Eating Disorders in Veterans: Tools and Resources for the Primary Care Clinician
Webinar Transcript

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la-shell_johnson@med.unc.edu: Good afternoon, everyone. I would like to welcome you to today's webinar titled, “Eating disorders among veterans a novel tool for screening and referral in primary care”. A few things to note participants will be muted upon entry and videos turned off for technical assistance. Please use the Q & A feature located at the bottom of your screens.

la-shell_johnson@med.unc.edu: You will also receive an email approximately one month from today, requesting feedback and impact on today's presentation. As a reminder, we will have a ten minute Q & A session at the end of this presentation. Slides and materials from today's presentation will also be provided at the end of the webinar.

la-shell_johnson@med.unc.edu: I will now go ahead and introduce today's speaker. Dr. Christine Peat is the Director of the National Center of Excellence for Eating Disorders (NCEED), and an Associate Professor of Psychiatry at the University of North Carolina Chapel Hill, UNC.

la-shell_johnson@med.unc.edu: As Director of NCEED, Dr. Peat has focused on broadly disseminated education and training on eating disorders to the health care providers across a variety of disciplines. Her research centers on eating pathology across the spectrum, but with a distinct focus on B heating disorder.

la-shell_johnson@med.unc.edu: She's particularly interested in the intersection between obesity, bariatric surgery and eating pathology and investigating physiological comorbidities associated with eating disorders. Dr. Peat is also a licensed psychologist in North Carolina, and as such treats eating disorders across the spectrum. Given her background and behavioral medicine, she has also established clinical services in GI Surgery, where she provides both psychotherapy and behavioral medicine interventions to this patient population.

la-shell_johnson@med.unc.edu: In addition to our clinical and research responsibilities, Dr. Peat is also the Associate Director of Program Development in the Clinical Psychology Internship Program at UNC. I will now turn things over to Dr. Christine Peat.

Christine Peat (she/her): Great thanks so much, La-Shell. I appreciate it. Um, and thanks everybody for having me here this afternoon. I'm really pleased to be able to present on eating disorders specifically in a primary care setting that might be interfacing with veterans. I know we have lots of different folks who are with us here this afternoon. So, there should be plenty of time for questions at the end of today's session specifically for those of you that might have further questions about how to apply some of what we're talking about here today.

Christine Peat (she/her): Um. I'll also note that there will be a brief presentation from some of your colleagues here at Jesse Brown to kind of give you some more specifics for those of you that are looking to refer within the VA. Um, so I'll make sure to turn things over to Amy, towards the end of my presentation.

Christine Peat (she/her): Um! So again thank you for joining. I'm really happy to be here with all of you, and I just wanted to give you a quick overview of what I'm hoping we can achieve together here this afternoon. Um, first and foremost, just given the amount of misinformation sort of old stereotypes about eating disorders. I want to talk a little bit about evidence based tools or strategies for detecting eating disorders in your practice, and also a little bit about best practices for eating disorders in a primary care, setting.

Christine Peat (she/her): Uh, right just to introduce our center a little bit for those of you who maybe, uh may not be familiar with the work that we do. Um, our website is here at the bottom. This is just a quick screenshot. Um! We are a SAMHSA funded center that was founded in 2018. That is designed entirely to provide education and training on the management of eating disorders. We primarily do this work with healthcare providers. Um, but we also do some in terms of public awareness and just raising overall eating disorder. Literacy. Um, I'll, I'll give a highlight uh towards the end about some of the resources that we offer, but we certainly encourage you to visit our website to learn more about eating disorders and some more specific information for those of you that might be looking for treatment guidelines, those sorts of things all right.

Christine Peat (she/her): So, as a little bit of a level set when it comes to talking about eating disorders. One of the things I like to do is really kind of give an overview of the social and economic impact of eating disorders here in the US. Uh, these data come from a report that was published in 2020 through Deloitte Economics uh, in collaboration with the Academy for Eating Disorders and Striped, which are two uh notable eating disorder organizations here in the field.

Christine Peat (she/her): Um! What you can see on the left hand side of your screen are some current prevalence estimates with respect to eating disorders. Here at the US. Um! What we've learned through the Deloitte report is that roughly, 28 million Americans will struggle with an eating disorder at some point in their lifetime. This means that roughly, 9% of the US population will struggle with one of these conditions at some point. Um, and I think it's really important to highlight this kind of information,

because I think these numbers really stand in contrast to some of what we typically think about when it comes to eating disorders. I think a lot of times folks will think about these as conditions that are kind of rare. Don't necessarily affect that many people, but we know that isn't true. Um, somewhat troublingly. We also know that these are conditions that are life threatening um on the bottom left hand side of the screen. There you can see that the same report estimated that roughly, ten thousand people will die each year as a result of their eating disorder, such that one person will die every fifty, two minutes from an eating disorder.

