic,  
impulsive

Neuroticism:  
anxiety about  
anxiety!

**Experiential Avoidance**  
(limited behavioral repertoire)

+

**Emotional Intolerance** of negative  
affect

# BODY IMAGE DISTURBANCE

Common feature of many eating disorders BUT...

Not a requirement for an eating disorder diagnosis

Not all individuals with body image disturbance develop an eating disorder

Patients with AN often **overestimate** their current body size (*Mohr et al., 2010*).

Neuroimaging studies have found differences in **serotonin receptor activity, abnormal activation of parietal cortex** (Bailer et al., 2004; Wagner et al., 2003).

The parietal cortex **helps to create a map of the body using the sensory information it processes**, problems with creating this body map may underlie body image distortions (Titova et al., 2013).

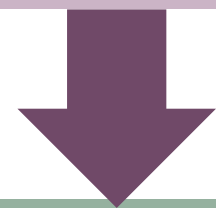
# BODY AVOIDANCE

Body sensations & interoceptive experiences (i.e. hunger, satiety) may feel **threatening or dangerous**

Impairs ability to learn from emotions (emotional competence)



**Difficulty trusting body**, including changing size/shape, interoceptive experience

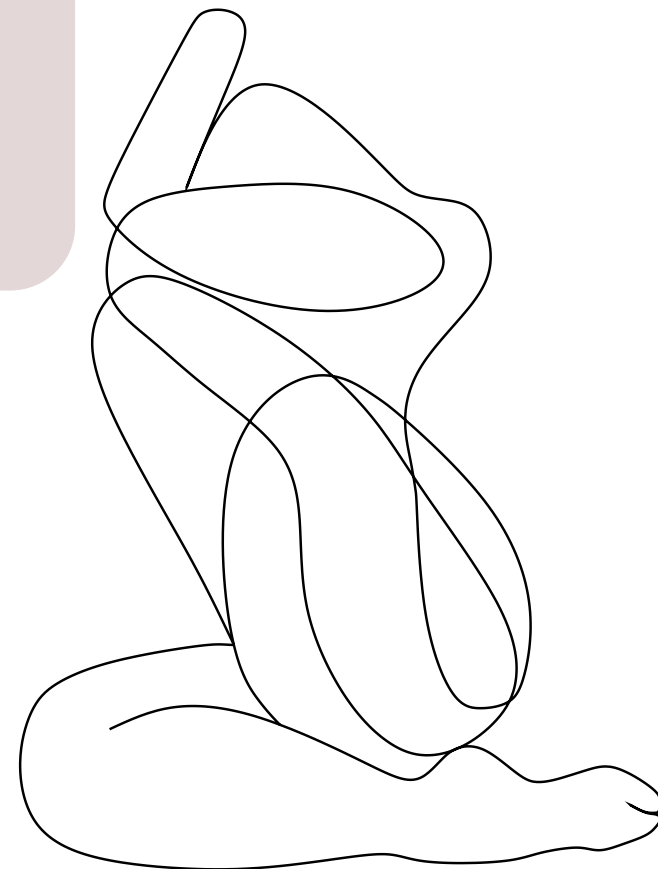


**Reduced trust** that body “knows what it is supposed to do”

Influenced by weight stigma

# BODY MISTRUST

Primary symptom connected to IA & ED symptoms was **not feeling one's body was a safe place**



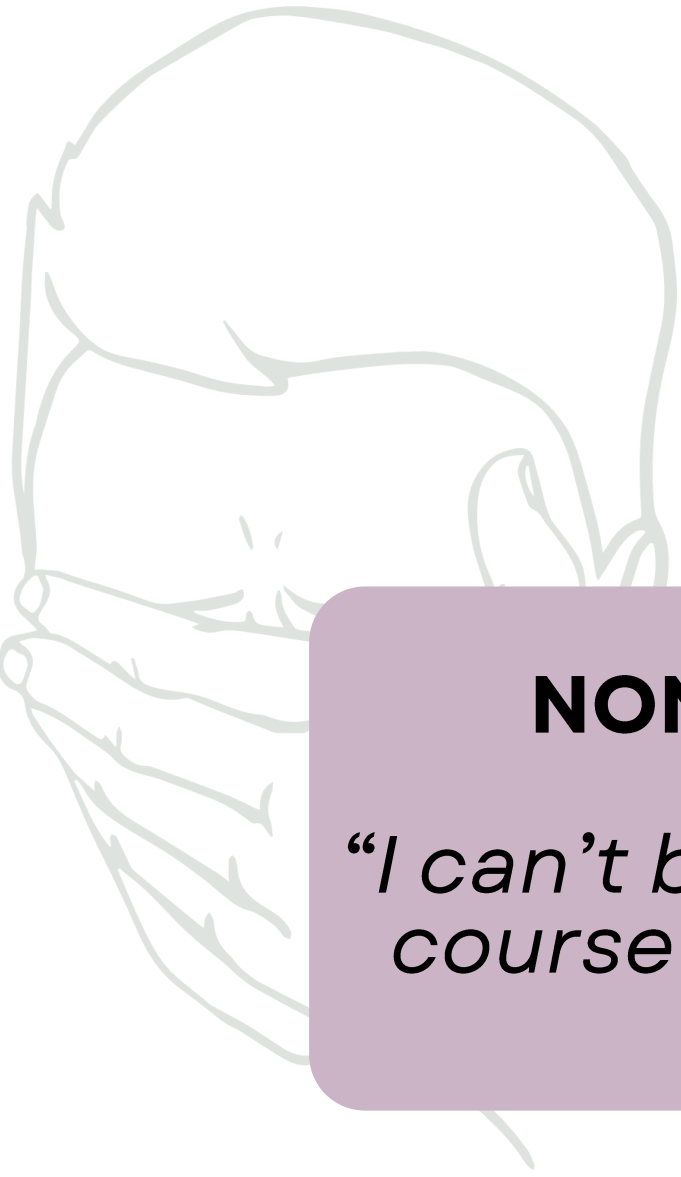
Higher eating restraint, eating concerns, weight/shape concerns, binge/purge behaviors associated with...



Lower ability to maintain **awareness of body sensations without distraction**

Lower ability to regulate distress by **attending to body sensations**

Lower ability to **listen to the body for insight**



# SHAME

## NON-SUSTAINING

*“I can’t believe I did this...of course this person hates me.”*

### Connected to ED & avoidance

ex: ED behaviors, isolate, lash out, self-harm

## ADAPTIVE/SUSTAINING

*“I don’t like how I handled that situation”*

Correct behavior to **repair relationship**  
(growth fostering)

Adhere to **social norms & values**

# DIET CULTURE

Diet culture is a **cultural belief system** that values thinness and appearance over health and well-being.

**Preoccupation with physical appearance** coupled with adhering to “perfect” eating standards.

**Obsessive discussions** about calorie limits, types of foods consumed, exercise expectations, and other methods used to lose weight.

