by less frequent weighing. Furthermore, this may reduce the iatrogenic danger of intensifying the already heightened overconcern that these patients have with minor fluctuations in body weight.

Acknowledgement

We would like to thank Claudia Kraiuhiro for her assistance.

References

AGRAS, S. & WERNE, J. (1978) Behaviour therapy in anorexia nervosa: a data-based approach to the question. *Controversy in Psychiatry* (eds J. P. Brady & H. K. H. Brodie), pp. 655–675. Philadelphia: Saunders.

AMERICAN PSYCHIATRIC ASSOCIATION (1987) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, revised) (DSM-III-R). Washington, DC: APA.

ANDERSON, A. E. (1985) *Practical Comprehensive Treatment of Anorexia Nervosa and Bulimia*. Baltimore: Johns Hopkins University Press.

DAY, S. (1974) Dietary management of anorexia nervosa. *Nutrition (London)*, **28**, 289–295.

GARFINKEL, P. E. & GARNER, D. M. (1982) *Anorexia Nervosa: A Multidimensional Perspective*. New York: Brunner/Mazel.

GARNER, D. M. (1985) Iatrogenesis in anorexia nervosa and bulimia nervosa. *International Journal of Eating Disorders*, **4**, 701–726.

MAXMAN, J. S., SIBERFARB, P. M. & FARRELL, R. B. (1974) Anorexia nervosa: practical initial management in a general hospital. *Journal of the American Medical Association*, **229**, 801–803.

PARDEE, I. (1941) Chachexia (anorexia) nervosa. *Modern Clinics of North America*, **25**, 755–773.

TOUYZ, S. W., BEUMONT, P. J. V., GLAUN, D., *et al* (1984) Comparison of a lenient and strict operant conditional programme in refeeding patients with anorexia nervosa. *British Journal of Psychiatry*, **144**, 512–520.

——, —— & DUNN, S. M. (1987) Behaviour therapy in the management of patients with anorexia nervosa: a lenient flexible approach. *Psychotherapy and Psychosomatics*, **48**, 151–156.

VANDEREYCKEN, W. & MEERMANN, R. (1984) *Anorexia Nervosa: A Clinician's Guide to Treatment*. Amsterdam: Walter de Gruyter.

WILSON, A. H., TOUYZ, S. W., O'CONNOR, M., *et al* (1985) Correcting the eating disorder in anorexia nervosa. *Journal of Psychiatric Research*, **19**, 449–451.

*Stephen W. Touyz, PhD, *Head, Department of Clinical Psychology, Westmead Hospital, Westmead 2145, New South Wales, Australia*; Wolfgang Lennerts, MA, *Research Student, Department of Psychiatry, University of Sydney*; Richard J. Freeman, PhD, *Associate Professor, Department of Psychology, Simon Fraser University, Burnaby, British Columbia, Canada*; Peter J. V. Beumont, MPhil, MRCP, FRACP, FRANZCP, *Professor of Psychiatry, University of Sydney, New South Wales, Australia*

*Correspondence

British Journal of Psychiatry (1990), **157**, 754–757

Anorexia Nervosa in an 80-Year-Old Woman

S. G. GOWERS and A. H. CRISP

A woman aged 80 years had suffered with anorexia nervosa in adolescence and the condition was rekindled after 50 years of remission. The remission was seen in the light of affective disorder and a chronic grief reaction.

Recently, two reports have been published on anorexia nervosa in middle and old age (Hsu & Zimmer, 1988; Rammell & Brown, 1988). Hsu & Zimmer suggest that eating disorders are becoming more prevalent in old age, because of a dramatic increase in the incidence of eating disorders as a whole, with a proportion surviving as lifelong chronic cases and because older women are beginning to succumb to social pressures to be thin. Kellett *et al* (1976) had previously reported the case of a 52-year-old widow who developed classic anorexia nervosa in relation to the marriages of her daughters. She was preoccupied with the death of her husband eight years previously, but was not thought to be suffering with a primary depressive disorder (never scoring above 11 on the Hamilton scale and denying

https://doi.org/10.1192/bjp.157.5.754 Published online by Cambridge University Press

depressive symptoms including loss of appetite), and she failed to respond to imipramine. Launer (1978) described a 70-year-old anorectic with obsessional neurosis. She was not thought to be depressed but no detail is given of bereavements. She failed to respond to clomipramine given for her obsessional symptoms.

