Aspects of Food Refusal in the Elderly: The “Hunger Strike”

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Abstract: Objective: To present food refusal in old age as a means of attempting to control the outcome of intergenerational family conflicts. Method: Two cases are described. Results: Food refusal does not necessarily arise in the context of a classical eating disorder but may represent a form of protest, or hunger strike. Discussion: Food refusal is seen as distinct from a pure anorectic pattern of behavior. It may be a separate psychobehavioral entity in old age. Behavioral methods may help to encourage a resolution by setting clear limits and encouraging patients to share responsibility in decision making. © 2001 by John Wiley & Sons, Inc. Int J Eat Disord 30: 213–216, 2001.

Key words: eating disorder; undernutrition; elderly

INTRODUCTION

Anorexia and weight loss are common in the elderly and they have been linked to physical and psychological factors (Clarke, Wahlqvist, & Strauss, 1998; Clarke, Wahlqvist, Rassias, & Strauss, 1999; Thornton & Russell, 1997). Underlying psychiatric disorders may include affective illness, paranoid psychosis, obsessive-compulsive disorder, dementia, and anorexia nervosa. The altered eating patterns commonly found in patients with dementia point to a neuropathological substratum (Cullen, Abid, Patel, Coope, & Ballard, 1997). Anorexia nervosa has been described in later life (Gowers & Crisp, 1990; Cosford & Arnold, 1991; Hall & Driscoll, 1993; Nicholson & Ballance, 1998), but its prevalence is not known.

Eating disorders are underdiagnosed in the elderly because of scepticism on the part of clinicians and the frequency of depressive symptoms, which may cloud the clinical picture (Cosford & Arnold, 1992). The two cases described do not fit the diagnostic criteria for either an eating disorder or a depressive illness. Both present with food refusal, which appears to represent a form of protest. Food refusal is also encountered in children,
especially those with developmental disabilities (Kerwin, Ahearn, Eicher, & Swearingin, 1998).

CASE REPORT 1

QD is an 82-year-old widow with a 6-week history of food refusal, which became more marked after her admission to a nursing home 10 days prior to her admission to the hospital. She lost 3 kg in 1 week. She had been brought into the nursing home on a stretcher as she maintained that she was unable to walk. On arrival, however, she walked without assistance.

QD had attempted to persuade her son and daughter-in-law to let her move in with them. However, her daughter-in-law was not prepared to consider this because a previous attempt had already failed. The patient denied feeling depressed and stated that she was simply unable to eat. She appeared unconcerned by her weight loss. She complained of a sense of general fatigue and loss of energy but maintained her usual interests in reading and music.

The patient considered herself underweight at 47 kg. She said that her ideal weight was 51 kg at a height of 152 cm. There was no history of anorectic symptoms in the past.

Shortly after the death of her husband, she had moved closer to her only son. She became homesick, missing her old friends and neighborhood. Around her 80th birthday and shortly after the death of her sister, she stopped driving and gardening, declaring herself “too old and frail.”

On assessment, there was no evidence of cognitive impairment or of depressive illness. Investigations did not reveal any pathology to account for the appetite and weight loss. She was given a trial of antidepressants, but these either had no effect (fluoxetine; Prozac, Dista) or caused side effects that the patient could not tolerate (Lofepramine; Gamanil, Merck, Venlafaxine; Efexor, Wyem). Attempts to engage her at a psychological level were in vain.

QD decided to accept small and regular quantities of food when she was informed that the nursing home would not accept her back unless her weight and appetite returned to normal. Her son and daughter-in-law remained clear in their refusal to accept her. In due course, she was discharged to the care of the nursing home. Subsequent follow-up confirmed that she has maintained progress.

CASE REPORT 2

EJ was an 82-year-old widow. Two years earlier, she had developed symptoms of anxiety and food refusal, which resulted in weight loss of 10 kg. Her current admission was again precipitated by refusal to eat and weight loss despite receiving an intensive package of care following her previous discharge. She was admitted weighing 35 kg at a height of 147 cm. Up until the age of 80 years, her weight had been relatively stable around 57 kg.

