Eating Disorders and Disordered Eating: Overview and Considerations for Recognition and Treatment in Youth

1550-1650
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Disclosures

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Learning Objectives

At the conclusion of this webinar the participants will be able to:

1) Define the symptoms that characterize full and subthreshold eating disorders
2) Identify factors to consider when evaluating for an eating disorder in youth
3) Recognize unique factors and/or risk within specific subgroups
4) Understand levels of care and multi-disciplinary approach to eating disorder treatment
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DHA Clinical Communities Speaker Series
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Overview
What are we talking about?

- Eating disorders are serious psychiatric illnesses characterized by a persistent pattern of unhealthy eating or dieting behavior that can cause health problems and/or emotional and social distress.

- Even if an individual does not meet the formal criteria for an eating disorder, he or she may experience disordered eating attitudes and/or behaviors that cause substantial distress and may be harmful to both physical and psychological health.

- Biopsychosocial illness
  - Etiology/maintenance
  - Consequences

APA, 2013; Culbert et al., 2015
<table>
<thead>
<tr>
<th>Truth</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Many people with eating disorders look healthy, yet may be extremely ill.</td>
</tr>
<tr>
<td>2</td>
<td>Families are not to blame, and can be the patients’ and providers’ best allies in treatment.</td>
</tr>
<tr>
<td>3</td>
<td>An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.</td>
</tr>
<tr>
<td>4</td>
<td>Eating disorders are not choices, but serious biologically influenced illnesses.</td>
</tr>
<tr>
<td>5</td>
<td>Eating disorders affect people of all genders, ages, races, ethnicities, body shapes and weights, sexual orientations, and socioeconomic statuses.</td>
</tr>
<tr>
<td>6</td>
<td>Eating disorders carry an increased risk for both suicide and medical complications.</td>
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<tr>
<td>7</td>
<td>Genes and environment play important roles in the development of eating disorders.</td>
</tr>
<tr>
<td>8</td>
<td>Genes alone do not predict who will develop eating disorders.</td>
</tr>
<tr>
<td>9</td>
<td>Full recovery from an eating disorder is possible. Early detection and intervention are important.</td>
</tr>
</tbody>
</table>

Publicly available at: https://www.aedweb.org/resources/online-library/publications/nine-truths
Why are eating disorders important to consider, especially in youth?

- **Seriousness**
  - Eating disorders have among the highest mortality rates of any psychiatric disorder
  - Eating disorders are associated with serious health consequences
    - Potentially lasting consequences for youth

- **Course and Timing**
  - Many experience a protracted symptom course, even with treatment
  - Average age of onset for many eating disorders is during youth
  - Early intervention may produce better long-term outcomes

APA, 2013; Arcelus et al., 2011; Keel & Brown, 2010; Mitchell & Crow, 2006; Treasure & Russell, 2011
## ED Prevalence in Youth

- **US Epidemiology: Lifetime prevalence**
- **10,123 youth age 13-18**

<table>
<thead>
<tr>
<th></th>
<th>AN</th>
<th>BN</th>
<th>BED</th>
<th>Sub-AN</th>
<th>Sub-BED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>0.3%</td>
<td>0.9%</td>
<td>1.6%</td>
<td>0.8%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Female</td>
<td>0.3%</td>
<td>1.3%</td>
<td>2.3%</td>
<td>1.5%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Male</td>
<td>0.3%</td>
<td>0.5%</td>
<td>0.8%</td>
<td>0.1%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

APA, 2000; Swanson et al., 2011
### Co-Occurring Disorders in Youth with EDs

- **10,123 youth age 13-18**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>AN</th>
<th>BN</th>
<th>BED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
<td>10.9%</td>
<td>49.9%</td>
<td>45.3%</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>23.9%</td>
<td>66.2%</td>
<td>65.2%</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>13.0%</td>
<td>20.1%</td>
<td>26.8%</td>
</tr>
<tr>
<td>Behavioral Disorder</td>
<td>31.7%</td>
<td>57.8%</td>
<td>42.6%</td>
</tr>
</tbody>
</table>

*APA, 2000; Swanson et al., 2011*
What to Look For
Anorexia Nervosa (AN)