Dally (1969) has attempted to explain the occurrence of anorexia in people aged over 35. He sees it as a variant which he terms 'anorexia tardive', and relates the condition to the subject's stage of life, and suggests that anorexia tardive might arise out of a resentful dependence on others or as a reason for retiring to bed after a lifelong history of pain or minor illness.

It is likely that as some anorectics do not shed their illness at the end of their reproductive life (Theander, 1985), some will remain with their condition into old age. However, one of Hsu & Zimmer's five cases and that of Rammell & Brown had no previous evidence of an eating disorder before a post-menopausal onset.

Crisp (1980) has suggested that late-onset anorexia nervosa, including that arising after the menopause, might represent, in the predisposed person, an attempt to achieve control, through avoidance of further decay, during a time of mounting personal uncertainty – that is, it is a response to the recognition of inner bereavement which has destabilised a long-standing fragile adolescent narcissistic adjustment. Such a response might also be activated or reinforced by external loss, for example, of a parent or spouse.

Case report

The subject, an 80-year-old widow, contacted one of the authors (AHC) after a radio programme about eating disorders. She believed herself to have anorexia nervosa and wanted an opinion, but did not wish to enter treatment.

Born in 1908, she developed anorexia nervosa at the age of 15 shortly after her menarche. In the patient's opinion social pressures to be thin, particularly from women's magazines (which she believes to have contained more dieting articles in 1923 than in 1988) combined with family factors to precipitate anorexia nervosa. Her father, a headmaster, strove to direct his children towards a university education, while sexual matters were strictly taboo.

She recalls her pride at losing weight from 57 kg to below 33 kg by abstinence and occasional laxative abuse and her fear when contemplating weight gain. She developed secondary amenorrhoea. Bingeing and vomiting were not features. She missed a complete year of school between the ages of 15 and 16, became regressed and childlike, and shared her mother's bed, refusing all food. Her medical attendant had diagnosed consumption. When the patient was 16, her obese mother went to stay for several months with her maternal grandmother, who was dying of cancer, and while the mother was away, the patient's disorder remitted and her weight rose to over 50 kg.

She left home to study at university at the age of 18 and while maintaining a normal weight, continued to avoid identifiable carbohydrate food and chocolates. She met her future husband while a student and believes that his non-judgemental acceptance of her was largely responsible for her full recovery. She took up work as a teacher and did not return home after university, gaining in confidence in her relationship with this man, who was five years her senior. She married at the age of 25 and from the point of view of her anorexia nervosa, the years until her menopause at the age of 48 were unremarkable, except that having risen to a weight of around 63 kg by the age of 28 she lost 3 kg with each of her four succeeding pregnancies. She had no further menstrual irregularities.

Her husband died when the patient was 65, and this appears to have led to a re-emergence of her anorectic attitudes. Some months after his death, having been depressed with complaints of early morning wakening and loss of appetite, though not weight loss at this stage, she took an overdose of barbiturates and alcohol and was admitted to a psychiatric hospital. She refused electro-convulsive therapy but after a short admission was discharged and has received no psychiatric treatment since. She considers that the depression lifted with supportive help from her general practitioner over the next year. The affective distress also lessened as her anorexia nervosa recrudesced. For the past ten years she does not consider herself to have been depressed. Since then, she has lived on a diet of fruit and vegetables with occasional lean meat or fish. She attempts to cut out all fat and sugar from her diet and takes regular laxatives in a conscious and readily acknowledged effort to control her weight, which she maintains at 79% of mean matched population weight (weight 45.8 kg, height 1.63 m). Her lifetime weight biograph is shown in Fig. 1.

Within the family there is a history of eating/weight disorder. Her mother was massively obese. A male nephew of the patient, who was brought up by the patient's parents, and one of the patient's daughters have suffered with anorexia nervosa. Another daughter and two grandchildren show some anorectic features and preoccupation with

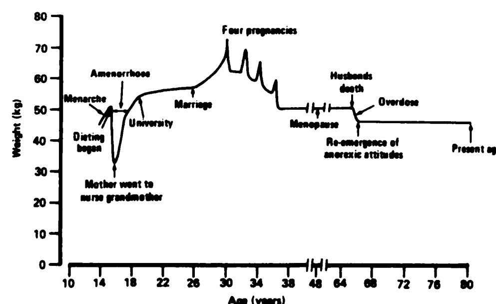

FIG. 1 Weight biograph.

