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CDP Presents A Monthly Webinar Series

Eating Disorders: General and Military-Relevant Considerations

Presenters:

Marian Tanofsky-Kraff, Ph.D.

Jason M. Lavender, Ph.D.

Natasha A. Schvey, Ph.D.

Upcoming Training & Events

Before We Get Started in:

01:00:00

Q & A – You can submit a question via chat at any point during the presentation. Questions will be answered during or during the last 10 minutes of the program. While chatting, please select "Everyone" in chat so all can see your comments and questions!

Resources – You can find a presentation PDF and additional resources on your CE21 account page.

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Help – for assistance, please e-mail Micah Norgard at micah.norgard.ctr@usuhs.edu

1

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To receive credit, you must attend the webinar all the way through the Q & A section at the end of the presentation.

Please do NOT leave the webinar!

2

Disclaimer

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3

3

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SAVE THE DATE

2023

To register for these webinars and other upcoming training events, visit https://deploymentspsych.org/training

February 15th	**Eating Disorders: General and Military-Relevant Considerations** Presented by Drs. Marian Tanofsky-Kraff, Natasha Schvey, and Jason Lavender
March 16th	**Integrated Treatment Approaches to Treat Comorbid PTSD and History of TBI** Presented by Dr. Amy Jak
April 5th	**Healing Racial Trauma: Strategies for Children, Teens, and their Families** Presented by Drs. Christi Culpepper, and Jamila Ray
May 2nd	**Self-Help Plus: A Cost-Effective, Scalable, Evidence-Based Stress Management Course** Presented by Dr. Teresa Au
June 28th	**A Quick Walk Through the New VA/DoD Clinical Practice Guidelines for PTSD** Presented by Dr. David Riggs
July 25th	**Nonsuicidal Self-Injurious Behaviors in Military Kids and Teens** Presenter TBD…stay tuned!
September 14th	**Nonprofit Spotlight: Stop Soldier Suicide** Presented by Dr. Sonja Batten
October 11th	**Sleep Survival: How to Manage Poor Sleep Opportunities** Presented by Drs. Maegan M. Paxton Willing, Diana Dolan
November & December	***TBD…stay tuned!***

4


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Upcoming Training Events:
Assessing Military Clients for Trauma and Post-Traumatic Stress Disorder Online via Zoom
February 16th
Military-Connected Couples: Evidence-based Approaches to Treatment and An Intervention Model for Treating Infidelity Online via Zoom
February 21st
Online Prolonged Exposure (PE) for PTSD Training via Second Life
February 22nd and 23rd
Training on Assessment of PTSD and Suicide Risk Management in Veterans via Zoom
February 27th and 28th
Online Prolonged Exposure Therapy (PE) Training via Zoom
March 8th and 9th
Register now for these upcoming trainings:
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5


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Eating Disorders: General and Military-Relevant Considerations
Training on Assessment of PTSD and Suicide Risk Management in Veterans
National Center for PTSD
PTSD Consultation Program
FOR PROVIDERS WHO TREAT VETERANS
Supporting Providers Who Serve Veterans
CDP
Uniformed Services University
February 27-28 May 3-4 July 19-20
10:00 AM – 6:30 PM Eastern time
14 Credits
Target Audience:
Licensed behavioral health providers who regularly treat U.S. Veterans (or who intend to treat U.S. Veterans) in the community can apply. This training is NOT intended for behavioral healthcare providers working in VA or DoD settings.
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6

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ANSWERING THE CALL
with Focus, Flexibility, and Fidelity:
Implementing EBPs in the Wake of Public Health Crises

Evidence-Based Psychotherapy Conference, May 11, 2023
Pre-Meeting Institute EBP Workshops, May 9-10, 2023

Pre-meeting EBP workshops include:
- Motivational Interviewing Skills
- Acceptance and Commitment Therapy
- CBT for Chronic Pain

Keynote: George Bonanno, Ph.D.
Columbia University

Trauma and the Resilience Paradox:
Adaptation Through Flexible Self-regulation

Workforce Capacity and Wellbeing in U.S. Psychologists Karen Stamm, Ph.D., American Psychological Association
Vulnerable Populations & Collective Trauma Ingrid Cockhren, M.Ed., PACEs Connection
Trauma-Informed & Culturally Sensitive Therapy with Ethnic Populations Priscilla Dass-Brailesford, Ph.D., Georgetown University School of Medicine
A Stepped Care Framework to Support Recovery after a Mass Casualty Event Lisa Brown, Ph.D., ABPP Palo Alto University, Stanford University
Approaches to Transdiagnostic Care with the Special Operations Forces Community Lauren Brenner, Ph.D., Massachusetts General Hospital
Modified CREST for the Treatment of Hoarding Disorder in Veterans During COVID Julie Holcomb, M.S. & Chad Vacco, M.A., Dept of Veterans Affairs

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7

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Sorry We Missed You!