Christine Peat (she/her): More importantly than that information, however, is that eating disorders don't discriminate, I think, for a long time we've had these stereotypes um about who might look like they have an eating disorder who might be affected when in reality we know that eating disorders can affect any age, race, gender, sexual orientation, gender presentation. And so it's important for us to be thinking about a really um, varied demographic when it comes to who we might be screening or thinking about. Um that might be struggling with an eating disorder.

Christine Peat (she/her): Uh, the other information that came from the Deloitte report were some estimates with respect to the economic burden of eating disorders here in the US. And I know that this is a busy slide. But I'll try to walk you through some of the information point by point. Um! What you can see here on the top left hand side of your screen is the total economic cost estimated in a single year to the US Economy. So, the Deloitte report found that the eating disorders cost the economy roughly sixty-four billion dollars in a year.

Christine Peat (she/her): These are treatment costs. These are other economic costs. Um, but all told, we're talking about a really staggering cost and something that really is um, you know, a sort of a public health uh concern. When you think about some of those costs and break them down. Um, we're talking about largely treatment costs. So, if you can see here on the bottom left hand side of your screen, there are really staggering numbers when it comes to things like ER visits in patient hospitalizations at two hundred and nine million dollars. Again, just knowing that eating disorder treatment is costly, especially when we're at those kind of highest levels of care.

Christine Peat (she/her): We also know, however, that there are um, other socio losses when it comes to eating disorders, so individuals who are adults might need to take time off from their jobs in order to engage in eating disorder treatment. Parents or caregivers may need to take time off from their jobs in order to provide care for a child or a loved one who might be ill. And all of these things collectively really underscore the overall impact of eating disorders here in the US. So collectively, what we're really saying is that eating disorders are common conditions that are life-threatening and incredibly costly to the US.

Christine Peat (she/her): So, when we think a little bit about these diagnoses, I want to just do a brief refresher about what we consider to be eating disorders. Again, I know that there are some pop culture terms. There are some terms that might get used in sort of a sub threshold kind of fashion, so I find it

helpful to make sure that we're doing um a little bit of a level set when it comes to the diagnoses that are currently um classified as eating disorders. So, the first that I'll highlight for you is a diagnosis that many of you may be familiar with. But some of you may not know of a diagnosis called Other Specified Feeding and Eating Disorder, and I'm intentionally starting with this diagnosis, because, especially in a primary care, setting, this is the diagnosis you are most likely to see. We really think about Other Specified Feeding and Eating Disorder as folks that kind of fall in this continuum of disordered eating. These might be folks that dabble with a handful of symptoms from that one diagnosis and a handful of symptoms from another diagnosis. They might not meet every single diagnostic criterion for some of the diagnosis that you're familiar with. But instead kind of have these sub-threshold presentations or kind of ping pong back and forth between different symptoms. And this, I think again to highlight it's important for you to be thinking about is what you will most likely see in a primary care setting. It's not always going to be a really frank presentation of Anorexia Nervosa, or Bulimia Nervosa. It's more likely to be someone who's describing, you know, maybe misuse of laxatives or diuretic somebody who's engaging in risky dieting behaviors that kind of fall on that disordered eating spectrum. The other diagnosis that you are very likely to see in a primary care setting, is what's called binge eating disorder. This diagnosis is characterized by recurrent episodes of binge eating. Now, when it comes to binge eating, I think sometimes there's also some misinformation here. So when we talk about what a binge eating episode looks like we're really talking about an episode of eating where an individual experiences a loss of control. They feel like they cannot stop meeting once they've started. Even if they wanted to stop feeling as though they can't.

Christine Peat (she/her): And it's that sense of loss of control that's really the hallmark for a binge eating episode, not just the amount of food that's being eaten, because some folks might eat a really large volume of food, and other folks might not eat nearly as much. It's that. It's the loss of control. That's really the hallmark of a binge eating episode. And so, folks with binge eating disorder are having these recurrent eating episodes where they feel out of control. Can't stop themselves sometimes multiple times a day, and then almost invariably feeling guilty shame, disgusted with themselves afterwards Again, very common in a primary care setting Anorexia nervosa is a diagnosis that I'm sure many of you in here are familiar with the defining feature here. However, is not so much the weight status of the individual, but more the intense fear of gaining weight, or an intense fear of being fat. In some respect, these individuals are so afraid of this weight gain, or of a higher weight than what they currently are that they'll do things to intentionally either lose weight or prevent weight gain.