## The Language of “Fat”

Unworthy  
Failure  
Shameful  
Embarrassment  
Sexually undesirable  
Safe  
Unsuccessful  
Gross  
Lack of purpose  
Burden  
Unhealthy  
Weak  
Unfulfilled  
Uncomfortable in body  
Unlovable

**Shame-Based**



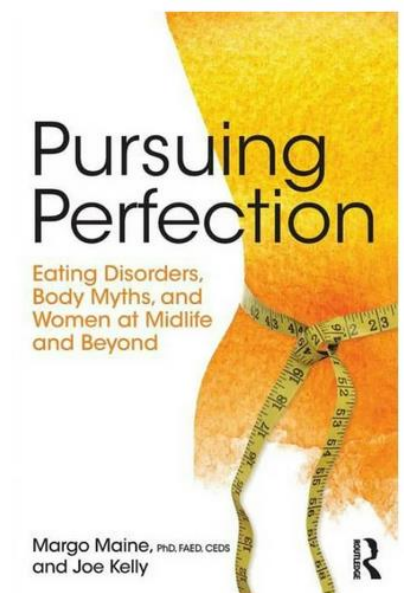
# PERFECTIONISM





“

...they spiral through frightening and dreary stages of severe dieting, bingeing, purging and weight obsession, as they try to be perfect and meet our culture's appearance expectations. The **pressure to be perfect** leads them to a perfect problem: the deeply embedded (but mistaken) **belief that our meaning, self-worth and value to others are based on how our bodies appear, what we weigh, and what we eat.**

”





# TREATING WOMEN IN MIDLIFE WITH EATING DISORDERS

- The Power of Connection
- Evidence-Based Treatments
- Essential Tools

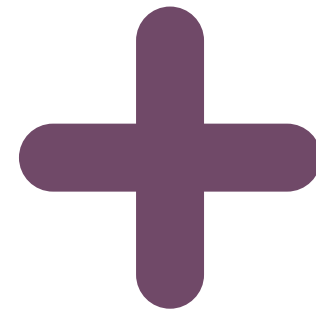


# THE IMPACT OF CONNECTION

Rooted in Relational-Cultural Therapy

As relational connection increases  decrease  ED symptoms

Dismantling power-over strategies



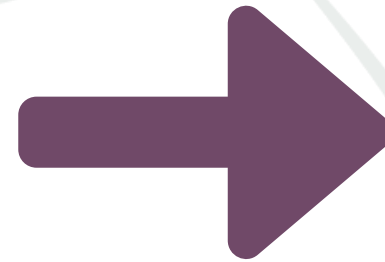
Diversity, culture, and oppression central to therapeutic relationship

# THE IMPACT OF CONNECTION

Rooted in Relational-Cultural  
Therapy

**As relational connection increases**  **decrease**  **ED symptoms**

EDs and trauma rooted in  
disconnection from self  
and others



People heal in connection  
with others  
Repairing disconnection is  
vital

# GROWTH FOSTERING RELATIONSHIPS



**ENGAGEMENT**



**EMPOWERMENT &  
MUTUAL  
EMPOWERMENT**



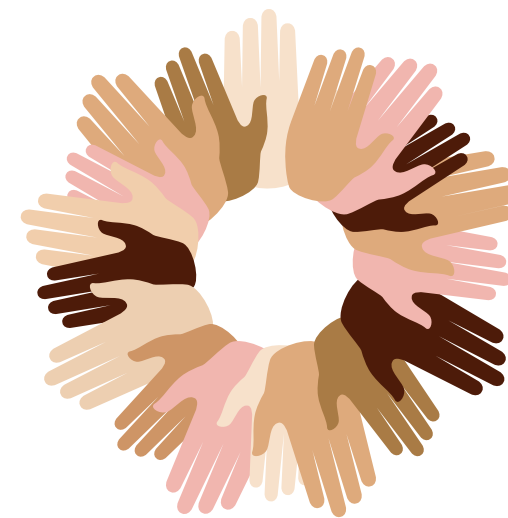
**MUTUALITY**



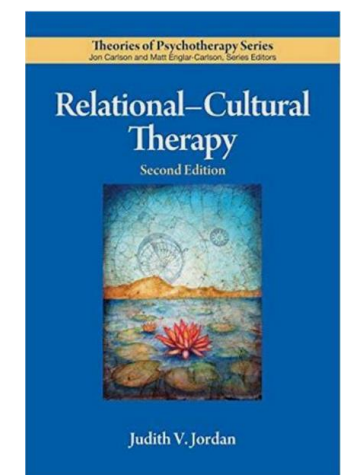
**AUTHENTICITY**



**EMPATHY & MUTUAL  
EMPATHY**



**DIFFERENCE &  
DIVERSITY**



Jordan,  
2017

# UNIFIED PROTOCOL (UP) + ACCEPTANCE & COMMITMENT THERAPY (ACT)

## **UP TARGETS:**

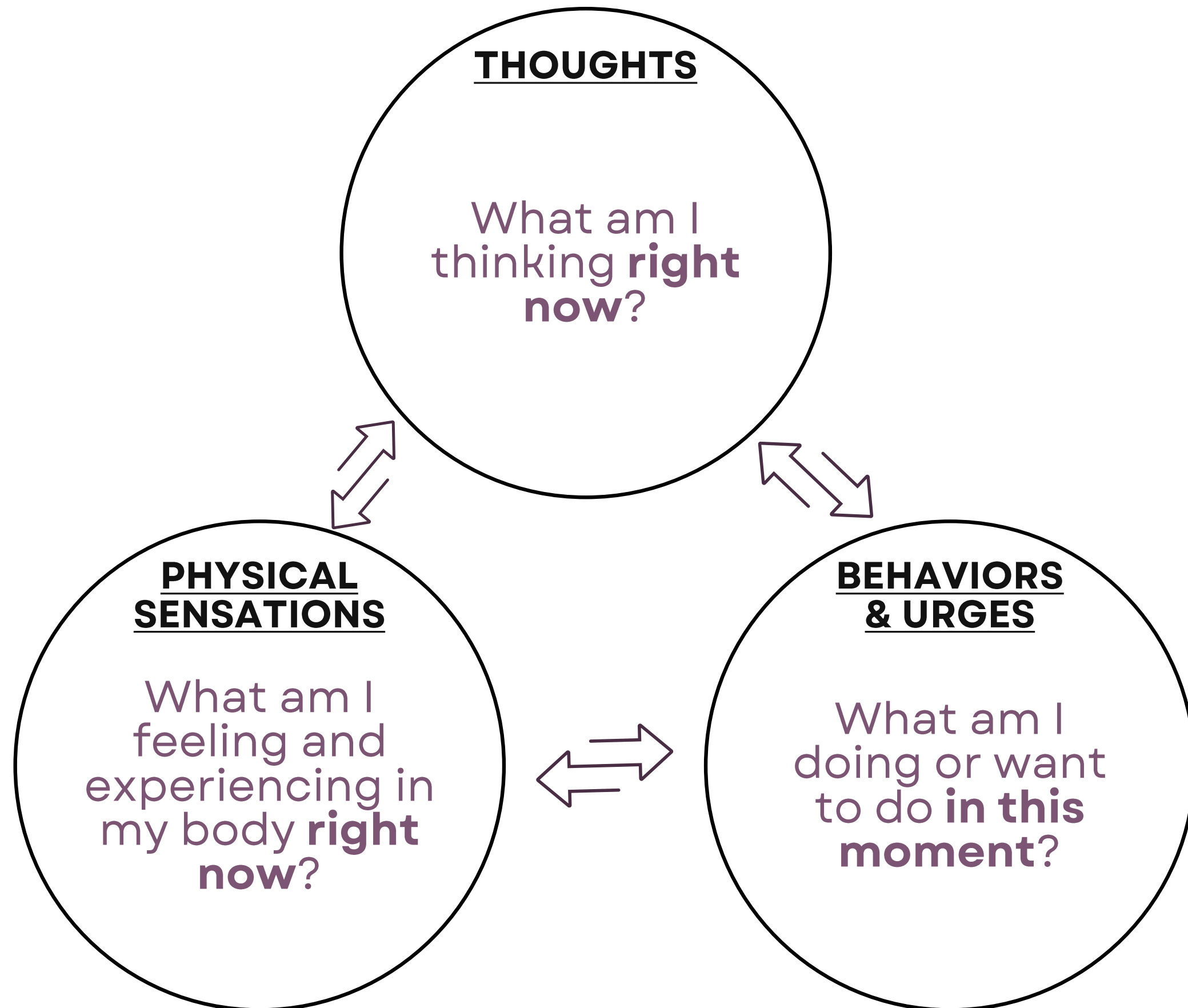
- Emotional avoidance
- Negative affect
- Emotion driven behaviors