We have you covered!
Check out last month's series:

Psychological Flexibility and ACT in Chronic Pain: Theory and Application

CDP presentations are always delivered in professional manner and the amount of applicable skills shared is amazing.

This was a great presentation very current perspective and packed with information, very helpful to my practice.

This was a very thoughtful, useful presentation. Amanda is clearly an expert in this area and her ability to relay her years of experience into a succinct and accessible presentation is unmatched. Please, bring her back for more trainings!

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8

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Enhancing Your Experience

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10

10

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11

Disclosures

All faculty, course directors, planning committee, content reviewers and others involved in content development are required to disclose any financial relationships with commercial interests. Any potential conflicts were resolved during the content review, prior to the beginning of the activity.

Drs. Tanofsky-Kraff, Dr. Lavender, and Dr. Schvey have no financial interests to disclose.

12

Eating Disorders:
General and Military-Relevant Considerations

Natasha Schvey, PhD
Jason Lavender, PhD
Marian Tanofsky-Kraff, PhD

February 15, 2023

13

Outline

- Eating Disorders
- Assessment
- Evidence-Based Treatments: Overview
- Military-Relevant Considerations

14

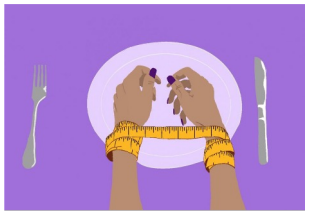
A Brief Note About Language

- Throughout this presentation, we will be using person-centered language
- Instead of:
  - *The anorexic patient*
  - *The bulimic*
  - *The obese person*
- We will say:
  - *The patient with anorexia*
  - *The person with bulimia*
  - *The person with obesity (or better yet, high body weight)*
- We encourage you to begin using this person-centered language if you are not already

15

What is an "Eating Disorder"?

- A **persistent disturbance** of eating behavior, or behavior intended to control weight, which significantly **impairs** physical health or psychosocial functioning
- This disturbance should not be secondary to any recognized general medical disorder or any other psychiatric disorder



16

Anorexia Nervosa

1. Restriction of energy intake relative to requirements → significantly low body weight (given age, sex, development, etc.)
2. Intense fear of gaining weight or becoming "fat," or persistent behavior interfering with weight gain
3. Disturbance in experience of weight or shape, self-worth unduly influenced by weight or shape, or persistent lack of recognition of seriousness of low weight

17

Anorexia Nervosa Subtypes

- Binge-eating/purging type
  - Regularly engages in <u>either</u> binge-eating or purging behaviors
- Restricting type
  - *Does not* regularly engage in <u>either</u> binge-eating or purging behaviors

** Restriction is common across both: subtypes are about presence or absence of regular binge-eating or purging*

18

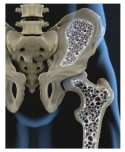
Anorexia Nervosa: Common Comorbid Psychopathology

- Major Depressive Disorder
- Anxiety Disorders
- Substance Use Disorders (especially binge-purge subtype)
- Obsessive Compulsive Disorder
- Obsessive Compulsive Personality Disorder
- Other Features
  - Competitiveness and perfectionism
  - Anxiety perceived as *functional* for achievement of valued goals
  - Continued starvation may be anxiolytic

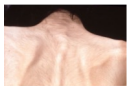
19

Anorexia Nervosa: Medical Consequences

- Amenorrhea
- Constipation/GI distress
- Cold intolerance
- Lanugo
- Anemia



- Hypotension
- Impaired renal function
- Cardiac arrhythmia
- Osteoporosis
- Death (including by suicide)



