Clinical Considerations of Disordered Eating and Eating Disorders: A Military Perspective

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1330 – 1430 (ET)

Presenter

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Ms. Rumph began her career in healthcare as a respiratory therapy and critical care air transport provider in the Air Force. Following her military service, she completed her undergraduate, internship and graduate work with Saint Louis University. As a clinical dietitian, she has provided clinical nutrition support for critical care and inpatient nutrition. She also provided clinical nutrition and nutrition counseling to clients in residential care for eating disorder treatment while working at McCallum Place in St. Louis, Missouri. Ms. Rumph is board certified in sports nutrition and eating disorders.

Since 2015, Ms. Rumph has been providing nutrition counseling for the Department of Defense. From 2015 to 2021, she served as the registered dietitian in the Puyallup, Washington Patient Centered Medical Home (PCMH). Since 2021 to present, she has been providing nutrition care for soldiers as a dietitian on the Joint Base Lewis-McChord, Washington Holistic Health and Fitness (H2F) team.

Disclosures

- Priscilla Rumph has no relevant financial or non-financial relationships to disclose relating to the content of this activity
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Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Describe the contributing risk factors to development of eating disorders in the military setting.
2. Identify the signs and symptoms of disordered eating/eating disorders.
3. Explain how to begin the conversation with a patient for the assessment of disordered eating/eating disorders.

Cognitive Dissonance

Please, consider the information presented today with an open mindset.

- Many of us get used to thinking “This is just how we do it in the military”
- After hearing new information, most people have an initial tendency to resist…This is totally normal.
- Cognitive dissonance is a significant barrier to change…it is very challenging to navigate new information that conflicts with our current knowledge and value system.
- Despite the potential discomfort associated with the information discussed today, I can provide assurance that the information presented is accurate.

Thank you!

Military Members are a High-Risk Population for Eating Disorders (ED)

- High performing, perfectionism
- High training load
- Comparison of bodies
- Pervasive stress
- Bullying about shape/size
- Trauma
- High-pressure environment
- Inaccurate weight and body composition standards
- Widespread dieting mentality and weight cycling
- Often engaging in excessive exercise (overtraining)
- “Fit-fluencers”
- Inaccurate belief that lower body fat is better, faster, stronger

Eating Disorders in the Military… a significant threat to Readiness

- $64.7 Billion - Annual Economic Costs of Eating Disorders
- Estimated prevalence of Eating Disorders in military personnel = 10%, 3x higher than civilian population.
  - Male service members may be at equal or greater risk than female service members.
  - November 2020 Defense Health Board report highlighted Active Duty Service women were disproportionately impacted by eating disorders, therefore affecting health and readiness.
- Disordered Eating – 1/3 of service members
  - Self-induced vomiting, diet pills, diuretics, laxative use, fasting
  - Untreated can place service members at risk for developing eating disorders
- Serious comorbid health problems, as well as dehydration, stress fractures; and decreased strength, performance and cognitive function impacting readiness

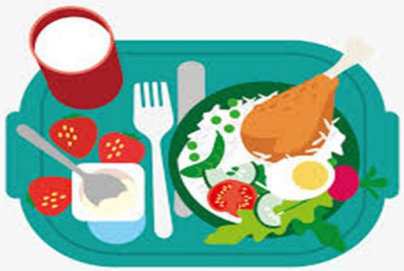
Key Factors of Human Physiology

Two essential factors to understand before our discussion today:

- Impacts of low energy availability
- Impacts of dietary restriction

Energy Availability

- The amount of energy left over and available for your body's functions after the energy expended for training is subtracted from the energy you take in from food



(stock.adobe.com, n.d.)

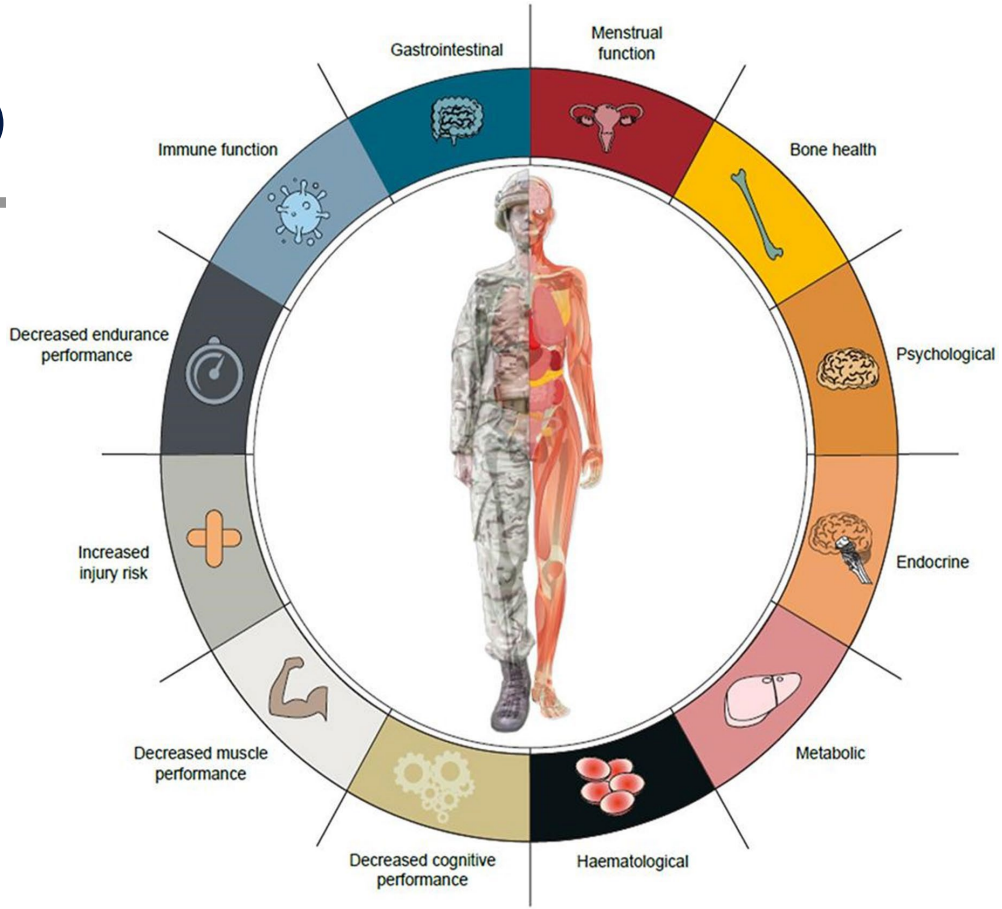
Low Energy Availability (LEA)