- **Diagnostic Criteria**
  - Restricted energy intake resulting in significantly low body weight (i.e., less than minimally normal in adults or less than minimally expected in youth)
  - Intense fear of weight gain or fear of becoming fat, or persistent behavior interfering with weight gain despite low weight
  - Disturbance in experience of body weight or shape, body weight or shape overvaluation, or persistent lack of recognition of seriousness of current low body weight

- **Subtypes**
  - Restricting
  - Binge-eating/purging

APA, 2013
Bulimia Nervosa (BN)

- Diagnostic Criteria
  - Recurrent binge eating behavior
    - Consuming in a discrete period of time an unusually large amount of food
    - Experiencing a sense of lack of control over eating during the episode
  - Recurrent inappropriate compensatory behaviors to prevent weight gain (e.g., purging, fasting, excessive exercise)
  - Binge eating and compensatory behaviors both occur ≥ 1x/wk for 3 mo
  - Overvaluation of body shape and weight
  - Does not occur exclusively during anorexia nervosa

APA, 2013
Binge Eating Disorder (BED)

- **Diagnostic Criteria**
  - Recurrent binge eating behavior (large amount + loss of control)
  - Binge eating episodes associated with ≥ 3:
    - Eating much more rapidly than normal
    - Eating until uncomfortably full
    - Eating large quantities of food when not physically hungry
    - Eating alone because of embarrassment over how much one is eating
    - Feeling disgusted, depressed, or very guilty afterwards
  - Marked distress about binge eating
  - Binge eating occurs ≥ 1x/wk for 3 mo
  - No recurrent use of compensatory behavior and does not occur exclusively during anorexia nervosa

APA, 2013
Avoidant/Restrictive Food Intake Disorder (ARFID)

- Diagnostic Criteria
  - Feeding/eating disturbance (e.g., apparent lack of interest in eating food; avoidance based on the sensory features of food; worry about aversive consequences of eating) leading to failure to meet appropriate nutritional and/or energy needs involving (one or more):
    - Significant weight loss or failure to achieve expected weight gain/growth
    - Significant nutritional deficiency
    - Dependence on enteral feeding or oral nutritional supplements
    - Marked interference with psychosocial functioning
  - Not due to lack of available food or a culturally sanctioned practice
  - Rule out AN and BN, no disturbance in body image
  - Not attributable to a concurrent medical condition and not better explained by another mental disorder

APA, 2013
Additional Feeding Disorders

- **Rumination Disorder**
  - Repeated regurgitation of food > 1 mo; re-chewed, re-swallowed, or spit out
  - Not attributable to a GI or other medical condition
  - Rule out AN, BN, BED, ARFID
  - If occurring in context of other mental disorder, severe enough to warrant additional clinical attention

APA, 2013
Additional Feeding Disorders

- Rumination Disorder
  - Repeated regurgitation of food > 1 mo; re-chewed, re-swallowed, or spit out
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  - Rule out AN, BN, BED, ARFID
  - If occurring in context of other mental disorder, severe enough to warrant additional clinical attention

- Pica
  - Persistent eating of nonnutritive, nonfood substances > 1 mo
  - Inappropriate to the individual’s developmental level
  - Not part of a culturally supported or socially normative practice
  - If occurring in context of other mental disorder or medical condition, severe enough to warrant additional clinical attention
Subthreshold Presentations

- **Other Specified Feeding or Eating Disorder**
  - Feeding or eating disorder symptoms that cause clinical distress or impairment, but do not meet the full criteria for any of the disorders.
  - **Examples**
    - **Atypical AN**: all criteria for anorexia nervosa are met, *except* that despite significant weight loss, weight is within or above the normal range.
    - **Purging Disorder**: recurrent purging behavior to influence weight or shape in the absence of binge eating.
    - **BN or BED (of low frequency and/or limited duration)**: criteria for BN or BED are met, except lower behavior frequency or less than 3 mo.

- **Unspecified Feeding or Eating Disorder**
  - Used when clinician chooses not to specify the reason that criteria are not met, including when there is insufficient information or time to make a diagnosis.