**one of the highest mortality rates of any psychiatric disorder*

20

Anorexia Nervosa: Course

- Highly variable
  - Recovery after single episode
  - Fluctuating pattern of weight regain and relapse
  - Chronically deteriorating course
- Crossover is common
  - Across subtypes
  - With other eating disorders
    - ~1 in 3 people with anorexia nervosa cross over to bulimia nervosa
    - ~ 1 in 4 people with bulimia nervosa cross over to anorexia nervosa

21

Bulimia Nervosa

1. Binge eating (≥ 1x/week for 3 months)
2. Inappropriate compensatory behaviors to prevent weight gain (≥ 1x/week for 3 months)
3. Self-evaluation unduly influence by body weight/shape
4. Rule-out anorexia nervosa

22

Definition of Binge Eating

- An episode of binge-eating is characterized by both of the following:
  - Eating, in a discrete period of time an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

  And
  - A sense of lack of control over eating during the episode

23

Binge-Eating Episode

Eaten Within a 30 Minute Period

- 9 inch Sara Lee cheesecake
- 1 pint low-fat frozen yogurt
- 20 oatmeal cookies

24

Compensatory Behaviors

- Self-induced vomiting (purging)
- Misuse of…
  - Laxatives
  - Diuretics
  - Enemas
  - Other medications
- Fasting
- Excessive exercise
- Insulin omission (in individuals with T1D)

25

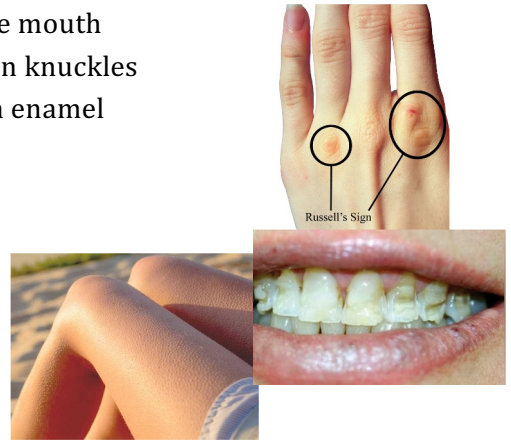
Bulimia Nervosa: Common Comorbid Psychopathology

- Mood disorders
- Anxiety disorders
- Post-traumatic stress disorder
- Substance use disorders
- Personality disorders (e.g., BPD)
- Self-harming behavior

26

Bulimia Nervosa: Physical Signs

- Sores around the mouth
- Calluses/scars on knuckles
- Damage to tooth enamel
- Dry, flaky skin
- Cold sensitivity



27

Bulimia Nervosa: Medical Consequences

- Electrolyte imbalance
- Gastrointestinal issues
- Menstrual irregularities
- Postural hypotension
- Esophageal tears/ruptures
- Arrhythmias
- Dental problems
- Metabolic alkalosis
- Parotid swelling
- Chronic renal failure…

28

Bulimia Nervosa: Course

- Typically begins in late adolescence or early adulthood
- Binge eating usually occurs during or after an episode of dieting or restriction
- Persists for at least several years in high percentage of clinical cases

29

Binge-Eating Disorder

- Binge eating (≥ 1x/week for 3 months) episodes associated with 3 or more of the following:
  - Eating…
    - Much more rapidly than normal
    - Until feeling uncomfortably full
    - Large amounts when not physically hungry
    - Alone because of embarrassment over what/how much one is eating
  - Feeling disgusted with oneself, depressed, or very guilty afterwards
- Marked distress regarding binge eating
- No regular compensatory behaviors

30

Binge-Eating Disorder: Course

- Research data on the natural course is mixed
  - May remit spontaneously or persist long-term
  - Sometimes crosses over to bulimia nervosa
- Patient reports indicate a long history of binge eating problems (~20 years)
- Long history of frequent and unsuccessful dieting attempts

31

Binge-Eating Disorder often co-occurs with, but is distinct from, high body weight/obesity

- Individuals with Binge-Eating Disorder (versus those with high body weight but no BED) show:
  - Greater caloric consumption, more unstructured eating
  - Greater eating disorder psychopathology
  - Elevated rates of psychiatric comorbidity
  - More impairment and lower overall quality of life