LEA:

- Insufficient calorie intake leading to inability to meet energy needs

Signs & Symptoms

- Repeated illness/injury
- Delayed recovery time
- Reduced cognitive function
- Decreased physical performance
- Cessation or disruption of menstrual cycle
- Reduced libido

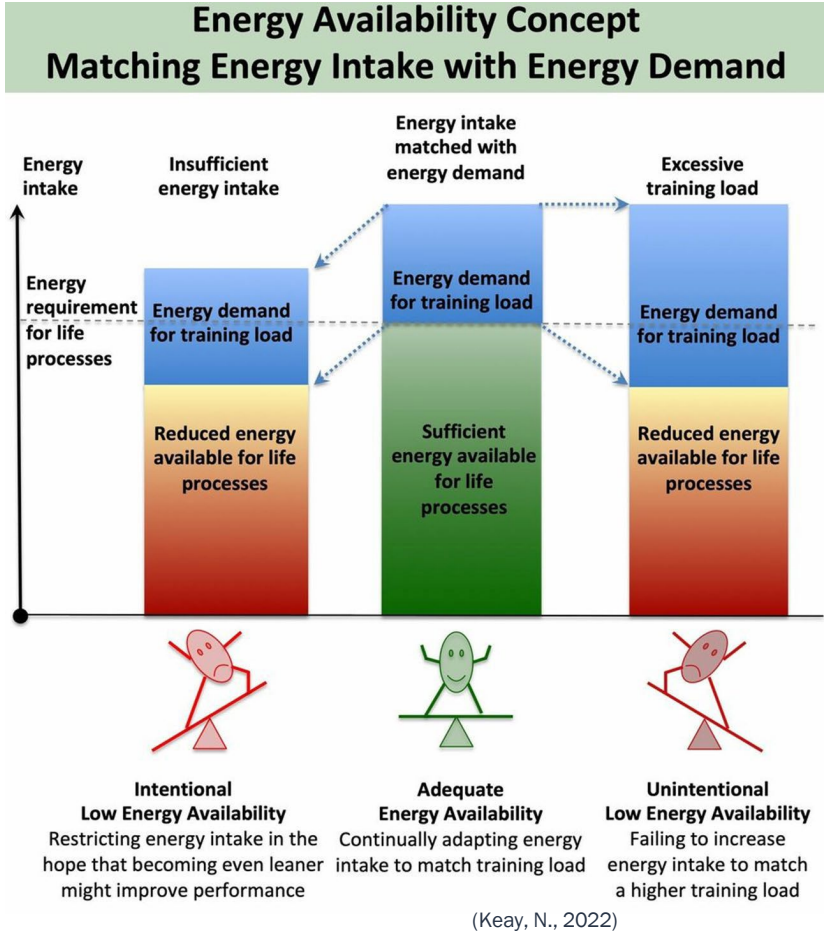


(O'Leary, T., et al., 2020)

Low Energy Availability (LEA)

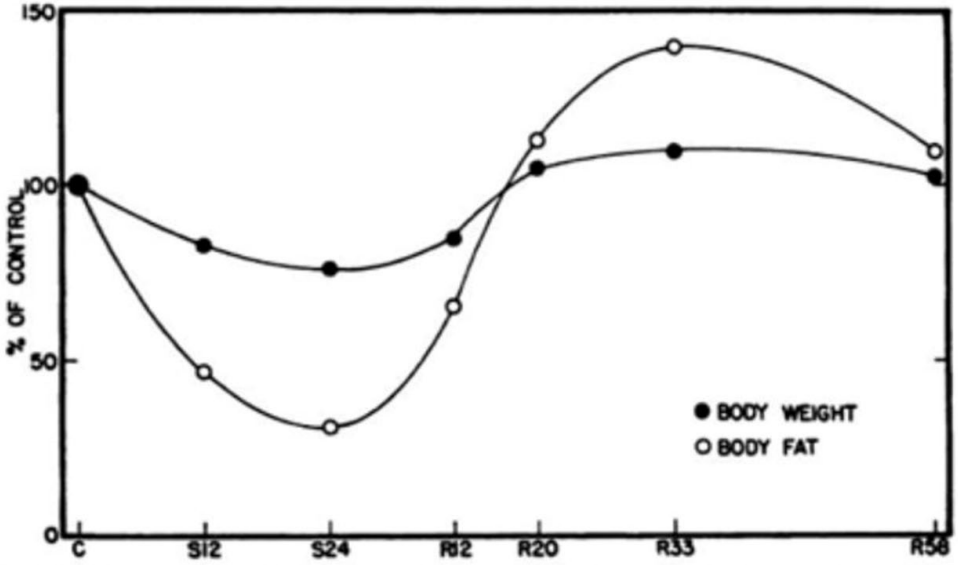
LEA:

- Insufficient calorie intake leading to inability to meet energy needs



(Keay, N., 2022)

Weight Cycling



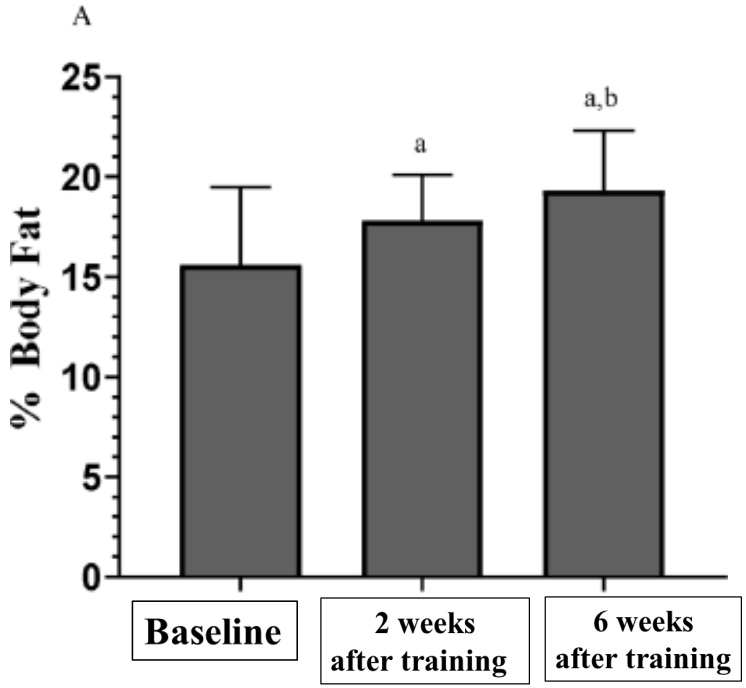
(Keys et al., 1950)