## **ACT TARGETS:**

- Relational connection
- Emotional avoidance
- Non-judgmental observation & acceptance of emotion

Barlow et al., 2011; Manlick et al., 2013

# EMOTION AWARENESS



# THE FUNCTION OF ANGER



Assists with  
**transformation**

Rational and  
emotional **response**  
**to violation, threat,**  
**insult, injustice**



Has a bad reputation

**Cultural expectations** to stand  
up for oneself without  
“sounding angry or bitter”

**Negative labels** - drama queen,  
oversensitive, exaggerating,  
aggressive

## In the literature...



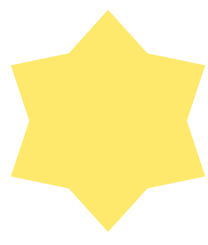
**Inward expression** - suppression,  
rumination, hostility

**Outward expression** - cognitive  
processes (i.e. reappraisal), verbal  
expression of anger

**Cognitive reappraisals** are  
connected to emotion regulation

**Mindfulness mediates** hostile  
expressions of anger

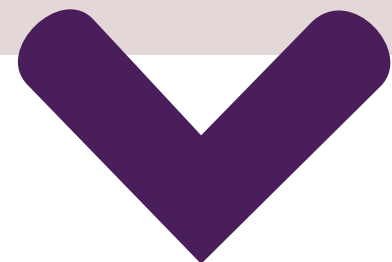
**Suppression and rumination** of  
anger leads to more intense  
outward expressions of anger



# JEAN'S ANGER

## Inward Expression

- Rumination (obsessive thoughts about weight loss, food intake)
- Suppression of anger



## Hostile behavior toward body

- Self-harm
- Restrict/binge cycle
- Body shaming

## Core Skills

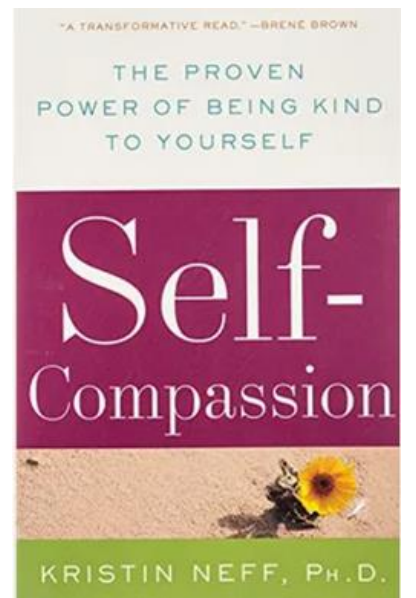
### Cognitive Re-Appraisals

“Maybe I can tolerate my body today”

### Mindfulness

Noticing & naming emotions  
Non-judgmental awareness

# SELF-COMPASSION





# JEAN'S AVOIDANCE STRATEGIES

## COGNITIVE

Rumination  
Suppression  
Distracting  
Obsessive thoughts about body image

## SUBTLE BEHAVIORAL

Avoiding eye contact  
Shifting body posture  
Crossing arms over chest

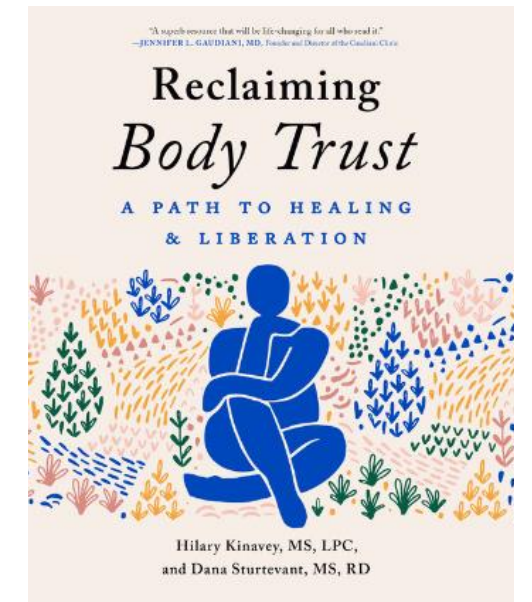
## SAFETY SIGNALS

Phone  
Medications  
Fidgets

## GOAL: Practice alternative action tendencies



Congruent affect, staying in the present moment (3-point check), anchoring/grounding, sitting upright, naming emotions

# BODY TRUST



Body trust is a **strength-based, trauma-informed, scientifically grounded healing modality** - a way out of the predictable, repetitive pattern of dieting, disordered eating and weight cycling fueled by shame, trauma, and body-based oppression.