32

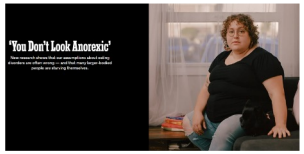
Avoidant/Restrictive Food Intake Disorder (ARFID)

- Persistent failure to meet appropriate nutritional and/or energy needs associated with one or more of the following:
  - Significant weight loss
  - Significant nutritional deficiency
  - Dependence on feeding tube or oral nutritional supplements
  - Marked interference with psychosocial functioning
- No disturbance in experience of body weight or shape, and not exclusively concurrent with Anorexia or Bulimia Nervosa
- Not explained by lack of food availability or by culture
- Not attributable to a concurrent medical condition, and not better explained by another mental disorder
- Sub-types
  - Low appetite and lack of interest in eating
  - Sensory sensitivity (picky eaters)
  - Food avoidance and/or fear of aversive consequences (e.g. pain, nausea, choking)

33

Other Specified Feeding or Eating Disorder: Examples

- Atypical anorexia nervosa: All AN criteria, but not underweight despite significant weight loss
- All criteria for bulimia nervosa or binge-eating disorder except behaviors occur < 1x a week and/or for < 3 months
- Purging disorder: Recurrent purging behavior to influence weight/shape in absence of binge eating
- Night eating syndrome: Recurrent episodes of night eating after awakening from sleep or in excess after evening meal

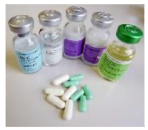


By Kate Siber
Oct. 18, 2022

34

Muscularity-Oriented Disordered Eating

- Focus on muscularity AND leanness (vs just weight)
- Disordered eating practices
  - Protein (over) consumption
  - Extreme dietary restriction
  - Bulking and cutting
  - Continual access to food
  - Eat for 'functionality'
  - Eat beyond feeling full
  - "Cheat" meals or days
  - APED use
- Muscle Dysmorphia



35

Outline

- Eating Disorders
- **Assessment**
- Evidence-Based Treatments: Overview
- Military-Relevant Considerations

36

Challenges with Eating Disorder Assessment

- Limitations of self-report due to: recall and other biases; limited eating disorder and/or mental health literacy; minimization of symptoms; cognitive effects of malnutrition
- Complicated diagnostic concepts (e.g., loss of control, overvaluation of body weight/shape) can be difficult to understand and evaluate

37

General Clinical Assessment for EDs

- Broad topics to address first
  - History of eating patterns, body image concerns, and life events
  - Weight history (including recent significant loss)
  - Previous treatment for eating disorder, or other forms of psychopathology
  - Presenting problem or reason seeking treatment

38

General Clinical Assessment for EDs

- Eating disorder behaviors
  - Typical daily patterns of intake: breakfast, snack, lunch, snack, dinner, snack
  - Binge eating and loss of control

39

Assessing Eating Episode Size

- For DSM-5-TR, amount consumed must be "definitely larger" than what most people would eat given the circumstances to quality as an eating binge
  - Context: e.g., Thanksgiving, special events, buffets, development (age), cultural practices
- Examples of "large"
  - 4 Bagels or
  - 6 slices of large pizza
  - 6 pancakes (6" diameter) with butter and syrup

40

Assessing Loss of Control*

- Example questions:
  - "Did you have a sense of loss of control at the time?"
  - "Did you feel you could have stopped eating once you had started?"
  - "Did you feel you could have prevented the episode from starting?

**Likely to be the more (and possibly only) relevant feature of a "pathological" binge eating episode*

41

General Clinical Assessment for EDs

- Eating disorder behaviors
  - Typical daily patterns of intake: breakfast, snack, lunch, snack, dinner, snack
  - Binge eating and loss of control
  - Restrictive eating: quantity, food types, etc.
  - Purging behaviors: self-induced vomiting, use of diet pills, laxatives, diuretics
  - Use of appearance-/performance-enhancing substances
  - Excessive/compulsive exercise
  - Weighing behavior (frequency, motivations, goals)
  - Other body checking behaviors

42

General Clinical Assessment for EDs

- Eating disorder thoughts and attitudes
  - Perception of body size
  - Fear of weight gain and/or fear of being fat
  - Food rules (e.g., good, bad, forbidden, timing)
  - Perceived importance of body shape and weight