- Keys et al. (1950) showed that, after weight loss due to semi-starvation, body fat rose to approximately 140% of pre-starvation body fat percentage.
- Repeated weight cycling is associated with progressive increases in weight (body fat) after each successive restrictive diet and decrease in lean body mass (Anderson et al., 2001; Bosy-Westphal et al., 2013; Lee et al., 2010)

Weight Cycling

Army Ranger Studies

- As with the Minnesota Starvation Study, the Ranger studies illustrate how body fat increases after insufficient dietary intake



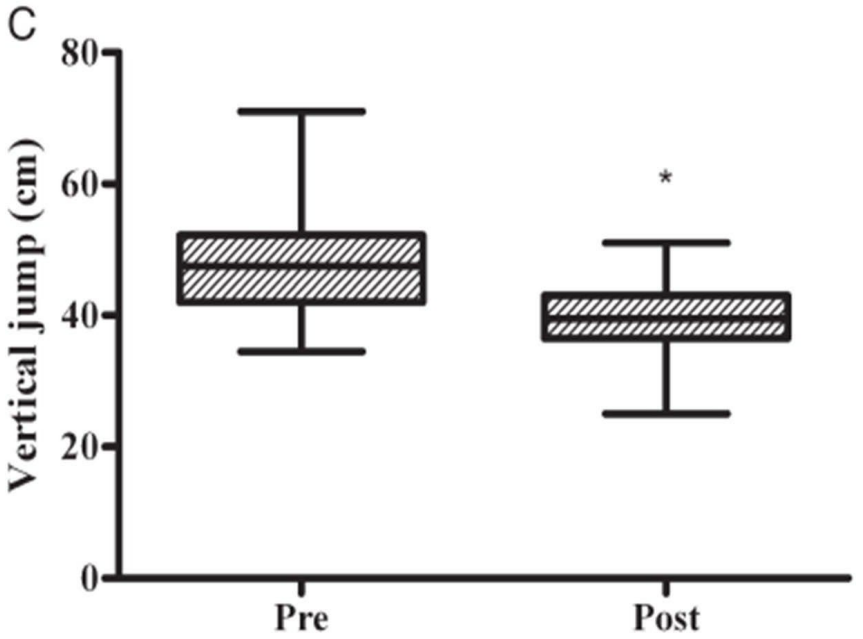
(Nindl et al., 2007)

Weight Cycling

Army Ranger Studies

- Insufficient dietary intake negatively impacts strength and power.

Insufficient intake is negatively impacting physical performance, health and readiness.



(Nindl et al., 2007)

Types of Eating Disorders

- Situational Disordered Eating/Eating Disorder related to Military Height/Weight standards
  - Depending on severity and pervasiveness of symptoms, may or may not be diagnosed as Other Specified Feeding & Eating Disorders (OSFED)
- Atypical Anorexia Nervosa (AAN)
- Binge Eating Disorder (BED)
- Muscularity Oriented Disordered Eating
- Bulimia Nervosa (BN)
- Anorexia Nervosa (AN)
- Avoidant Restrictive Food Intake Disorder (ARFID)

Situational Disordered Eating/Eating Disorder related to Military Body Composition Standards

- Military Environment…why do service members often engage in dietary restriction…which often results in LEA and weight cycling?
  - It is time for a hard look and an honest conversation about the foundation of the standards.
    - As with any situation in which we know there are inaccuracies and dangers, a pause in enforcement of the standards is warranted until a multi-disciplinary team can develop an alternative.

Town Hall

Video:

[Army Commitment to Improving Overall Nutrition (on Microsoft Teams)]

Situational Disordered Eating/Eating Disorder related to Military Body Composition Standards

- 22 y/o soldier
- Yes, on day of this photo, his measurements failed height/weight tape test
- High physical performance score
- Positive health metrics
- Experiencing symptoms of low energy availability as a result of dietary restriction

(Courtesy of Ms. Rumph)

Situational Disordered Eating/Eating Disorder related to Military Body Composition Standards

- 22 y/o female soldier
- Does not pass tape test
- Was initially experiencing symptoms of Low Energy Availability
- Army Combat Fitness Test (ACFT) score of 560 (Max score is 600) since resolving LEA
- Returned to disordered eating behaviors in effort to decrease weight for career advancement/military school

(Courtesy of Ms. Rumph)

Situational Disordered Eating/Eating Disorder related to Military Body Composition Standards

- 23 y/o female soldier
- Does not pass tape test
  - Decreased weight but tape indicated increase in % body fat due to decrease in neck size which negatively impacts calculation
- Collegiate athlete prior to joining Army
- Continued symptoms of Low Energy Availability

(Courtesy of Ms. Rumph)

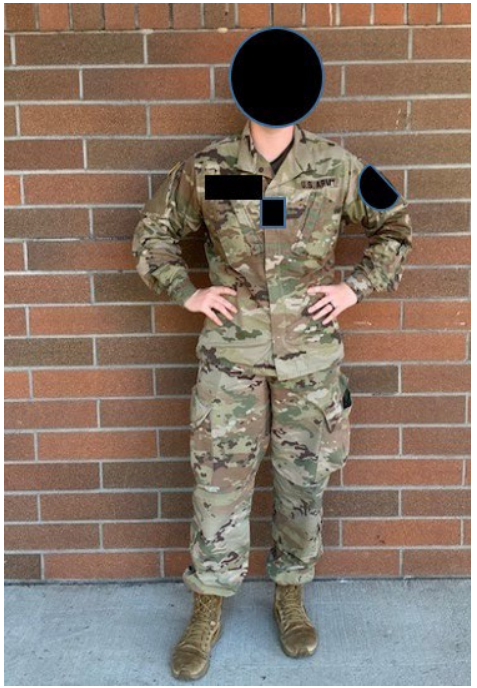
Situational Disordered Eating/Eating Disorder related to Military Body Composition Standards

- 21 y/o male soldier
- Does not pass tape test
- History of training for strength & performance prior to Army
- Now undergoing medical board for injuries related to LEA from eating only one time per day + engaging in excessive physical activity in effort to pass tape test

(Courtesy of Ms. Rumph)

Situational Disordered Eating/Eating Disorder related to Military Body Composition Standards

- 25 y/o female soldier
- Does not pass tape test
- Collegiate soccer player
- Successfully engaged in counseling and behavior changes to recover from eating disorder
- Has now returned to disordered eating in effort to attend military school needed for promotion



(Courtesy of Ms. Rumph)

The Limitations of Using %Body Fat as a Standard

USA (NHANES 1999-2004) Trend: Total (Enhanced Analysis)

Age (years)	Region	Centile	Total Mass (lbs)	Tissue (lbs)	Fat (lbs)	Lean (lbs)	BMC (lbs)	Fat Free (lbs)
39.2	33.1	14	157.8	151.5	52.2	99.3	6.3	105.6
39.2	33.2	15	158.2	151.8	52.6	99.2	6.4	105.6

USA (NHANES 1999-2004) Trend: Fat Distribution (Enhanced Analysis)

Age (years)	Android (%Fat)	Gynoid (%Fat)	A/G Ratio	Total (%Fat)
39.2	31.2	42.3	0.74	34.5
39.2	30.7	42.4	0.72	34.6

World Health Organization BMI Classification

BMI = 26.2 (kg/m^2)

Weight (lbs.) for height = 65.0 in.