~Center for Body Trust  
Hilary Kinavey, LPC & Dana Sturtevant,  
RD



# EXPOSURE PRINCIPLES & INTEROCEPTIVE AWARENESS

- Exposure Principles (overview)
- Interoceptive Awareness

# EMOTION EXPOSURES



- Naturalistic
- Imaginal
- In vivo/Situational
- Interoceptive

## Core Skills

### Psychoeducation

- Mindfulness
- Counter avoidance
- Stay present/aware

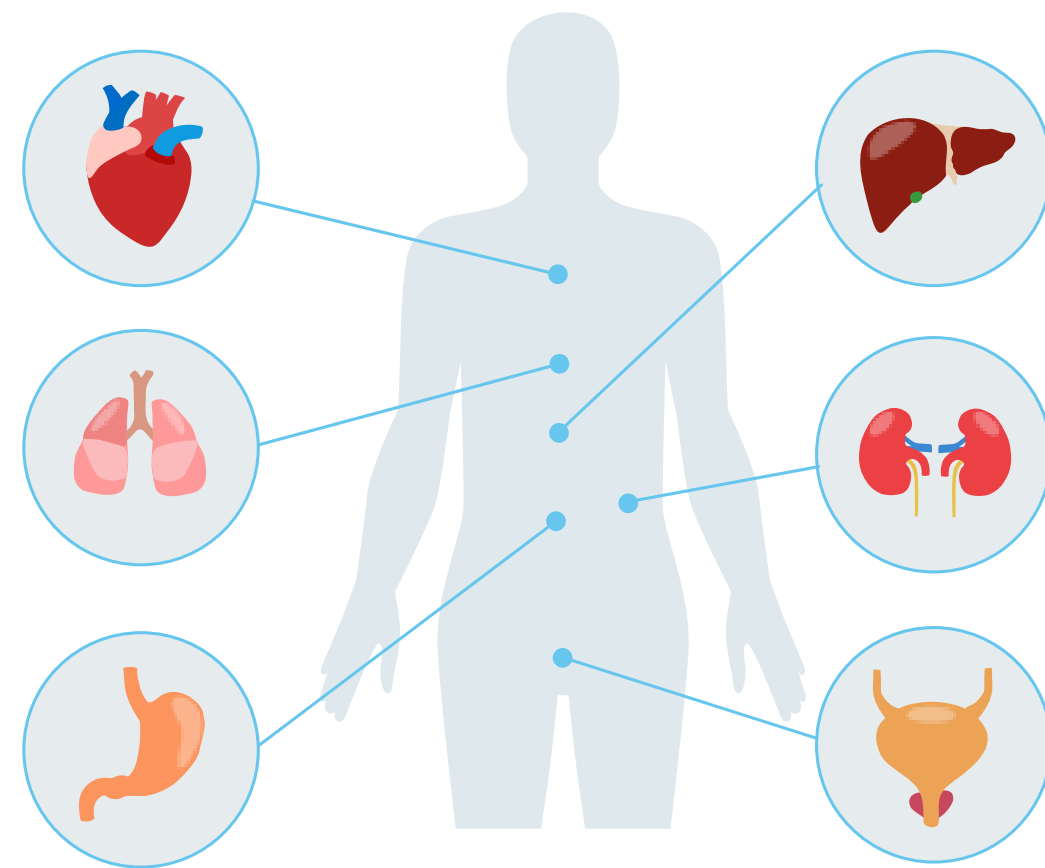
### Create Hierarchy

### Interoceptives

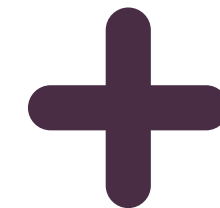
# BODY TOLERANCE HIERARCHY

	<b>Description</b>	<b>Avoid (0-8)</b>	<b>Distress (0-8)</b>
<b>1</b>	Describe physical sensations while in session while looking in the mirror.	8	8
<b>2</b>	Explore negative appraisals related to the body while looking in the mirror in session.	7	8
<b>3</b>	Engage in a body self-care activity.	7	7
<b>4</b>	Identify negative appraisals related to the body while eating a snack in session.	7	7
<b>5</b>	Do a 3-point check in session while eating a snack.	6	7
<b>6</b>	Do a 3-point check (physical sensations, thoughts, behaviors/urges) with support in session.	5	6

# WHAT IS INTEROCEPTION?



The process by which the **nervous system** senses, interprets, and integrates signals within the body to **maintain homeostasis (WOT)**



Information about **internal physiological states** is communicated to the brain to support physical and emotional well-being (including effective response to stress via emotional awareness and regulation)

# INTEROCEPTIVE AWARENESS



Consciously sensing, interpreting, and integrating information about the **state of our inner experience**

**Integration** of bodily sensations, cognitive processes, and emotions

Strong connection to better **emotion regulation, emotional competence, and emotional awareness**