43

General Clinical Assessment for EDs

- Impairment, co-occurring symptoms, and other factors
  - Time spent thinking about, planning, or otherwise preoccupied with food/eating
  - Psychosocial functioning (various domains), and impairment due to eating disorder symptoms
  - Mood symptoms, anxiety symptoms, substance use disorder, trauma history, suicidality
  - Food (in)security

44

General Clinical Assessment for EDs

- Social media and app use
  - Calorie counting, fitness, weight-related apps
  - Social media
    - #Thinspo, thinspiration
    - #Fitspo, fitspiration
    - Pro-ana and pro-mia
    - Fat talk, weight-based teasing
- Participation in activities with strict weight control and/or appearance focus
  - Athletics, especially certain sports
  - Dance
  - Modeling

45

Multi-Disciplinary Evaluation

- Eating disorders often require multi-disciplinary treatment and may require a higher level of care; a complete evaluation should usually also include:
  - Medical exam and labs (physical health)
  - Psychiatry/medication consultation
  - Nutritional/dietary evaluation by a registered dietician
    - Make sure they are someone with **knowledge about and experience** with working with patients that have eating disorders!

46

Eating Disorder Questionnaires

- Considerations for selection and use
  - Purpose (e.g., diagnostic screening, symptom severity, treatment progress, etc)
  - Suitability for the given individual(s) (e.g., based on age, language, other sociodemographics, etc.)
  - Freely available or must purchase?
  - Ease of scoring and interpretation (e.g., availability of norms, established clinical cut-offs, etc)

47

Screening Questionnaires

- SCOFF [5 items]
  - A brief screening questionnaire for primary care settings
  - Evaluates self-induced vomiting, loss of control eating, recent significant weight loss, feelings of fatness, and food preoccupation
- Eating Disorder Screen for Primary Care [ESP; 5 items]
  - Evaluates satisfaction with eating patterns, eating in secret, impact of weight on self-evaluation, and personal/family history of eating disorders
- Eating Disorder Diagnostic Scale [EDDS; 23 items]
  - Assesses eating disorder behaviors and attitudes and allows for *probable* diagnosis of DSM-5 eating disorders (an overall symptom score can also be calculated)

www.psychtools.info/scoff/ www.phenxtoolkit.org/protocols/view/120602

48

Symptom Questionnaires

- Eating Disorder Examination-Questionnaire [EDE-Q; 28 items]
  - Focuses on past 28 days (4 weeks)
  - Binge Eating and Compensatory Behavior Frequencies
  - Global Score (average of four subscales: dietary restraint, and concerns about eating, shape, and weight) with norms and clinical cut-offs available
- Clinical Impairment Assessment [CIA; 16 items]
  - Evaluates psychosocial impairment (past 28 days) resulting from eating habits, exercising, and feelings about eating, shape, and weight
  - Clinical cut-off for significant impairment

https://www.cbte.co/for-professionals/measures/

49

Outline

- Eating Disorders
- Assessment
- **Evidence-Based Treatments: Overview**
- Military-Relevant Considerations

50

Multidisciplinary Team Approach

- Treating an eating disorder generally involves a combination of psychological therapy and nutritional counseling, with medical and psychiatric monitoring
  - For patients who are underweight, weight restoration is the first and essential goal

51

Components

- Psychotherapy
  - Individual/Group: Cognitive-behavioral therapy, interpersonal therapy, dialectical behavior therapy
  - Family: Family-based therapy (strongest evidence based treatment for anorexia nervosa)
- Targets vary by diagnosis and form of therapy
  - Restoring weight and normalizing eating patterns
  - Reducing restraint/restriction that prompts bingeing
  - Improving interpersonal relationships/functioning
  - Challenging cognitive symptoms (e.g., weight/shape overvaluation)
  - Engaging parents/caregivers to re-establish healthy eating in youth
  - Improving coping and emotion regulation

52

Components

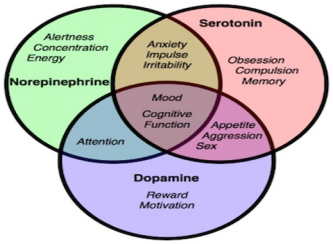
- Nutrition/dietary education and counseling
  - Working with a registered dietician (RD) to address knowledge and understanding of nutrition, metabolism, etc.
  - May assist with meal planning and related skills (e.g., shopping, food preparation)