(Courtesy of Ms. Rumph)

Limitations of Army Body Composition Test

- Tape test not accurately assessing body composition (New Army body comp study ongoing)
- Ranges for acceptable %body fat need reconsideration
  - Would %Fat-free mass be a better indicator?
- Calorie restriction does not have the same result for all individuals

- Dietary restriction results in individual variations to body weight and %body fat changes
  - Some soldiers lose weight on the scale but then fail to make progress with tape
    - Often due to weight loss in neck which negatively impacts %body fat calculation
  - For some individuals, dietary restriction fails to produce weight loss and actually results in low energy availability (LEA) and a stalling of %body fat reduction

- The implementation framework of the standard results in pattern of weight cycling
  - Repeated weight cycling results in reduction of lean muscle mass and increased %body fat

Consider the impact of our romance with “military appearance”

- Overemphasis on “appearance” has a real and significant cost.
  - When do we start focusing on the factors that actually impact readiness?

- Our current system undervalues actual health and physical performance.
  - “Height/weight is next week. Do what you have to do.”
  - “What used to work doesn’t work anymore.”
- We can create a system that emphasizes performance and improves our military readiness while decreasing risk of injury.

- Recommend creation of multi-disciplinary panel of medical providers (eating-disorder informed dietitians, psychologists, medical doctors, social workers, occupational therapists, strength coaches and physiologists) to develop regulations that promote health and performance.

Atypical Anorexia Nervosa (DSM-V: OSFED)

- Criteria for anorexia nervosa are met except low weight
  - Weight is within or above the average range
- Most common reasons for hospitalization in eating disorders:
  - Bradycardia
  - Electrolyte abnormalities
- Limitations of name (Atypical AN)
  - Many clients are overlooked or deemed not sick due to lack of low weight criterion

Atypical Anorexia Nervosa

Contents lists available at ScienceDirect

Eating Behaviors

journal homepage: www.elsevier.com/locate/eatbeh

Atypical Anorexia Nervosa, not so atypical after all: Prevalence, correlates, and clinical severity among United States military Veterans

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ARTICLE INFO

Keywords:
Veterans
Military
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Atypical Anorexia Nervosa
Other specified feeding and eating disorders

ABSTRACT

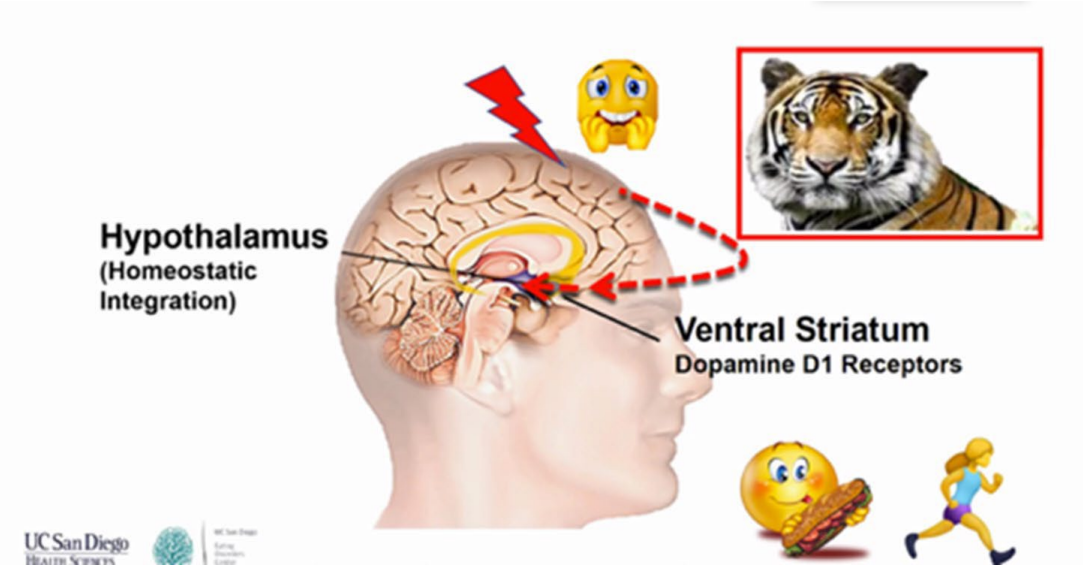
Objective: DSM-5 Atypical Anorexia Nervosa (AAN), a new eating disorder diagnosis, presents similarly to Anorexia Nervosa (AN) in the absence of severe underweight. The prevalence of AAN and other DSM-5 eating disorders was estimated in a sample of Veterans. Sociodemographic, mental health, and eating behavior correlates were examined.

Method: Iraq and Afghanistan war era Veterans (N = 1137, 51.6% female) completed the Eating Disorder

(Masheb et al., 2021)

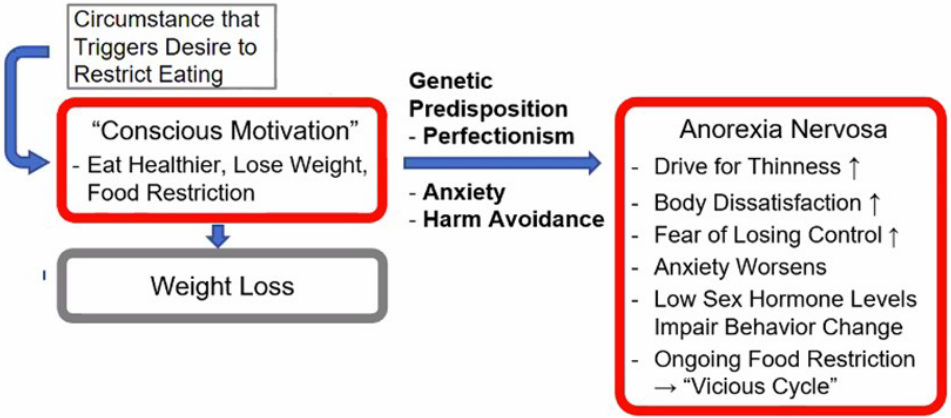
Neurobiology of Dietary Restriction

Signal goes in reverse direction from typical; Fear is so strong the signal goes downward and terminates desire to eat.