# WHAT EMOTIONS FEEL LIKE IN THE BODY:

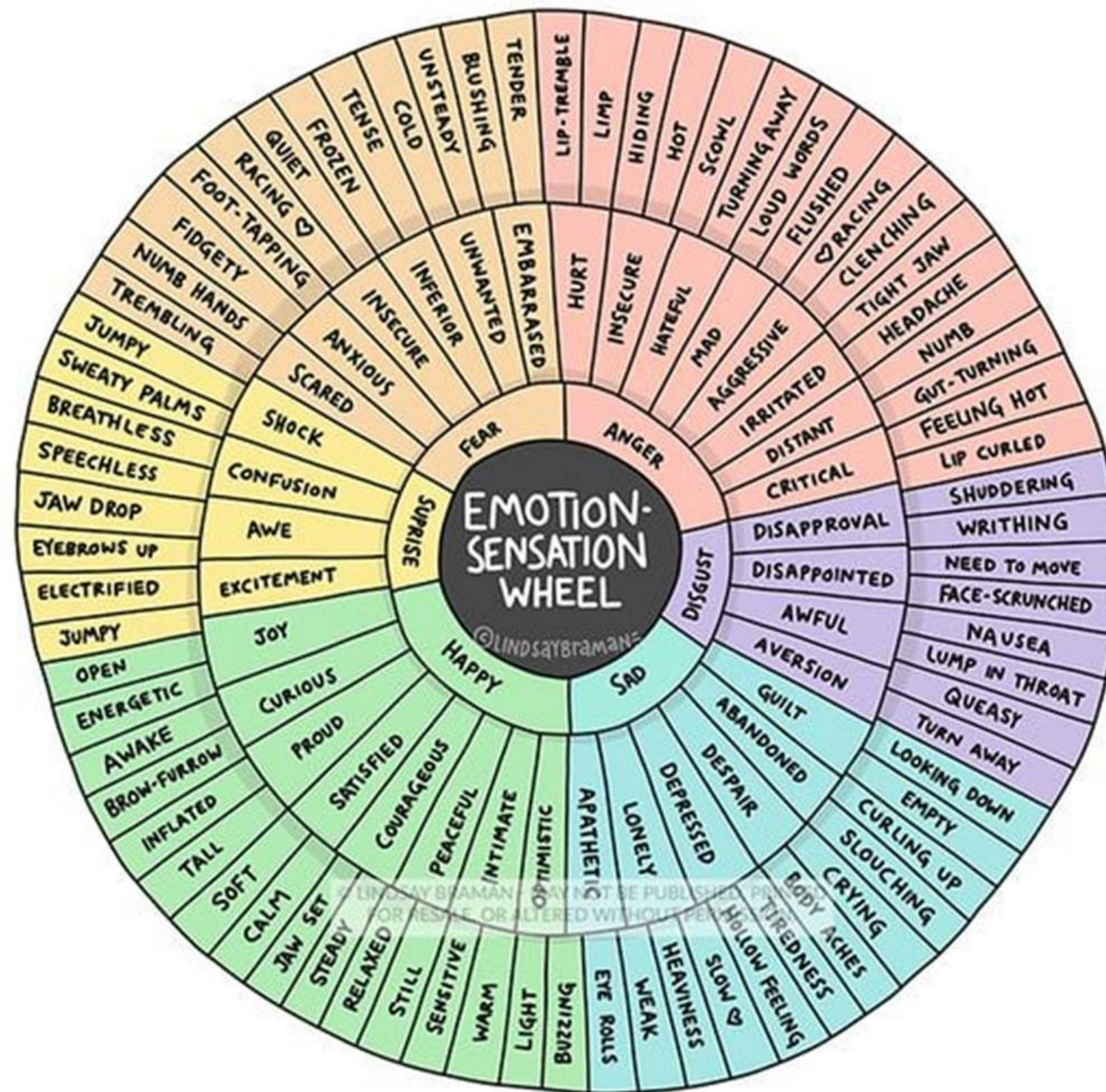


image source: Lindsay Braman, LMHCA



# HELPFUL QUESTIONS TO ASK CLIENTS



Khalsa, 2019

**How often** do you focus your attention on these sensations?

**In what context** do these sensations occur (i.e. internal, external environment)?

**How intensely** do you perceive these sensations (0-10)?

**To what degree** are you aware of your internal body sensations? How does this impact your ED symptoms?

# INTEROCEPTION - EDS & BODY AWARENESS

## EATING & DIGESTION

**Sensory:** smells, tastes, textures, chewing, swallowing

**Digestive-specific physiological cues:** hunger, satiety, nausea, fullness, bloating, pain

**Mechanoreception**

## BODY AWARENESS

**Pressure** from clothing, stretching of skin

**Increased somatic sensitivity** of violated body parts

**Numbness** (lack of awareness), derealization

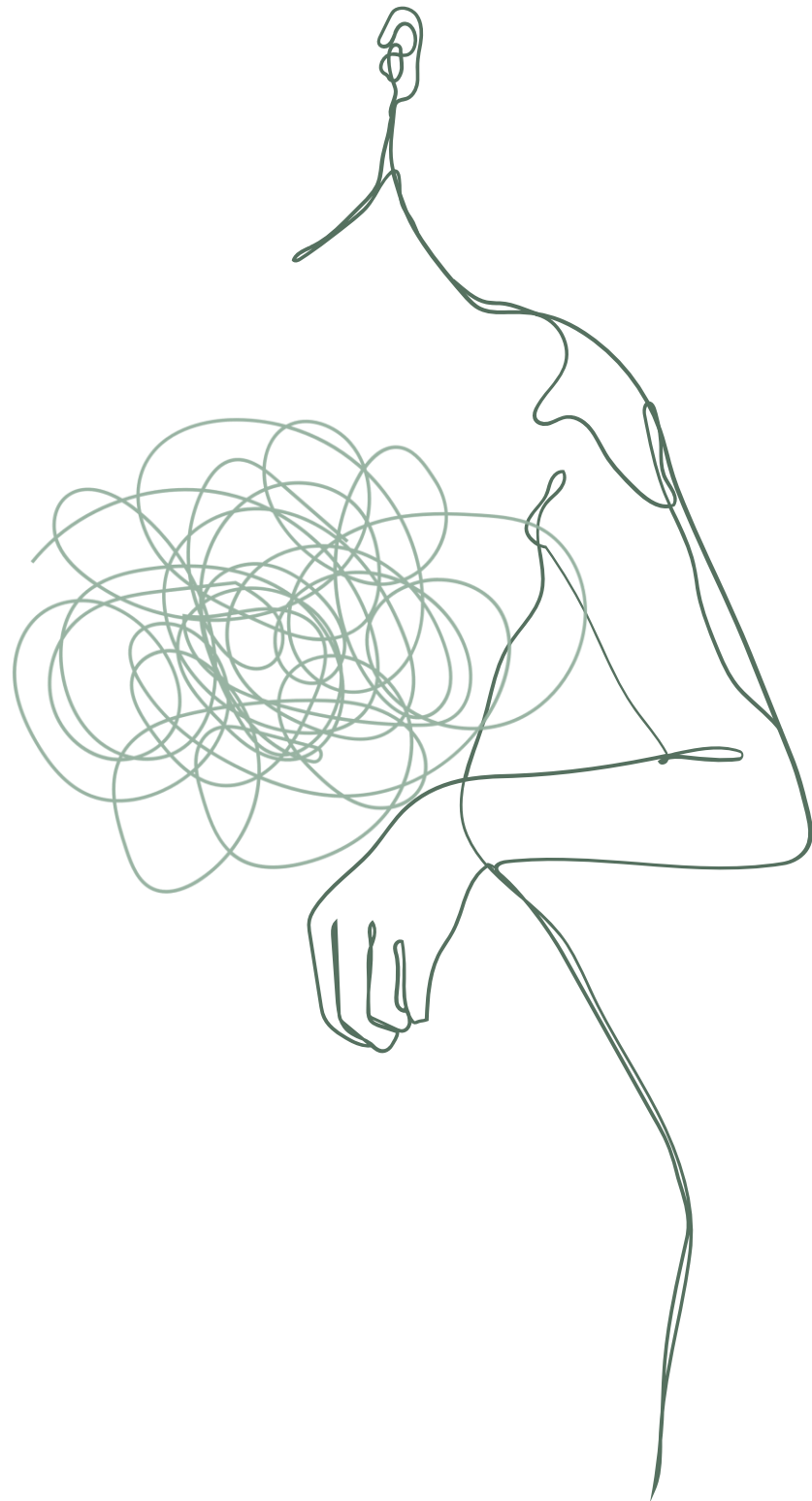
## EMOTION

**Anxiety:** dizziness, shortness of breath, muscle tension

**Fear:** racing heart, sweaty palms, hypervigilance

**Shame/disgust:** hot face, knot in stomach

# INTEROCEPTIVE EXPOSURES



Designed to **build tolerance** to physical sensations & **increase IA**

Targeting physical sensations that are **connected to emotional experiences**

Sensations may be **uncomfortable but not dangerous**, thus reducing avoidance behaviors

Becoming **“body investigators”** (curious)

# PSYCHOEDUCATION & RATIONALE

Our physical sensations are not the problem, rather our **reactions** to them are



Our emotional response is based on the **interpretation** of the physical sensations




Exposure to physical sensations in a **neutral context** allows us to understand the complex emotional response and DO something with it



Over time, this **breaks the association** that these sensations are threatening or dangerous

# ASSESSING READINESS

- 
- **stable** (medically, psychologically, safety)
  - able to **tolerate emotional distress** without relying on avoidance strategies
  - **aware** of internal physical sensations

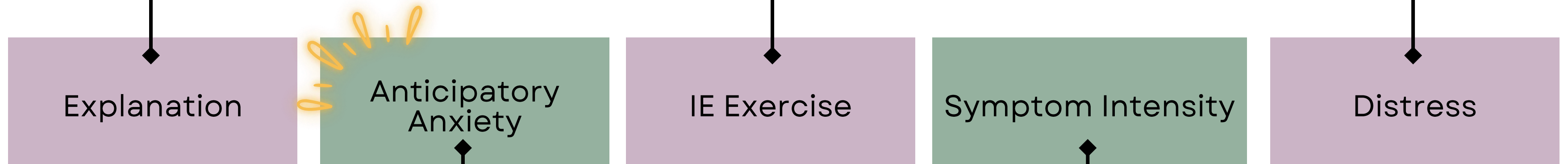


# INTEROCEPTIVE EXPOSURE (STEP-BY-STEP)

explain exercise in detail, including timing

conduct exercise for allotted time

assess distress level (0-8)



check SUDs (0-8); rate level of anticipatory anxiety for the exercise

what do you feel in your body?  
how intense is it? (0-8)