https://doi.org/10.1192/bjp.157.5.754 Published online by Cambridge University Press

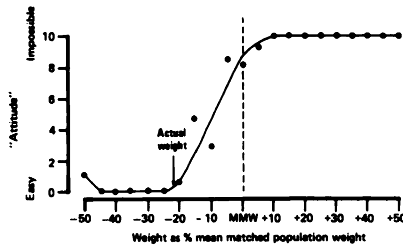

FIG. 2 Subject's attitudes to living at different hypothetical weights.

certain foods, though maintaining a low normal weight. Four other first-degree relatives suffer with asthma, eczema and psoriasis, which appear to have been particularly sensitive to stressful life events. There is no family history of depression or other psychiatric disorder.

At interview, the patient was open and forthcoming about her symptoms. Her attitude reflected the ego-syntonic nature of her symptoms, while her lack of defensiveness or denial is probably explained by her expectation that she would not be coerced into treatment. Her phobic avoidance of normal body weight is illustrated by her responses to a questionnaire on her attitudes to her ability to live at different hypothetical weights (Fig. 2). The shape of the response curve closely matches that of the pooled results of an anorectic population (Crisp *et al*, 1986), in that her aversion to mean matched weight is almost as marked as her attitude to obesity.

Her manner suggested an extreme attention to detail and she thought that her preoccupation with neatness and order at home and a tendency to parsimony related to her anorectic state. She was financially very comfortable, was sprightly and drove her own car, suggesting no immediate threats to her security or independence. There was no evidence of depressed mood, tearfulness or suicidal ideology. Sleep was unimpaired and she retained her appetite and preoccupation with food. She was able to discuss her husband without distress and was no longer preoccupied with loss. She maintained a quiet social life but kept in close and active contact with her extended family. Cognitively, she was remarkably well preserved for her age, with good long-term and short-term memory and calculating abilities, and she was exceptionally well informed of current events.

Discussion

Anorexia nervosa is a disorder of which the cardinal symptoms are behavioural (self-induced weight loss which is not the result of loss of appetite), psychological (phobic avoidance of normal body weight), and endocrine (chiefly a reduction in the output of gonadotrophins with amenorrhoea in women) (Crisp, 1980). Associated features which may be present are an overconcern with food and nutrition, bingeing, conscientiousness, obsessional and depressive symptoms, and physical symptoms resulting from emaciation. Characteristically a disorder of adolescence, anorexia nervosa has been viewed as an avoidance stance, providing a maladaptive solution to an existential problem (often related to puberty), sooner or later afflicting the subject and her family (Crisp, 1980).

Retrospective assessment would suggest that the subject fulfilled the above criteria for anorexia nervosa at the age of 15 and her self-reports of the social and family precipitants were typical. There is considerable evidence for a current diagnosis of anorexia nervosa in the subject now aged 80, who we believe to be the oldest case reported. She shows many of the psychological and behavioural features, while endocrine changes are not applicable. Why should this patient develop anorexia nervosa at this stage in her life?

It would appear that after her husband's death, she suffered a depressive reaction with suicidal intent, from which she fully recovered in terms of her subjective mood and biological symptoms, including her appetite. Depression and grief are common themes in reports of anorexia nervosa in the elderly. Indeed, the extensive review by Swift *et al* (1986) of the relationship between affective disorder and eating disorders failed to resolve the link between these conditions at any age. Three of Hsu & Zimmer's (1988) five elderly patients were either depressed at presentation or had a history of major depression. Rammell & Brown's (1988) case had suffered three major losses including that of her husband. She felt that she had not been able to grieve fully and had suffered episodic depression since. She did not suffer loss of appetite, had an intense fear of gaining weight and failed to respond to antidepressants, although she recovered with weight restoration and management of her eating disorder.

Parkes (1980), in an extensive review of his own and other studies of grief, describes the essential features as a preoccupation with the dead person, with tearfulness and extreme distress with any reminder of them. Our patient was not distressed discussing her husband. Further, Parkes states here that a case of nine and a half years is the longest grief reaction he has seen. Our patient was bereaved 15 years previously. Where weight loss is present in chronic grief, this is seen as being due to loss of appetite or a loss of interest in food related to a preoccupation with the 'searching' feature of grief in which the essential needs of the subject are neglected. In an earlier study, Parkes (1964) reviewed 94 cases of admission to the Bethlem Hospital for

https://doi.org/10.1192/bjp.157.5.754 Published online by Cambridge University Press

psychiatric treatment within six months of a bereavement: anorexia nervosa was not the presenting condition in any.