(DeSarbo, 2019)

Genetic Predisposition to Prediction Error



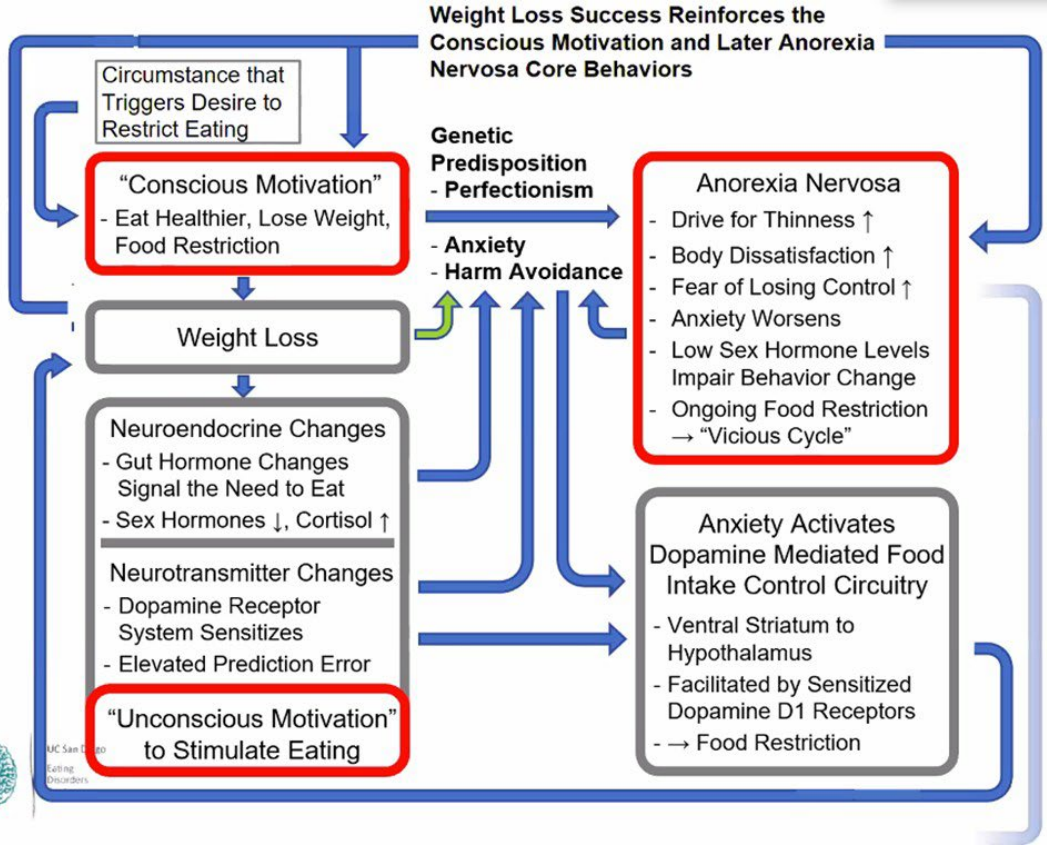
UC San Diego Health Sciences

UC San Diego Eating Disorders Center

Physiol & Behav. 2019; 206:185-190

(DeSarbo, 2019)

Genetic Predisposition to Prediction Error

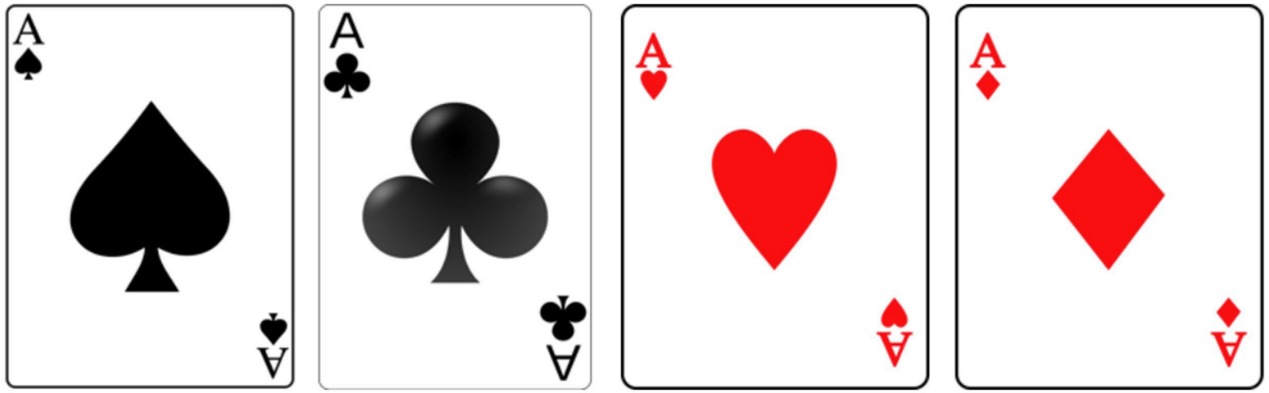


(DeSarbo, 2019)

Physiol & Behav.
2019; 206:185-190

UC San Diego
Health Sciences

Consider the Factors…We Can Reduce the Environmental Risks



(Bulik, 2021)

Binge Eating Disorder

- The DSM-5 defines Binge Eating Disorder (BED) as:
  - Eating in a discrete period of time in which the individual consumes an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances
  - A sense of lack of control over eating during the episode or a sense that one cannot stop eating or control themselves (ex: a ball rolling down a hill)
  - The absence of a compensatory strategy (such as over exercising, calorie restriction or purging)

Binge Eating Disorder

- These binge eating episodes must be associated with three or more of the following to be diagnosed as having the disorder:

  - Eating much more rapidly than normal
  - Eating until feeling uncomfortably full
  - Eating large amounts of food when not feeling physically hungry
  - Eating alone because one feels embarrassed by how much one is eating
  - Feeling disgusted with oneself, depressed or very guilty afterwards

Binge Eating Disorder

- A 2007 study asked 9,282 English-speaking Americans about a variety of mental health conditions, including eating disorders. The results, published in Biological Psychiatry, found that 3.5% of women and 2.0% of men had binge eating disorder during their life
  - This makes BED more than three times more common than anorexia and bulimia combined.
  - BED is also more common than breast cancer, HIV, and schizophrenia.