# INTEROCEPTIVE EXPOSURES ED & BODY AWARENESS

## **BODY AWARENESS**

**Pressure** from clothing,  
stretching of skin

**Increased somatic  
sensitivity** of violated  
body parts

**Numbness** (lack of  
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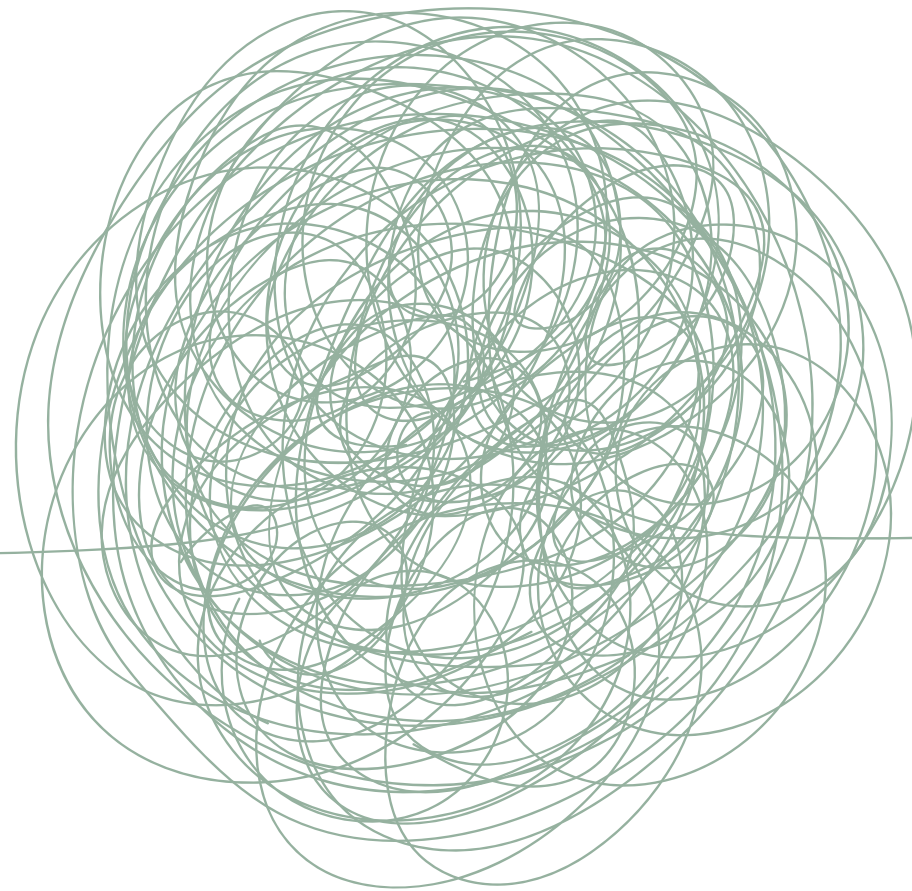


Wearing a tight  
belt/shirt

Wearing tight clothing  
intentionally in certain  
parts of body

Stare in the mirror or at  
a wall without moving  
or blinking

# REMEMBER THOSE AVOIDANCE STRATEGIES?



- asking for reassurance
- compulsions/rituals
- looking away
- distraction
- dissociation
- thought suppression
- humor
- over-discussing
- procrastinating
- being with a “safe” person or object



# SUBJECTIVE UNITS OF DISTRESS (SUDS)

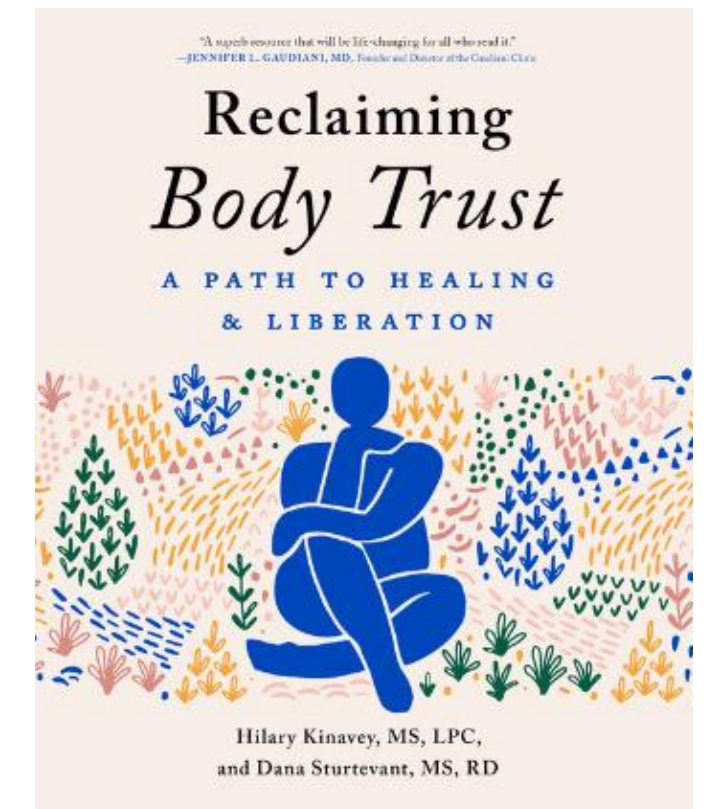
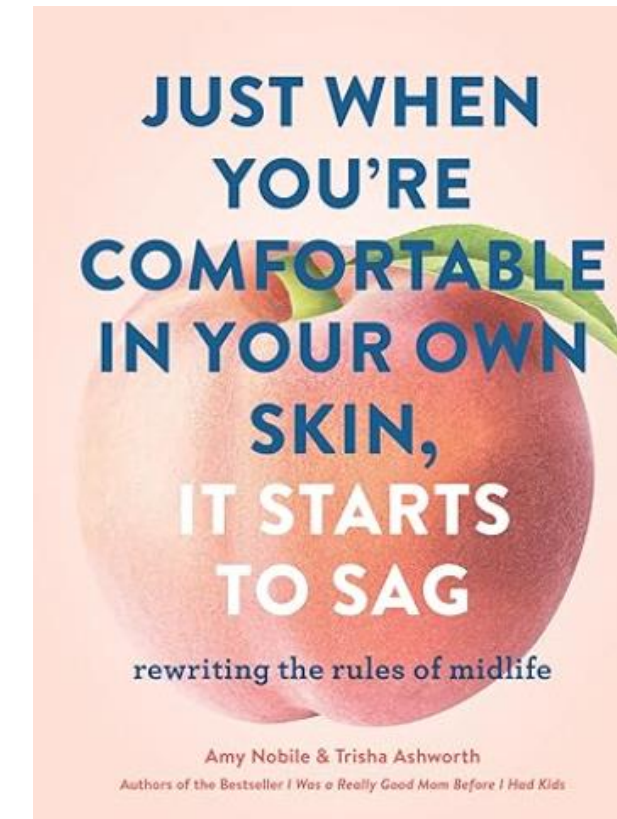
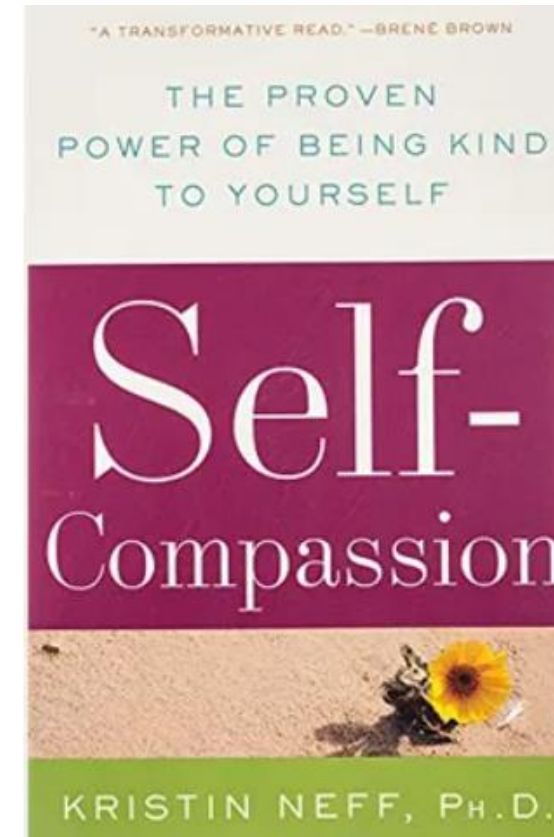
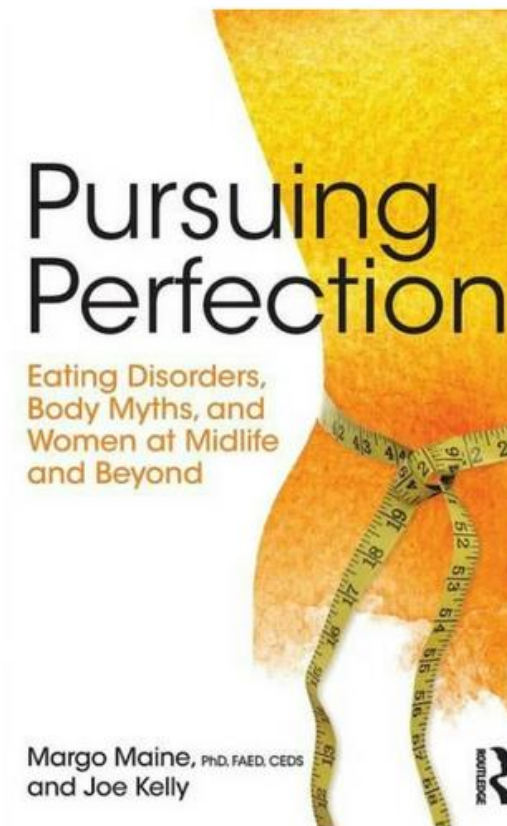
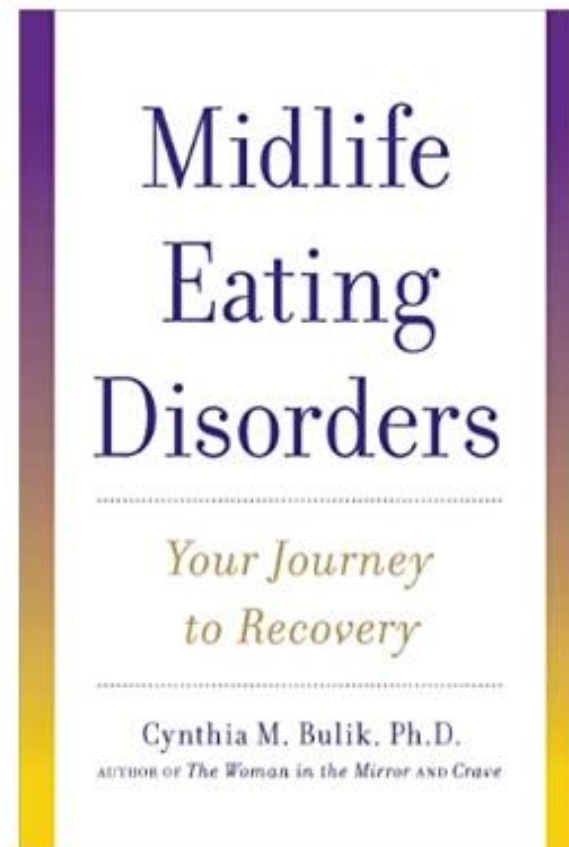
## SCALE 0-8