APA, 2013; Keel, 2007; Moskowitz & Weiselberg, 2017
A Closer Look: Cognitive Symptoms

- Body Image Disturbance
  - Overvaluation of body weight and shape
  - Fear of weight gain
  - Body image distortion

APA, 2013; Ahrberget al., 2011; Glashouwer et al., 2019; Sattler et al., 2019
Types of eating disturbance

- Overeating
  - Eating an unusually large amount of food given context
- Loss of control eating
  - Eating while experiencing a sense of loss of control (e.g., unable to stop)
- Binge eating
  - **Objective**: eating unusually large amount of food + loss of control
  - **Subjective**: loss of control, regardless of the amount of food eaten
- Restriction
  - Limiting quantity or type of food
  - Fasting: going long periods without eating
A Closer Look: Behavioral Symptoms

- Compensatory behaviors
  - Purging behaviors
    - Self-induced vomiting
    - Laxative, diuretic, or other medication misuse (e.g., insulin)
  - Non-purging behaviors
    - Fasting
    - Exercise
      - Driven/compelled or excessive

APA, 2013; Bryden et al., 1999; Keel, 2007; Mond et al., 2006
Beyond the diagnoses...

- Other behaviors to look for
  - Food rituals
    - Excessive chewing, doesn’t allow foods to touch, cutting foods into small pieces
  - Body checking
    - Checking thickness of joints (e.g., wrists), checking body parts for fat, mirror checking or avoidance
  - Apparent preoccupation with weight, food, calories
    - Frequently talking about or focus on dieting or weight loss
    - Extreme focus on calorie counting or macronutrient content of food
  - Problems with social or occupational functioning due to...
    - Rigid exercise routine
    - Avoidance of eating in front of others

Sunday et al., 1995; Walker et al., 2018
Medical Complications
Medical Complications

- **Considerations to Start**
  - Every organ system in the human body can be affected by an eating disorder
    - Major metabolic changes
    - Cardiovascular, fluids and electrolytes, musculoskeletal/growth, reproductive, gastrointestinal
  - **Malnutrition**
    - Can be present even with normal or high body weight
    - Amount and speed of weight loss can be as important as current body weight
  - Most medical complications appear reversible, though some may be irreversible

Forney et al., 2016; Katz & Vollenhoven, 2000; Mitchell & Crow, 2006; Robinson et al., 2016; Rome & Ammerman, 2003
Medical Complications

- Cardiovascular
  - Bradycardia
    - Don’t confuse with indication of athleticism
  - Hypotension (including orthostatic) or hypertension
  - Poor peripheral perfusion
    - Feeling cold
  - Number one cause of death in eating disorders, especially AN

Casiero et al., 2006; Forney et al., 2016; Mitchell & Crow, 2006; Rome & Ammerman, 2003
Medical Complications

- Fluids and Electrolytes
  - Causes of dehydration and/or electrolyte abnormalities
    - Poor intake of fluids, vomiting, laxative or diuretic use
  - Potential consequences
    - Kidney dysfunction, altered cognition, cardiac arrhythmia/arrest

Bermudez & Beightol, 2004; Forney et al., 2016; Mitchell & Crow, 2006; Rome & Ammerman, 2003
Medical Complications

- **Fluids and Electrolytes**
  - Causes of dehydration and/or electrolyte abnormalities
    - Poor intake of fluids, vomiting, laxative or diuretic use
  - Potential consequences
    - Kidney dysfunction, altered cognition, cardiac arrhythmia/arrest
  - Water loading
    - Excessive drinking of water
    - Dilution and imbalance of electrolytes, particularly sodium
  - Refeeding Syndrome
    - A serious and potentially fatal complication of changes in metabolism accompanying nutritional restoration
    - Primarily related to related phosphorus, potassium, and/or magnesium

Bermudez & Beightol, 2004; Forney et al., 2016; Mitchell & Crow, 2006; Rome & Ammerman, 2003
Medical Complications

- Reproductive
  - Low estradiol in girls, low testosterone in boys
  - Clinical effects depend on stage of development
    - Incomplete pubertal development
      - Pubertal delay/arrest
    - Complete pubertal development
      - Women: Amenorrhea, infertility
      - Men: Decreased sex drive