Christine Peat (she/her): So that might be, you know, cutting out large amounts, calories, skipping meals, any kind of sort of dietary restriction is really what's kind of being driven by that fear of weight gain. So, some of these individuals might end up getting to a really low body weight. Some of these individuals may have precipitous weight loss. But one of the things I want to highlight for those of you working in a primary care setting, is that something called a typical anorexia nervosa is very likely to show up in your practice. And we really think about this diagnosis as sort of like anorexia nervosa in higher weight bodies. These are going to be individuals that have that same cognitive feature of being really afraid of weight gain, a really entrenched desire to lose weight. They may be engaging in the exact, same risky, dieting behaviors that someone of low weight might be doing. You know, folks may be

eating only 500 calories a day. They might be skipping multiple meals, doing things like a water fast, for you know, multiple days, or sometimes weeks in a row.

Christine Peat (she/her): But these folks often go undetected for their eating disorder because they're not underweight, or because they aren't necessarily showing obvious signs and symptoms of an eating disorder. So, I wanted to make sure to highlight this diagnosis here to make sure that those of you that are working in a primary care setting, are aware that this is a diagnosis that is very common in a primary care setting um, but can often go overlooked.

Christine Peat (she/her): Bulimia nervosa is another diagnosis that I'm sure many of you are familiar with and the defining feature. Here are these recurrent binge eating episodes similar to what we talked about with binge eating disorder. However, these binge eating episodes are paired with what we would call inappropriate compensatory behaviors. So these are going to be things like self, induce vomiting abuse of laxative diuretics, sometimes compulsive exercise, enemas, fasting. The idea here is that these individuals are pairing a binge eating episode with one of these behaviors in an attempt to kind of make up for the Binge eating episode, or to kind of cancel out the calories that they ate during a binge.

Christine Peat (she/her): The other diagnosis that some of you may not be familiar with is what's called avoidant restrictive food intake disorder, or ARFID, and the defining feature here is an eating or feeding disturbance that is manifested by a persistent failure to meet nutritional needs. So, these are folks that are simply not getting in the caloric intake or the nutritional intake that they need on a daily basis. Some of you might be thinking well, that sounds an awful lot like anorexia nervosa. How might this be different from that diagnosis? And the real difference here is the cognitive presentation.

Christine Peat (she/her): These are not folks that are driven to lose weight. These are not folks that are afraid of gaining weight or becoming fat. These are individuals who simply fail to meet their nutritional needs, and it can be for a number of different reasons. There are some proposed kind of subtypes for ARFID. Some individuals just simply lack an interest in food. They just don't find that they're motivated to seek out food on a regular basis. Some individuals find that they have issues with the sensory characteristics, with food. So that might be difficulties with texture, color, smell those sorts of things. And then some folks have had really aversive experiences when it comes to their eating, so they may have had a choking accident. Maybe they've gotten really nauseous after eating um. And so these individuals um have these sorts of experiences that make it hard for them to meet their nutritional needs. I want to note here this isn't sort of a one off thing I forgot to eat this morning, or I don't like a particular food because of the texture it is.

Christine Peat (she/her): It's really a more pervasive pattern that can lead folks to be malnourished, and sometimes have really significant weight loss that would require hospitalization.

Christine Peat (she/her): So when we think a little bit about warning signs for eating disorders. I'm not going to read all of these that you have these here in front of you. But, what I will note is that any of these signs here might be considered red flags for an eating disorder. They're certainly not going to be sufficient to die. Know someone with one of these conditions. But these might be things that we would encourage you to kind of perk your ears up a little bit and be considering. Okay, if I have a patient who's talking about these sorts of things, or I see evidence of these sorts of behaviors. I might want to show some degree of curiosity, and follow up with some additional questioning to rule in or rule out an eating disorder Diagnosis.

Christine Peat (she/her): For example, some of the common symptoms and medical complications associated with eating disorders are going to be listed here on the next couple of slides. One of the things that I will note, however, is that pretty much any body system can be affected by an eating disorder depending on that diagnosis. Some of the more common symptoms or more common complications are going to be listed on these slides, but this is also not an exhausted list. The majority of our patients will talk about having just some degree of fatigue or general delays. They just typically don't feel well.

Christine Peat (she/her): We have folks that might struggle with temperature dysregulation. There can be all kinds of cardiovascular or metabolic effects from the eating disorder. And one of the other things I'll highlight here is the GI complaints are pretty common with our folks, or nearly ubiquitous. I would say the vast majority of our folks have come in complaining of some kind of GI symptoms that might look a lot like a functional GI disorder, constipation, bloating diarrhea, all of these sorts of symptoms.