** Important for the RD to have **experience with eating disorders**, because goals/considerations are often different than other groups*

53

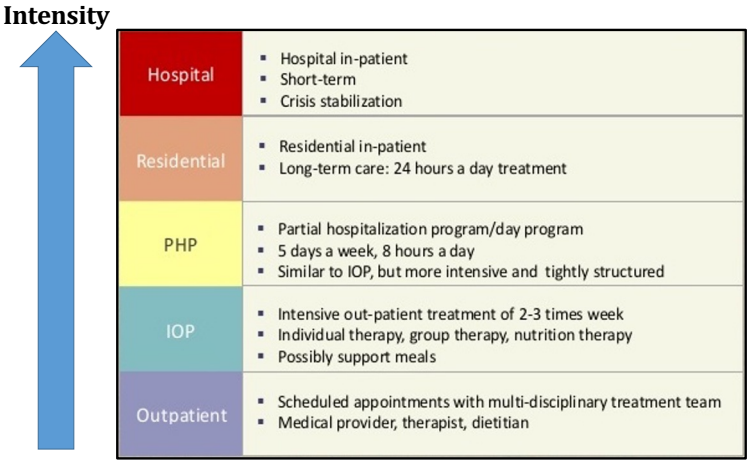
Components

- Psychopharmacotherapy
  - Medications directly targeting symptoms of the disorder
  - Other medications are used to treat co-occurring psychiatric symptoms commonly found in patients with eating disorders (e.g., mood/ anxiety symptoms, impulse control difficulties)
- Medical management



54

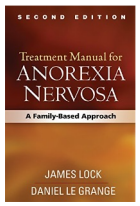
Levels of Care



55

Family-Based Treatment

- Primarily designed for adolescents; can be applied with young adults still living at home
- Used centrally for treating AN, but also for BN
  - The most well-researched (and empirically supported) psychological treatment for anorexia nervosa in youth
  - Agnostic view of the illness: Neither parents nor adolescent are to blame



'Standard' Format: 16-20 outpatient sessions

56

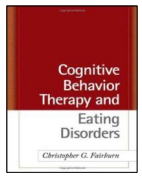
Family-Based Treatment: Suitability and Features

- Children and adolescents (younger than 18) with eating disorders who are medically stable and are living at home with family
- Family is able and willing to put significant time commitment into it treatment; family eats together
  - Parents are part of the solution and responsible for weight gain
- Therapist stance and role
  - Deference to parents in supporting the adolescent
  - Observer and coach during family meals

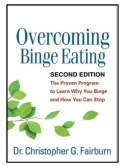
57

Cognitive Behavioral Therapy-Enhanced (CBT-E)

- Transdiagnostic ED treatment
  (Fairburn et al., 2003; Fairburn, 2008)
  - Leading evidence-based treatment in adults
  - Two versions: *Focused* (core treatment) or *Broad* (adds mood intolerance, perfectionism, low self-esteem, interpersonal difficulties)
  - Two intensities: 20-sessions (BMI > 17.5) or 40-sessions (BMI 15-17.5)



- Related: CBT-Guided Self-Help (CBTgsh)
  - Less intensive
  - Binge-spectrum disorders, <u>not AN</u>
  - Healthcare provider serves as facilitator/guide for following self-help manual



58

CBT-E: Core Features

- 4 Stages
  - 'Starting Well', 'Taking Stock', 'Setbacks', 'Ending Well'
- Core Elements
  - Personalized transdiagnostic formulation
  - Psychoeducation and self-monitoring
  - Establish regular eating to reduce restraint/restriction
  - In-session weighing
  - Incorporating significant others
  - Dealing with setbacks and maintaining change

59

Interpersonal Psychotherapy

- **Rationale**
  - Eating disorders develop within social and interpersonal contexts
  - Relationships between the patient and significant others impact the maintenance of the disorder and response to treatment
- **Focus**
  - Identifying and modifying the interpersonal context in which the eating problem has been developed and maintained
- **Links** onset to 1 of 4 problem areas:
  - Grief (eg, death or loss)
  - Role Dispute (eg, non-reciprocal expectations in relationships)
  - Role Transition (eg, difficulty coping with life changes)
  - Interpersonal Deficits (eg, history of inadequate relationships)