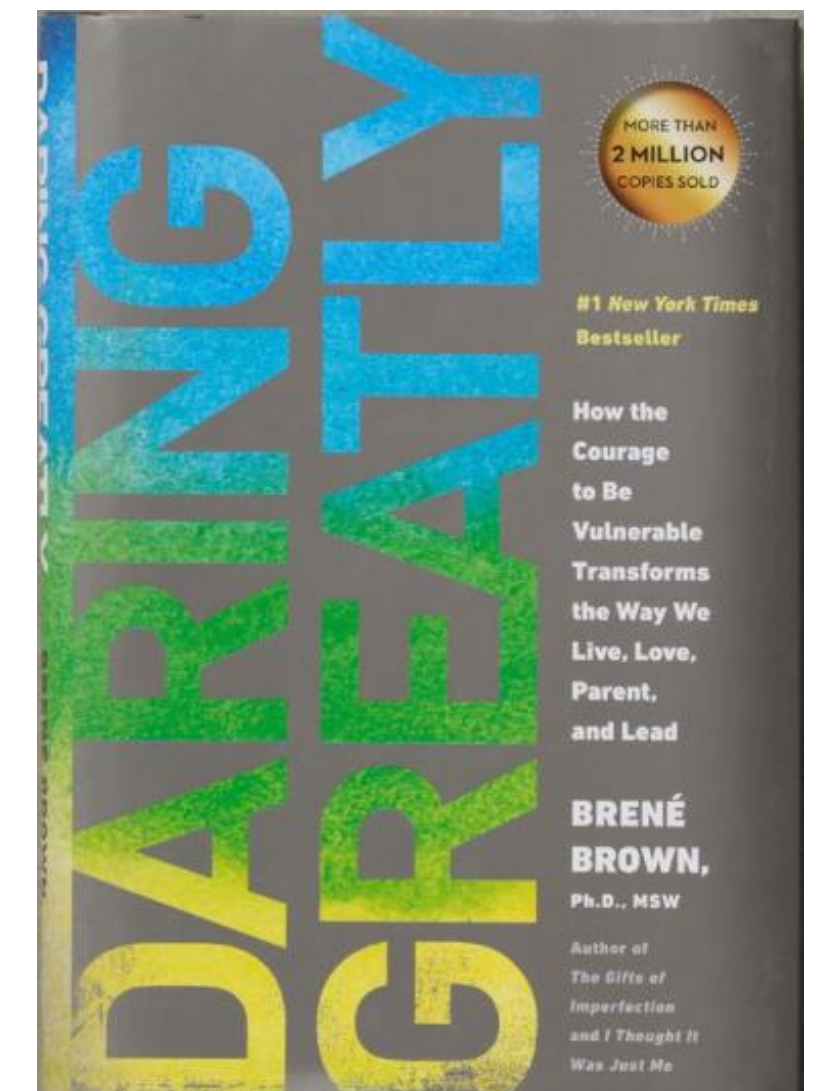
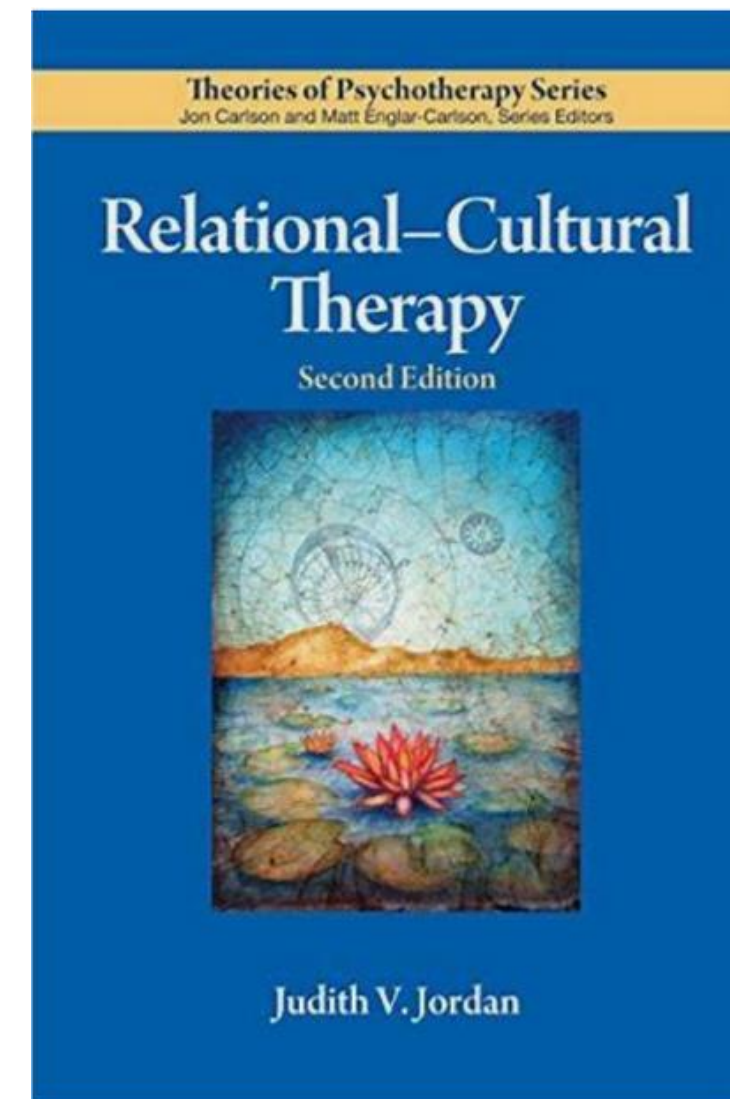
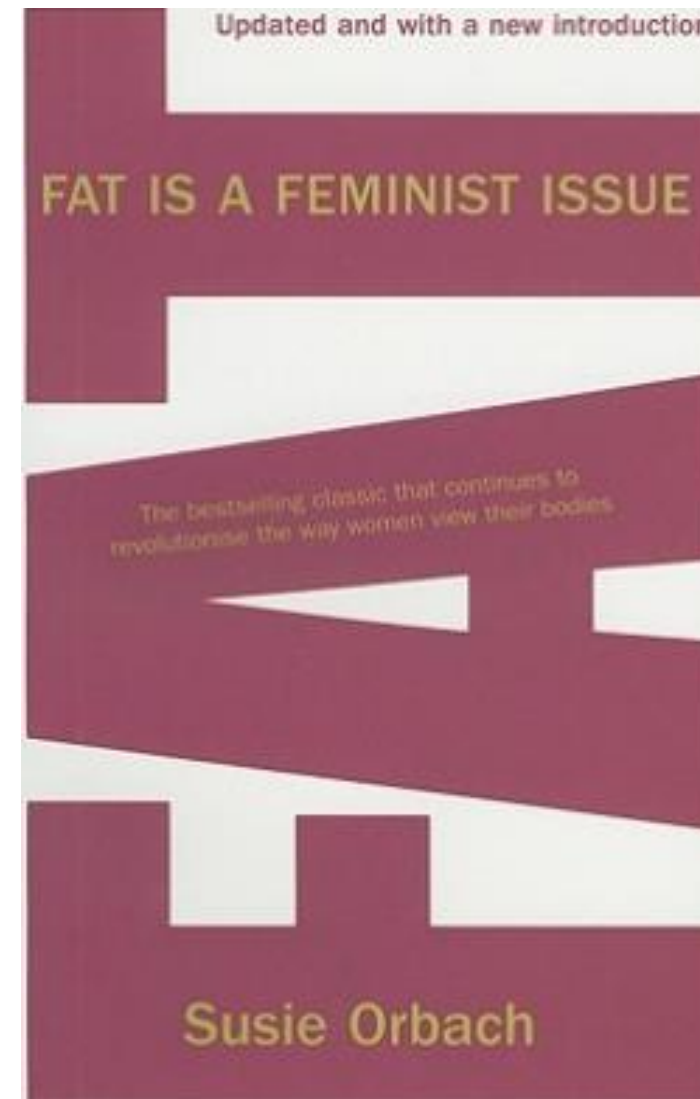
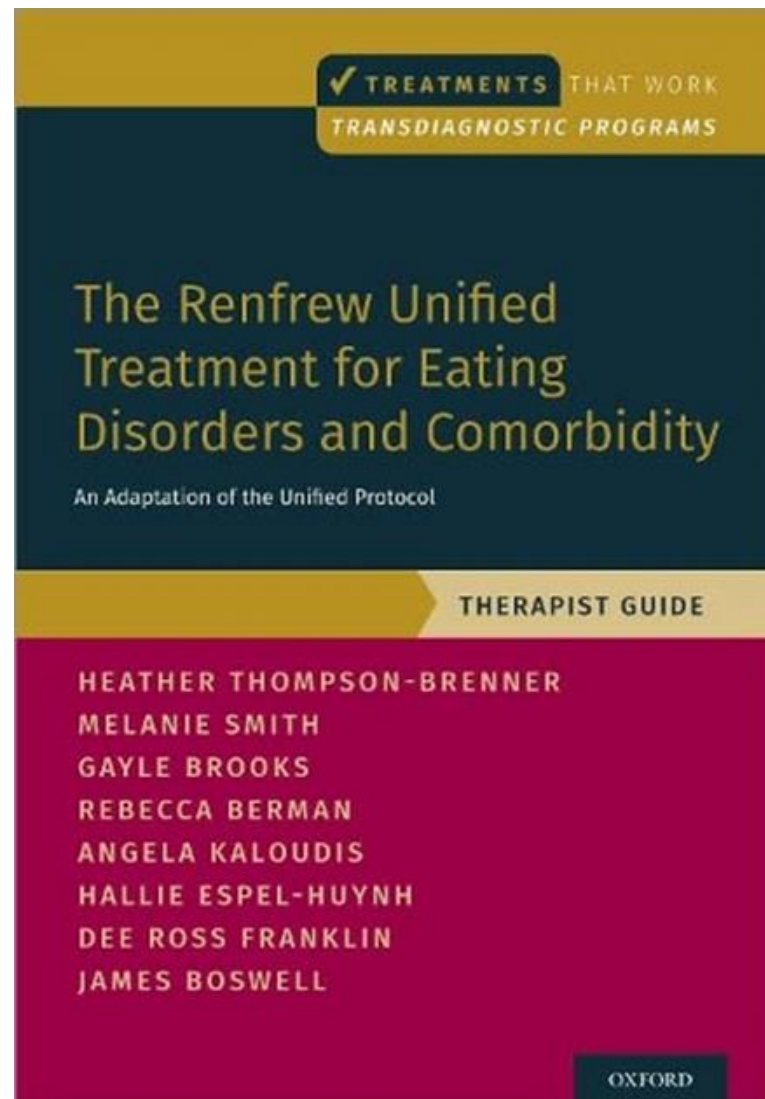
- Anxiety pre-exposure
- Level of intensity
- Level of distress
- Level of similarity