Weight Discrimination in the Military

Bias and discrimination against men with overweight in the military

Health Psychology Open
July-December 2020: 1–8

DOI: 10.1177/2055102920985374
journals.sagepub.com/home/hpo
SAGE

Andrew Christian, Bina Parekh and Gilly Koritzky

Abstract

Research on weight-bias against men and/or in the military is scarce. Such a bias might cause some military members, who are otherwise fit to perform their duties, to suffer from discrimination and undue stress. We showed military personnel a picture of a soldier who had either normal weight or overweight. In both conditions, the description of the soldier stated that his physical fitness and job-related skills were good. Nonetheless, the soldier's suitability for promotion was rated lower in the overweight condition. These findings improve our understanding of the impact of bias on the mental and physical health of men with overweight.

Committee Hearing

Video:

[20220302 MLP Hearing: "Assessing the Effectiveness of Suicide Prevention Programs" (Youtube)]

Shame contributes to dysfunctional eating behaviors

Making Explicit and Addressing Shame in Eating Disorders

Negri, Attà; Milesi, Stefano; Andreoli, Giovanbattista;

2022

Abstract

Shame is an emotion that has begun to be recognized for its role on psychopathology and its impact on access to treatment. In patients with eating disorder (ED) pathology, this role and impact are certainly important because of the self and others' judgment towards the body. In this study we sought to intensively investigate shame through a narrative projecting test to detect the complex and multifaced expression of this feeling in ED patients. We used the Thurston Cradock Test of Shame (TCTS) to compare levels of internalized shame in 40 ED patients with levels of shame in 100 nonclinical individuals. ED patients' narratives had more shame contents ($F = 12.59$, $p = .004$), expressed more directly ($F = 8.18$, $p = .009$), with less aggressive defenses ($F = 5.54$, $p = .027$) and more maladaptive story resolutions ($F = 4.72$, $p = .046$). Results highlight the role played by shame in the maintenance of dysfunctional eating behaviors. Eliciting narratives with shame-related stimuli is one way to develop metacognitive skills about this highly disabling emotion in interpersonal relationships and build an effective working alliance at the beginning of treatment.

Limitations of recommending diets for weight loss

Army Ranger Studies

- Shows how individuals respond differently to dietary restriction

(Friedl et al., 1994)

Extreme differences in the response to energy deficit between individuals were demonstrated by two of the leanest individuals who completed the study. They both started at 6–8% BF, 75–77 kg body weight, and a body mass index of 24.5 kg/m^2 and completed the course at 4–5% BF, but one weighed 69 kg (−9.0% of initial body weight) and the other weighed 59 kg (−23.4% of initial body weight). These two men bracketed the full range of relative weight loss observed in this study. The young soldier with the highest weight loss also achieved the highest FFM loss (13.8 kg of initial FFM, or ~40% of his total muscle mass). Thus, relative to the other men, one was remarkable for his ability to adapt to the restricted energy intake and the other was remarkable for his failure to adapt. This highlights the difficulty of modeling weight loss due to restricted energy intake, especially in the absence of direct measurements or better predictors of individual metabolic responses (12, 28).

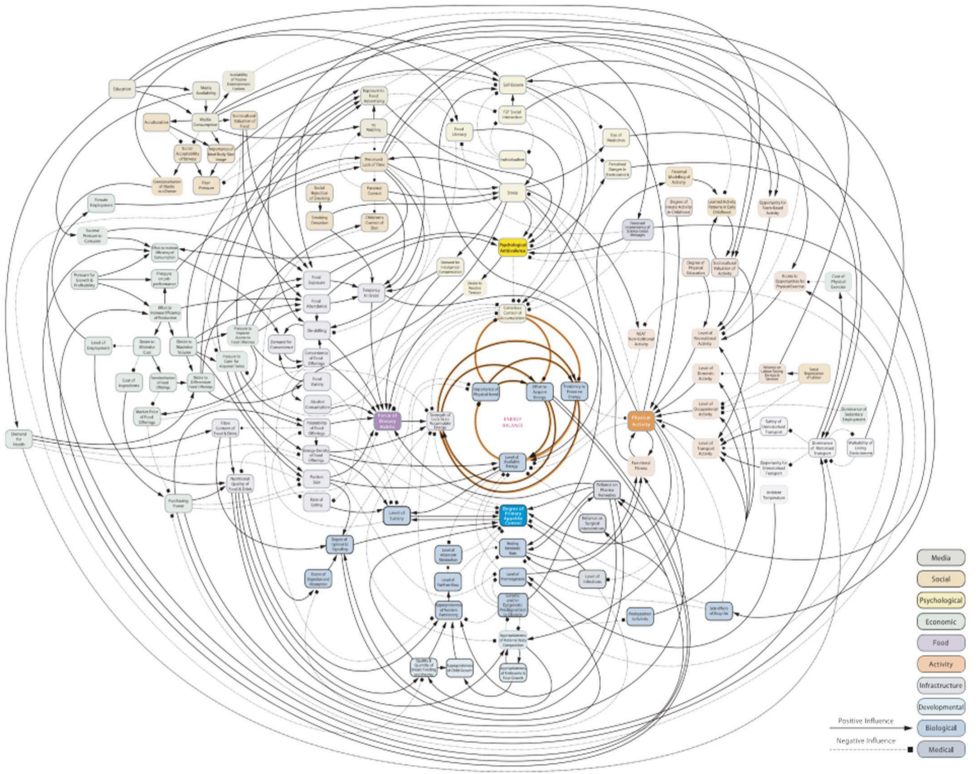
Obesity System Atlas

Weight is impacted by over 100 factors.

As the Ranger Studies illustrate, it is not as simple as calories in, calories out.

Not saying that calories “don’t matter”…but there are many limitations in our understanding of calories and body weight.

We need to be honest about what we actually know and don’t know.