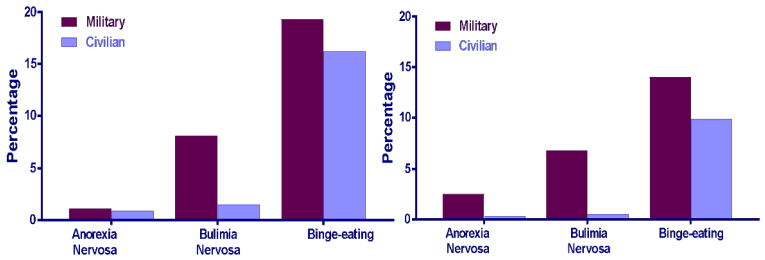
60

Outline

- Eating Disorders
- Assessment
- Evidence-Based Treatments: Overview
- **Military-Relevant Considerations**

61

Research suggests eating disorder prevalence is higher in service members compared with civilians



62

Prevalence of Eating Disorders

- Varies across services, preliminary estimated rates are high in military personnel: **10%** (~**3x higher** than in civilians)
  - 3% anorexia nervosa
  - 7% bulimia nervosa
  - >50% engage in binge eating or have binge-eating disorder
- Male service members may be at equal – or greater – risk than female service members
- **Most likely, these are <u>under</u>estimates**

63

Estimated 1 in 3 Service Members: "Situational" Eating Disorder

- **<u>Defined</u>:**
  - *"Abnormal eating behaviors, consistent with an eating disorder, practiced intermittently and in response to external pressures associated with significant distress, such as **military weigh-ins or army physical fitness testing**"*
- Disordered eating –in the absence of a diagnosable disorder is upwards of 30%
- Untreated, situational eating disorders may develop into full-syndrome eating disorders

64

Risk Factors for Eating Disorders in Service Members

Lifestyle
- Access to high calorie foods
- Limited time

Deployment
- Meals Ready to Eat (MREs): Prepackaged energy-dense meals
- Combat, especially for women

Stress Related to
- Safety
- Relocation
- High-intensity work

65

Risk Factors for Eating Disorders: Body Composition & Fitness Standards

- Pressure to "make weight"
- Fitness and Muscularity: Fit athletes struggle to make weight
- Need to achieve and maintain "military appearance"

66

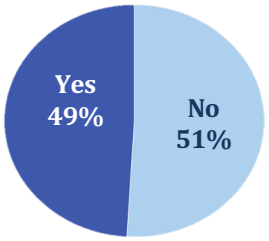
Risk Factors for Eating Disorders: Body Composition & Fitness Standards

- Concerns about standards associated with:
  - Body dissatisfaction
  - Unhealthy weight control behaviors
- Standards may also exacerbate **pre-existing** disordered eating
  - High rates of disordered eating *prior* to joining

67

Weight Stigma in the Military

Have you experienced at least 1 instance of weight stigma in the military?



Schvey, NA et al: Stigma and Health 2(4):281, 2017

68

Weight Stigma in the Military

Endorsement of Specific Weight Stigma Items.

	Presence[a] *n* (%)	Absence *n* (%)
A. Military-Specific Items		
Received disciplinary action as a result of body shape or weight	28 (24.0)	88 (75.2)
Coworkers/friends asking intrusive or personal questions about weight	27 (23.1)	90 (76.9)
Passed up for promotion/award due to weight or physical appearance	21 (18.1)	94 (80.3)
Primary care manager (PCM) said weight was problem even if in good health	20 (17.1)	97 (82.9)
PCM recommended diet even when you did not come to discuss weight loss	9 (7.7)	108 (92.3)
During fitness tests, being called names	11 (9.5)	106 (90.6)
Being made fun of/mocked during drills or training	10 (8.6)	107 (91.5)
Being told your shape/weight didn't meet military standards	50 (42.8)	67 (57.3)
Being the only heavy person or the heaviest person at work	19 (16.3)	98 (83.8)
Being told you were unattractive/ugly by a coworker	7 (6.0)	110 (94.0)
Receiving negative weight or appearance-related feedback on performance reports	20 (17.1)	97 (82.9)

Shank, LM et al: Body Image;28:25-33, 2019.