PROCEDURE	SYMPTOMS EXPERIENCED	INTENSITY	DISTRESS	SIMILARITY
Breathe through a thin <u>straw</u>  (2 minutes)  With fingers holding nose closed		Right after:   After 1 min:	Right after:   After 1 min:	

# BOOK RECOMMENDATIONS



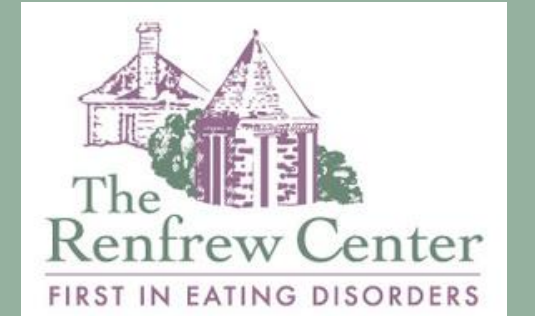
# BOOK RECOMMENDATIONS



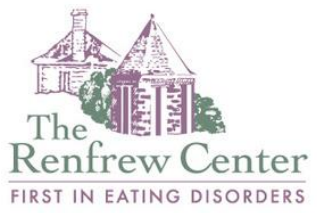
# Thank You!

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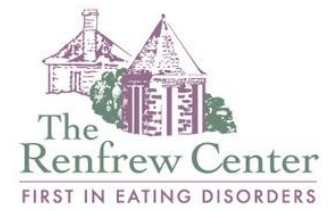


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