How can one link an adolescent onset of anorexia nervosa with concerns about pubertal development, the patient's perception of dynamics operating within her family of origin, and her relapse into anorexia nervosa in old age, with her history of grief and depression as frequently reported in late-onset cases? Is her recovery from both her depression and her grief reaction incidental, or related to her present psychopathology? A connection may be provided by the concept of the 'life review'.

Butler (1963) saw the reminiscences of the elderly as representing part of a normal process precipitated by the realisation of mortality and approaching death. The life review is characterised by a progressive self-reflection of past experiences and a resurgence of unresolved conflicts. If the life review is completed satisfactorily, new solutions to earlier difficulties will be integrated, giving new meaning to one's life. If, however, such conflicts are too painful, or insoluble, it may be necessary to defend against their intrusion into consciousness.

Crisp has always seen anorexia nervosa as providing an adaptive biological solution to an existential conflict and we would see the re-emergence of our subject's anorexia nervosa as an attempt to utilise a previously discovered coping strategy to keep negative emotions at bay (in this case panic and depression rooted in her long-standing sense of insecurity, reactivated by her husband's death). Her control of her body weight could be seen as giving her a sense of purpose and single mindedness, thereby reducing to the point of exclusion once again her emotionality at a time of personal uncertainty.

We would echo Hsu & Zimmer's (1988) plea that clinicians who care for the elderly consider the possibility of an eating disorder in the differential diagnosis of the patient with weight loss or vomiting. Anxieties about weight should be further investigated by careful history taking and, as in the younger subject, useful valuable information may be provided by a relative.

References

Butler, R. N. (1963) The life review: an interpretation of the reminiscences of the aged. *Psychiatry*, **26**, 65–72.

Crisp, A. H. (1980) *Anorexia Nervosa: Let Me Be*. London: Academic Press.

——, Matthews, B., Norton, K. R. W., *et al* (1986) Weight related attitudes and behaviour in anorexics, recovered anorexics and normals. *International Journal of Eating Disorders*, **5**, 789–798.

Dally, P. J. (1969) *Anorexia Nervosa*. London: Heinemann Medical Books.

Hsu, L. K. G & Zimmer, B. (1988) Eating disorders in old age. *International Journal of Eating Disorders*, **7**, 133–138.

Kellett, J., Trimble, M. & Thorley, A. (1976) Anorexia nervosa after the menopause. *British Journal of Psychiatry*, **128**, 555–558.

Launer, M. A. (1978) Anorexia nervosa in later life. *British Journal of Medical Psychology*, **51**, 375–377.

Parkes, C. M. (1964) Recent bereavement as a cause of mental illness. *British Journal of Psychiatry*, **110**, 198–204.

—— (1980) *Bereavement. Studies of Grief in Later Life*. London: Penguin.

Rammell, M. D. & Brown, N. (1988) Anorexia nervosa in a sixty-seven year old woman. *Postgraduate Medical Journal*, **64**, 48–49.

Swift, W. J., Andrews, D. & Barklage, N. (1986) The relationship between affective disorder and eating disorders: a review of the literature. *American Journal of Psychiatry*, **143**, 290–299.

Theander, S. (1985) Outcome and prognosis in anorexia nervosa and bulimia. Some results of previous investigations, compared with those of a Swedish long-term study. *Journal of Psychiatric Research*, **19**, 493–508.

*S. G. Gowers, BSc, MBBS, MRCPsych, MPhil, *formerly Lecturer in Psychiatry, St George's Hospital Medical School, London SW17 0RE, now Senior Lecturer, Department of Child and Adolescent Psychiatry, Adolescent Unit, Prestwich Hospital, Bury New Road, Prestwich, Manchester M25 7BL*; A. H. Crisp, MD, DSc, FRCP, FRCP(E), FRCPsych, *Professor of Psychiatry, St George's Hospital Medical School, London SW17 0RE*

*Correspondence

https://doi.org/10.1192/bjp.157.5.754 Published online by Cambridge University Press