Forney et al., 2016; Hetterich et al., 2019; Katz & Vollenhoven, 2000; Mitchell & Crow, 2006; Rome & Ammerman, 2003
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- Gastrointestinal
  - Constipation
    - Effects on malnutrition
    - Laxative abuse
  - Delayed gastric emptying
    - Fullness and bloating after meals
  - Acid reflux
  - Pancreatitis
  - Gallstones

Forney et al., 2016; Hetterich et al., 2019; Katz & Vollenhoven, 2000; Mitchell & Crow, 2006; Rome & Ammerman, 2003
Medical Complications

- Musculoskeletal
  - If growth is not complete
    - Height stunting
  - Decreased bone density/bone loss
    - Related to low weight, decreased sex steroid production (estrogen and testosterone), and increased cortisol (stress)
    - Risk of pathological fractures

Forney et al., 2016; Mitchell & Crow, 2006; Robinson et al., 2016; Rome & Ammerman, 2003
Other Considerations for Assessment/Evaluations
General Areas to Consider in Assessments/Evaluations

- **History (youth and family)**
  - Eating patterns, body image concerns, trauma, major life events
  - Lifetime highest and lowest weights, recent weight change
  - Previous treatment for eating disorder or other psychiatric disorder
  - Family history of eating disorders or other psychiatric disorders

- **Basic eating patterns**
  - General daily intake
    - Number of meals, snacks, time between eating
  - Attitudes toward food/eating
    - Interest in/enjoyment of eating?
    - Rules? Good vs Bad foods?
    - Time spent thinking about food
    - Eating in public or social settings
General Areas to Consider in Assessments/Evaluations

- General attitudes/behaviors related to shape/weight
  - Description of current body type
  - Reaction to hypothetical weight gain
  - Weighing frequency/monitoring, calorie counting

- Psychosocial functioning
  - Family
  - Peers
  - School and/or work
General Areas to Consider in Assessments/Evaluations

- Social media and app use
  - Calorie counting, fitness, weight-related apps
    - May be without parental knowledge/supervision
  - 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

Rodgers et al., 2016; Simpson & Mazzeo, 2017
Additional Considerations for Youth

- Binge Eating
  - Challenge in identifying ‘unusual quantity’ for an objective binge
    - Take into account gender, changing caloric needs with age and developmental stage
  - In youth, the focus is commonly on just loss of control eating, regardless of the amount of food consumed (subjective binge)

- Developmental level and food access/independence
  - Older youth have more access to and independence of food choice
  - Role of parents/caregivers, and family approaches to eating
Additional Considerations for Youth

- **Parents/caregiver reports**
  - In addition to assessing the youth directly, get reports and assessments regarding the youth from the parents/caregivers
  - Consider meetings both together and individually; when speaking with youth, be clear about nature and limits of confidentiality

- **Comprehension, minimization**
  - Age-appropriate questions, explanations, assessments
  - Consider assessing specific issues with multiple similar questions
  - Elicit examples when possible
  - Understand that denial, shame, embarrassment, etc. may affect responding
Additional Considerations for Military Dependent Youth

- **Stressors**
  - Stress can be a risk factor and trigger for disordered eating behaviors
    - Parental deployments
    - Combat-related parental safety
    - Relocations with PCS (school transitions, loss of peer groups)

- **Body composition and fitness standards**
  - Weight/shape-based attitudes more salient
  - Potential modeling of stricter weight control behaviors

Esposito-Smythers et al., 2011; Link & Palinkas, 2013; Ruff & Keim, 2014; Tanofsky-Kraff et al., 2013
Males and Youth with Overweight/Obesity
Males

- **Overview**
  - Eating disorder symptoms are more common among males than historically recognized
    - Traditional 10 to 1 ratio
  - Still under-represented in clinical/treatment samples; prevalence from community samples shows differences are smaller
    - **AN**: M (.3%) vs F (.3%); **BN**: M (.5%) vs F (1.3%); **BED**: M (.8%) vs F (2.3%)
  - Apparent sex differences
    - Later average age of onset (full-threshold)
    - History of overweight
    - Treatment-seeking less and later
    - More psychiatric comorbidity