69

Physical Fitness Tests and Weight Requirements

- Each service has its own standards
- Ability to meet these standards impacts military career
  - Repeatedly failing could lead to separation
  - Opportunities for additional training, promotions, and ability to deploy/re-enlist determined partly by standards

70

Eating Disorders in Veterans

- Veterans may also be at greater risk for eating disorders compared with non-veterans
- Eating disorders are not routinely screened for in VHA settings
- Estimates vary WIDELY, depending on methods used
  - **Electronic medical records**
  - **Questionnaires**
  - **In-person or telephone interviews**

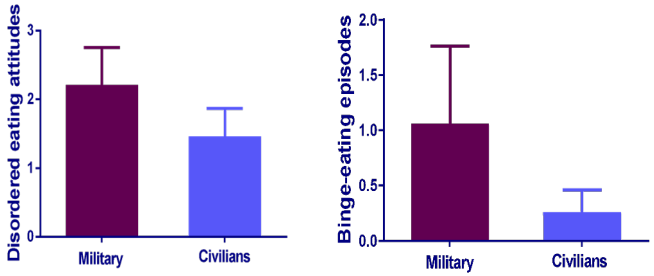
71

Risk Factors in Veterans

- Trauma exposure
- Military sexual trauma
- Poor eating habits during time in service
- Decrease in physical activity post-separation
- Entrenched disordered attitudes and behaviors

72

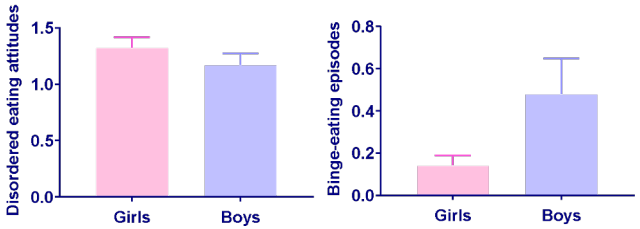
Adolescent Dependents of Service Members



Schvey NA et al, Int J Eat Disord. 2015; 48: 790-4

73

Adolescent Dependent Boys: Similar or higher rates of disordered eating than Female Peers



Quattlebaum M et al, Eat Behav, 2019; 33: 73-7

Consequence: *Affects the military children & families health, and pipeline for recruitment for future service with 77-86% of new recruits having a family member who served*

74

Risk for eating disorders among the military family

Risk Factors and stressors:

- Exposure to weight/appearance focus
- Spouse/parental deployment
  - Change of caretakers
  - Added responsibilities
  - Concerns about safety
- Multiple location changes
  - New social environments
  - School changes for child dependents
  - Lack of consistent support
- Exposure to spouse/parental focus on "making weight"
  - Observe extreme dieting or weight control behaviors
  - Parental (over)concern about appearance

75

Impact on military recruitment, readiness and retention

- **Eating disorders**
  - May be disqualifying, impacting **recruitment**
  - Are associated with serious comorbid health problems, impacting **readiness**
  - Can limit promotion and lead to separation or discharge impacting **retention**

76

Outline

- Eating Disorders
- Assessment
- Evidence-Based Treatments
- **Military-Relevant Considerations**
  - **Clinical Recommendations**

77

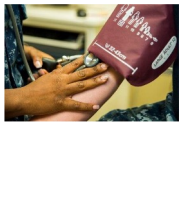
Adopt a Weight-Inclusive Approach

Emphasis on health and health-promoting behaviors **irrespective of weight**

78

Creating Weight-Inclusive Healthcare Spaces

- Ask patients if they would like to know their weight
  - Place scales in private areas
  - Remember… patients may avoid healthcare to avoid the scale
- Ensure supplies and equipment accommodate patients of all sizes
  - Blood pressure cuffs
  - Patient gowns
  - Exam tables
  - Armless chairs
  - Scales



79

Creating Weight-Inclusive Healthcare Spaces

- Language matters; avoid shame and blame
- Refrain from making assumptions
  - BMI alone cannot tell us about a person's diet, activity level, or health status
  - **Weight ≠ health**
- Ask about current health behaviors and any health-related goals
  - Focus on specific health behaviors (not scale number)
- Emphasize multifactorial etiology of weight and address weight sensitively
- Address and challenge weight stigma
- Regularly screen for disordered eating in all patients, irrespective of weight

80

Thank you!

81

Next Steps

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82

82