She denied feeling depressed, but looked somber and uncommunicative. She said that she was simply “unable” to eat. There was no evidence of any delusional beliefs. She considered herself to be underweight and stated that her ideal weight was 54 kg. There was no past history of dieting, concern over weight, or anorectic-type behaviors. She said that around her 80th birthday, the realization dawned on her that she was ageing, implying that she was getting frailer and more dependent on others.
Investigations failed to reveal any identifiable organic cause. She was treated with fluoxetine, but no change was noticed in her mental state or behavior. At least four antidepressants had been tried, but she had not complied. She also resisted attempts at engaging her in any psychological intervention. She told the staff that she wanted to live with her daughter and was clearly angry with her son-in-law, who would not allow this to happen. The staff noticed that she only ate food prepared and brought in by her daughter.

The patient had no previous psychiatric history. She was described by her daughter as always having been independent and strong willed, coping with living alone for 10 years following the death of her husband.

She appeared to respond to a firm and consistent approach from staff. Eventually, she started to accept small amounts of food from others. There was little change in her mental state, but her weight increased to 40 kg. She gradually realized that her wish to live with her daughter would not be fulfilled and that moving into residential care was inevitable.

**DISCUSSION**

Both patients found it difficult coming to terms with ageing and the associated loss of independence. Neither had a clear clinical depression and neither complained of loss of appetite. Rather, they had an unwillingness to eat. Both appeared determined not to gain weight and were unperturbed by their weight loss. In both cases, their families felt manipulated. Neither had any identifiable underlying physical cause on investigation.

Classical features of anorexia nervosa were absent. There was no morbid fear of normal body weight nor was there a distorted body image (Dally & Gomez, 1979). The refusal of food in both cases may be interpreted as a powerful indirect means of communications in an attempt to influence the outcome of a family conflict. Food refusal results in weight loss, which renders the elderly more frail and vulnerable, inducing guilt in the relatives and increasing the chance that they will capitulate.

The psychopathological features of anorexia nervosa in the elderly are similar to those found in younger individuals. They are also closely associated with obsessional and affective disorders, as with the younger group (Gupta, 1995; Russell & Megan, 1992).

Crisp (1980) postulated that late-onset anorexia may represent an attempt by a predisposed individual to exert control at a time of increased uncertainty. This explanation appears to hold true in both these cases. Etiologically, eating disorders in later life may occur in the context of a mother’s identification with a pubertal daughter whose sexual development poses a threat or they may be a means of expression against the family and a way of drawing attention to oneself. Power gained over the family may then serve as one of the maintaining factors (Cosford & Arnold, 1992).

Recurrence of anorexia nervosa in late life may represent the use of previously used coping strategies at a time of stress (Gowers & Crisp, 1990). Neither of the cases described had a previous history of anorectic behavioral patterns.

There are no published trials of treatment of eating disorders in the elderly. The evidence provided by case reports suggests that elderly patients are treated similarly to younger patients (Cosford & Arnold, 1991). The most effective treatment appears to be behavioral modification, with careful use of antidepressants when depressive symptoms exist.

Although the cases described do not fulfill the criteria for anorexia nervosa, the psychopathological processes are similar. Food refusal resembles an anorectic stance, but
with important differences. There is no disorder of body image nor is there a fear of normal body weight. Food refusal may be understood as a form of “hunger strike of the elderly.” This strategy is used when older individuals are overwhelmed by feelings of frailty and increased dependency. It appears to be a regressive process. Food is used to gain control over family members by inducing guilt and drawing attention to one’s frailty and helplessness. It may be understood as a form of protest when there are no other means of control available, particularly when individuals feel impotent and at the mercy of those around them. Not surprisingly, food refusal may occur at extremely difficult times of life, in childhood and in old age.

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REFERENCES