Lavender et al., 2017; Murray et al., 2017; Raevuori et al., 2014; Swanson et al., 2011
Males

- **Body Image**
  - Two dimensions
    - Body fat/leanness
    - Muscularity
  - Over time, there has been...
    - Increasing exposure to muscular male body across various forms of media
    - Increasingly positive connotation of muscular male body
    - Greater commercial value of muscular male body

Karazsia et al., 2017; Lavender et al., 2017; Murnen & Karazsia, 2017; Murray et al., 2017
Evolution of the Male Body Ideal

https://www.telegraph.co.uk/men/active/11822364/Are-action-figures-giving-boys-body-image-anxiety.html
Evolution of the Male Body Ideal

https://www.telegraph.co.uk/men/active/11822364/Are-action-figures-giving-boys-body-image-anxiety.html)
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https://www.telegraph.co.uk/men/active/11822364/Are-action-figures-giving-boys-body-image-anxiety.html)
Muscularity-Oriented Disordered Eating

- Disordered eating practices
  - Protein (over) consumption
  - Rigid rules
  - Compensatory efforts
  - Extreme dietary restriction
  - Bulking & cutting phases
  - Continual access to food
  - Eat for ‘functionality’
  - Eat beyond feeling full
  - “Cheat days”
  - APED use

Lavender et al., 2017; Murray et al., 2017; Murray et al., 2018; Murray et al., 2019;
Muscle Dysmorphia

- Preoccupation with insufficient leanness/muscularity
- Distress and/or impairment
  - Giving up important activities to maintain workout/diet schedule
  - Avoiding situations where one’s body is exposed to others
  - Continuing to work out, diet, or use appearance/performance enhancing substances despite adverse consequences

Pope et al, 1997; Pope et al., 2005; Tod et al., 2016
Other Considerations for Males

- Assessments/Evaluations
  - Shame/perceived stigma related to eating disorders being ‘feminine’
  - May be less familiar with eating disorders, require more psychoeducation and/or more motivation to seek treatment
  - If using an existing questionnaire or interview...
    - Most were developed and tested with only women, and are focused mostly on drive for thinness, weight loss, fear of weight gain, and related behaviors
  - Take into account gender and developmental status when considering what is an unusually large amount of food (e.g., adolescent male)

Andersen & Holman, 1997; Darcy et al., 2012; Griffiths et al., 2015; Lavender et al., 2017; Strother et al., 2012
Youth with Overweight/Obesity

- Higher weights among youth with eating disorders/disordered eating
  - Strong overlap between binge/loss of control eating and higher weight
  - Similar factors can contribute to both disordered eating and overweight/obesity
    - Genetic factors (e.g., metabolic predispositions)
    - Psychological factors (e.g., stress, personality)
    - Cultural/environmental factors (e.g., sociocultural ideal body types, food environment)
  - Overweight/obesity during youth is a risk factor for eating disorders in adulthood

Anzman-Frasca et al., 2012; Culbert et al., 2015; Fairburn et al., 1998; Haines & Neumark-Sztainer, 2006; Parsons et al., 1999
Youth with Overweight/Obesity

- The energy balance model of obesity is the foundation of most weight management programs
- ‘Dieting’ has been considered a risk factor for eating disorders
- Consider disordered eating, current or risk of new onset behaviors, when managing weight among youth
- Avoid shame and blame
- Ask about weight-based teasing/bullying
- Be aware of weight stigma in actions and language
  - Overweight vs chubby
  - High BMI vs obese
  - Unhealthy weight vs fat

Puhl et al., 2020; Puhl & Latner, 2007; Puhl & Suh, 2015; Neumark-Sztainer et al., 2002; Schvey et al., 2019
Brief Eating Disorders Treatment 101
Multidisciplinary Team Approach

- Treating an eating disorder generally involves a combination of psychological therapy and nutritional counseling, with medical and psychiatric monitoring
  - Psychologist/therapist, psychiatrist, dietician/nutritionist, physician