(Vandenbroeck et al., 2007)

Muscularity Oriented Disordered Eating

Muscle dysmorphia (MD)

- Pathological pursuit of muscularity & pervasive belief that one is of insufficient muscularity (Murray and Rodgers, 2022)
  - Not related to one's actual degree of muscularity
  - Often observed in clients with a range of physiological dimensions…even those with significant muscularity (body image distortion)

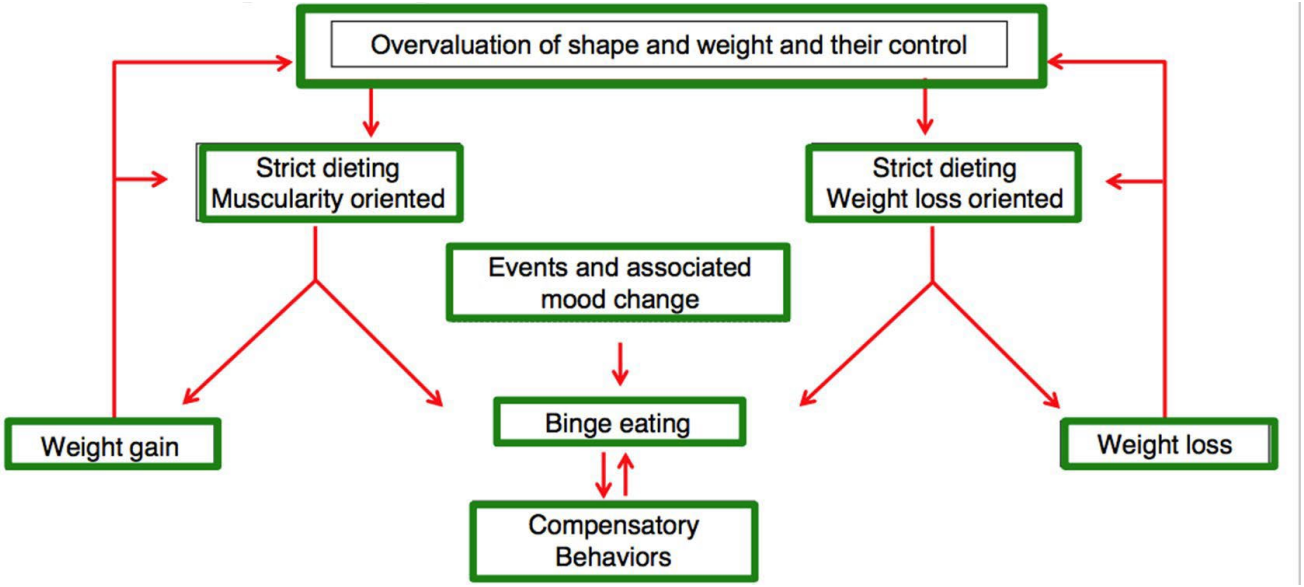
- Entry-level military: (Campagna and Bowsher, 2016)
  - Males: 12.7%
  - Females: 4.2%
- All genders impacted
- Societal impacts likely contributing to younger age of onset

Muscularity Oriented Disordered Eating

- Correlates:
  - Most robust correlate is eating psychopathology
  - Protein supplement use, Polysupplement use, Overexercise, strict meal portioning/planning (ex. chicken, broccoli, rice diet)
  - Trauma/Assault/Bullying Suicidality
  - Anxiety
  - Strong association with obsessive-compulsive symptomatology
- Sociocultural dimensions:
  - Internalization of the lean-and-muscular ideal
  - Media & interpersonal pressures
  - Appearance comparison

(Gruber and Pope, 1999; Murray et al., 2010; Pope et al., 1993, 1997)

Muscularity Oriented Disordered Eating



(Compte, 2021)

Muscularity Oriented Disordered Eating

Received: 4 March 2019 | Revised: 9 July 2019 | Accepted: 9 July 2019
DOI: 10.1002/eat.23144

ORIGINAL ARTICLE

International Journal of EATING DISORDERS WILEY

The development and validation of the muscularity-oriented eating test: A novel measure of muscularity-oriented disordered eating

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Muscularity Oriented Disordered Eating

1)	I have recorded the macro-nutritional values of everything that I ate.	0	1	2	3	4
2)	I have used meal replacement supplements when I felt full.	0	1	2	3	4
3)	What I ate has influenced how I think about myself as a person.	0	1	2	3	4
4)	There are definite foods I have avoided eating due to worry about how they might affect my shape or weight.	0	1	2	3	4
5)	I have felt less anxious about eating out if I knew the macro-nutritional content of the food at the restaurant.	0	1	2	3	4
6)	I have taken my own food out with me to social events in case the food on offer is inconsistent with my diet plan.	0	1	2	3	4
7)	I cannot achieve my body ideal unless I exert complete control over everything I eat.	0	1	2	3	4
8)	I have pre-cooked several meals in advance to ensure that I don't deviate from my diet plan.	0	1	2	3	4
9)	I have continued eating despite feeling full, in attempting to influence my muscularity.	0	1	2	3	4
10)	I have felt anxious when I run out of protein-based supplements.	0	1	2	3	4
11)	I have been deliberately trying to limit the overall volume of some foods, so that my muscles look more defined.	0	1	2	3	4
12)	If I broke any of my food rules, I attempted to make up for it at my next meal.	0	1	2	3	4
13)	I have felt anxious about others knowing the rules I have around what I eat.	0	1	2	3	4
14)	Other people don't seem to understand how important my food choices are to me.	0	1	2	3	4
15)	Ensuring proper adherence to my dietary ideals is more important to me than adhering to a work schedule.	0	1	2	3	4

(Murray et al., 2019)

Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances

2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influences by body shape and weight

E. The disturbance does not occur exclusively during episodes of anorexia nervosa

Bulimia Nervosa: Severity

- Severity:
  - Mild: An average of 1-3 episodes of inappropriate compensatory behaviors per week
  - Moderate: An average of 4-7 episodes of inappropriate compensatory behaviors per week
  - Severe: An average of 8-13 episodes of inappropriate compensatory behaviors per week
  - Extreme: An average of 14 or more episodes of inappropriate behavior per week

Bulimia Nervosa: Medical Considerations

- The recurrent binge-and-purge cycles of bulimia can affect the entire digestive system and can lead to electrolyte and chemical imbalances in the body that affect the heart and other major organ functions. Health consequences include:
  - Electrolyte imbalances that can lead to irregular heartbeats and possibly heart failure and death.
  - Electrolyte imbalance is caused by dehydration and loss of potassium, sodium and chloride from the body as a result of purging behaviors.
  - Potential for gastric rupture during periods of bingeing.
  - Inflammation and possible rupture of the esophagus from frequent vomiting.
  - Tooth decay and staining from stomach acids released during frequent vomiting.
  - Chronic irregular bowel movements and constipation as a result of laxative abuse.
  - Peptic ulcers and pancreatitis.