- Address the symptoms and medical consequences, and psychological, biological, interpersonal, and/or cultural forces that contribute to or maintain the eating disorder

- For patients who are underweight, weight restoration is a primary and essential goal

- Decisions about type of treatment, level of care, and other clinical issues are based on the patient’s developmental level, symptom presentation and severity, and other relevant factors
Components

- Psychotherapy
  - Individual/Group: Cognitive-behavioral therapy, interpersonal therapy, dialectical behavior therapy
  - Family: Family-based therapy
    - The strongest evidence based for treatment of youth, especially with AN

- Targets vary by diagnosis and form of therapy
  - Restoring weight and normalizing eating patterns
  - Reducing restraint/restriction that prompts binge eating
  - Improving interpersonal relationships/functioning
  - Challenging cognitive distortions (e.g., about body image)
  - Engaging parents/caregivers to re-establish healthy eating in youth
  - Improving coping and emotion regulation

Campbell & Peebles et al., 2014; Couturier et al., 2013; Hay, 2013
Components

- Nutrition/dietary education and counseling
  - Develop individualized plans based on patient needs
  - Working with a registered dietician to address knowledge and understanding of nutrition, metabolism, etc.
  - May assist with meal planning and related skills (e.g., shopping, food preparation)
  - Important for experience with eating disorders, because goals/considerations may be different than other groups

Ozier & Henry, 2011
Components

- Psychopharmacotherapy
  - Medications directly targeting the disorder
    - No FDA approved medication for AN
    - Fluoxetine FDA approved for BN
      - Bupropion associated with seizure potential in BN
      - Lisdexamfetamine FDA approved for BED
  - 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

Hay & Claudino, 2012; Himmerich & Treasure, 2018; Mehler & Anderson, 2017;
## Levels of Care

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital (Inpatient)</td>
<td>- Short-term</td>
</tr>
<tr>
<td></td>
<td>- Medical stabilization, rapid weight gain</td>
</tr>
<tr>
<td>Residential</td>
<td>- Longer-term care</td>
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<tr>
<td></td>
<td>- 24 hours/day treatment</td>
</tr>
<tr>
<td>Partial Hospital (PHP)</td>
<td>- 5-6 days per week, 6-10 hours per day</td>
</tr>
<tr>
<td></td>
<td>- Tightly structured treatment programming with multiple meals/snacks</td>
</tr>
<tr>
<td>Intensive Outpatient (IOP)</td>
<td>- Multiple days per week, ~4 hours per day</td>
</tr>
<tr>
<td></td>
<td>- Tightly structured treatment programming, with some meal support</td>
</tr>
<tr>
<td>Outpatient</td>
<td>- Individual outpatient sessions with members of multidisciplinary treatment team</td>
</tr>
<tr>
<td></td>
<td>- Psychotherapy ~1-2 per week</td>
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</tbody>
</table>

*Anderson et al., 2017; Derenne, 2017*
Eating disorders are biopsychosocial illnesses characterized by a diverse array of symptoms with serious psychosocial and health consequences that can affect youth of any weight status from any background.

Although males can experience symptoms consistent with traditional DSM-5 eating disorders, they may also exhibit musculity-oriented disordered eating behaviors related to the unique idealized male body.

Evaluating youth for eating disorders should include reports from both the youth and parents/caregivers, and family-based interventions have the strongest evidence base for treatment of youth with eating disorders.

Treatment for eating disorders is a multi-disciplinary endeavor and can occur within different contexts and levels of care depending on a patient’s needs and symptom severity.


References


References


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3. Click on the REGISTER/TAKE COURSE tab.
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   b. If you have not previously used the CEPO LMS click register to create a new account.
4. Verify, correct, or add your profile information.
5. Follow the onscreen prompts to complete the post-activity assessments:
   a. Read the Accreditation Statement
   b. Complete the Evaluation
   c. Take the Posttest
6. After completing the posttest at 80% or above, your certificate will be available for print or download.
7. You can return to the site at any time in the future to print your certificate and transcripts at https://www.dhaj7-cepo.com/
8. If you require further support, please contact us at dha.ncr.j7.mbx.cepo-lms-support@mail.mil