Anorexia Nervosa

A. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Anorexia Nervosa

- Restricting type:
  - During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self- induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

- Binge-eating/purging type:
  - During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Anorexia Nervosa: Self-starvation impacts

- Abnormally slow heart rate and low blood pressure, which mean that the heart muscle is changing. The risk for heart failure rises as the heart rate and blood pressure levels sink lower and lower.
- Reduction of bone density (osteoporosis), which results in dry, brittle bones.
- Muscle loss and weakness.
- Severe dehydration, which can result in kidney failure.
- Fainting, fatigue, and overall weakness.
- Dry hair and skin; hair loss is common.
- Growth of a downy layer of hair—called lanugo—all over the body, including the face, in an effort to keep the body warm.

Anorexia Nervosa: Diagnostic Markers

- Very possible to have normal labs
- Leukopenia
- Anemia
- Thrombocytopenia
- Dehydration = elevated BUN
- Hypercholesterolemia
- Elevation of hepatic enzymes
- Hypomagnesemia
- Hypozincemia
- Hypophosphatemia
- Hyperamylasemia
- If vomiting/abusing laxatives:
  - Elevated serum bicarbonate
  - Hypochloremia
  - Hypokalemia
- Low thyroxine & triiodothyronine
- Low estrogen (female)
- Low testosterone (male)
- Low bone mineral density
- Reduction in energy expenditure

Anorexia Nervosa: Associated Features

- Depressive signs/symptoms
- 4 C's
- Cold
- Crabby
- Constipated
- Concentration-poor
- Social withdrawal
- Insomnia
- Obsessive-Compulsive features
- Excessive exercise
- In Diabetes: may omit or reduce insulin to minimize carbohydrate metabolism
- Hypothermia
- Concerned about eating in public
- Feelings of ineffectiveness
- Strong desire to control environment
- Inflexible thinking
- Limited social spontaneity
- Overly restrained emotional expression
- Binge-eating/purging type= higher rates of impulsivity

Avoidant Restrictive Food Intake Disorder (ARFID)

An eating or feeding disturbance (e.g., an apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one or more of the following:

1. Significant weight loss (or failure to show expected weight gain or faltering growth in children)
2. Significant nutritional deficiency
3. Dependence on enteral feeding or oral nutritional supplements
4. Marked interference with psychosocial functioning

Avoidant Restrictive Food Intake Disorder: Diagnostic Criteria (cont.)

- The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice

- The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced

- The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

ED Warning Signs and Symptoms

Fearing certain foods	Decreased sex drive (seeking testosterone)
Describes diet cycling / restrictive eating	Repeated injuries/illness & Delayed recovery
Extreme mood swings	Menstrual irregularities (can occur even if no weight loss due to low energy availability)
Food rituals/fearing specific food types	Decrease in physical performance
Difficulty concentrating	Fluctuations in weight
Issues with dental, skin, hair and nails	Difficulty sleeping
Gastrointestinal malfunction	Issues with dental, skin, hair and nail health

ED Warning Signs & Symptoms (cont.)

Excessive & Rigid Exercise (can't miss a day)
Avoids eating around others
Preoccupation with weight, food, calories, body image, nutritional content
Refusal to eat certain foods, progresses to whole food groups and/or skipping meals
Obsession about appearance
May experience social withdrawal
Extreme mood swings, risky behavior, compulsive behavior

Potential Eating Disorders in Disguise

May report food allergy, gluten intolerance or irritable bowel syndrome symptoms but… • restriction of gluten may actually be disordered eating. • Symptoms of gastrointestinal distress after consuming gluten-containing foods may actually be result of gastrointestinal malfunction related to low energy availability
"I'm an athlete…my heart rate is always low"
Healthy eating to a fault ("Orthorexia") / "The Wellness Diet"
May state that "I'm not sick enough" for intervention/treatment
Symptoms can occur in any body size/shape

Avoid these common pitfalls

- Do not talk badly about any foods
  - All Foods Fit into a balanced, flexible eating pattern
  - Helpful strategy: Instead of telling clients to eliminate a food, listen for what is lacking in a person's dietary intake and encourage an increase in those items
- Be careful when providing dietary advice
  - Refer to appropriate individuals for nutrition counseling
- It is unhelpful and harmful to comment on any person's weight, body shape/size
  - Focus on actions that a person can take, for example
    - Walking to the mailbox
    - Improving sleep hygiene
- Be on alert if disordered eating/eating disorder symptoms are described/suspected
  - An individual's chance of recovery decreases as time goes by and symptoms often worsen without appropriate intervention

Bodies are complicated

- Weight
  - Health and Performance not as simple as BMI charts indicate
  - Weight cycling is a significant detriment to health and wellness

- Health
  - Focus on the factors that impact health
    - Move To Health is a great resource
  - Encourage engagement in health-promoting behaviors

Begin the Discussion with Clients/Patients

1. Do you feel like you have a comfortable relationship with food?
2. Do you feel like you have a comfortable relationship with your body?
3. Does food, or the thought of food, dominate your life?

- No to either of the first two questions and yes to the third raises concern for disordered eating behaviors and/or some form of body dysmorphia (may not be size/shape focused, of course; may reflect gender dysphoria or other forms of body/identity dysmorphia)
- If the screening questions are positive, particularly if ALL of them are positive, additional history must be obtained to further explore the patient's relationship with food and with their body.

(MAJ Luke Lindley, MD, FAAP at Madigan Army Medical Center Adolescent Medicine)

Recommendations

- Take warning signs seriously
  - Screen & identify
  - Refer all disordered eating concerns/take a team approach
- De-emphasize weight
  - Reduce stigma
- Explore your own values regarding weight, dieting, body image, and how that affects your practice
- Positive body and food talk
  - All foods fit - food neutrality!
  - Nutrients can be consumed with room for “fun” foods
  - Focus on nutrients that might be missing instead of recommending to “cut out” or “avoid” specific foods

Key Takeaways

- We are overdue for changes to height/weight standards
  - Our current system is hurting our service members
  - Our current system is NOT increasing health-promoting behaviors
  - We need regulations that foster improving health and physical performance and remove focus on weight/body composition
- Look at the whole person and their behaviors…not just weight alone
- Consider how to implement screening into your practice
- Don’t forget to listen to your male clients…their experience with eating and body dissatisfaction is being overlooked
- We cannot see disordered eating/eating disorders…individuals in all shapes/sizes can experience symptoms…it is key to listen and ask the right questions

Questions?

(istockphoto.com, n.d.)

Please remember, our clients that are struggling with disordered eating/eating disorders are fractured…not broken.

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