Christine Peat (she/her): And that doesn't mean that you can't have an eating disorder and a GI disorder. I think it just takes some really careful assessment, though, to kind of rule out what might be stemming from eating disorder behaviors, and what might kind of be more genuine GI complaints.

Christine Peat (she/her): Uh, one of the other things I'll also highlight here is that there tends to be pretty significant psychiatric comorbidity associated with eating disorders. So what you can see here on the bottom of the screen, are some estimates of anxiety and depression that tend to be comorbid with eating disorders. As a clinician, I'm really hard pressed to think of a single patient that hasn't struggled with anxiety or depression, while they also have had an eating disorder. So I think, given that many of you are likely to already be working with folks that have these co-morbid diagnosis, it's also worth thinking about whether or not some of those patients are also at risk for an eating disorder. I'll also note that substance use disorders tend to be comorbid with eating disorders. The numbers that you see here are likely to be underestimates, because I think there's a lot of reason to not report substance use disorders, and frankly eating disorders, whether that's in a research context or clinically.

Christine Peat (she/her): But these are particularly challenging comorbidities, especially if we have folks that might be eating very little throughout the day, and then, let's say, drinking large amounts of alcohol in the evening. And then having all kinds of sequeli after that. So again, just something I think is important to have on your radar, especially if you're taking care of some of these folks that are already struggling with a substance use disorder.

Christine Peat (she/her): One of the things that I'll do in the next couple of slides is highlight some of the impact of eating disorders that I think is often overlooked, or really not thought about a lot. And so, the World Health Organization did a survey across 14 countries of varying income levels and they specifically honed in on binge eating disorder. But, I think certainly these data could be extrapolated to other eating disorder diagnoses. These individuals were administered the SHE and Disability scale which assesses illness, severity in each of four different domains.

Christine Peat (she/her): And what you can see here on this slide on the left hand side are the different domains, and which individuals might be experiencing some degree of impairment, because of their particular diagnosis or their illness. And in this case it's been cheating disorder. So you can see that folks might be reporting impairment in their work, life, their home life for their social life because of their binge eating. And what you can see is that based on this study around half of individuals within binge eating disorder were reporting some degree of impairment in one of these areas, with 13% reporting severe impairment due to their binge eating disorder. And this was particularly notable in individual social lives, with 38% reporting some degree of impairment and 8% reporting severe impairment in their social life, because of their eating disorder. And, I highlight this information because I think it's important to really recognize that eating disorders are not conditions that just affect your relationship with food and your body. These are conditions that really have a global impact on your life. These are things that can really impair someone's quality of life, their daily interactions with their friends, their family, their colleagues. And, this is especially true when it comes to your social life, because we know that eating disorders are conditions that thrive in secrecy. Um! The more you can conceal your eating disorder, the more that you can withdraw from your social connections, it just gives more room to that eating disorder to flourish. So you can imagine that if you're really trying to conceal these conditions, one of the first things that you might do is really drop from the people that are there to support you, even though that could be something that's really beneficial for you in the long run.

Christine Peat (she/her): So when it comes to talking again about these diagnoses and the impact that they have on individuals. I really want us to have a shared vision of who we're talking about, and we discuss who's at risk for an eating disorder. For the longest time we've had this predominant stereotype of a young cisgender, and white woman who is struggling with let's say anorexia nervosa, and that's really the mental image that not only the general public, but often health care providers have in mind when they think about eating disorders. But, in reality we know that the eating disorder landscape, it tends to look more like the folks that you see here pictured on your screen. It's folks from every walk of life, everybody, weight, shape, and size, every race and ethnicity. So when we're thinking about who to be screening, who might be at risk. This is the image I really want us to have in mind, and I think it's also

particularly important to keep in mind that there are some racial and ethnic groups that might actually be at increased risk for eating disorders.

Christine Peat (she/her): So, what you can see here in the middle of your screen is this kind of third bullet point here towards the bottom. There was a study that was done in a community based sample, so not a clinical sample, not a treatment seeking sample, and they found that binge eating disorder in particular, was actually more common among Latina and African American women than among their white counterparts. So there is a growing body of evidence to indicate that there are some forms of eating pathology that might actually be even more prevalent in racial and ethnic minorities.

Christine Peat (she/her): In addition to that, we also know that, unlike other medical and mental health conditions, men are actually the minority when it comes to eating disorders, but that doesn't mean that they don't struggle with them. Um, especially when we think about sub threshold eating disorders, or kind of that OSFED presentation that we talked about. We know that eating disorder um behaviors and eating disorder diagnoses are nearly as common among males as they are among females. So again, when we're thinking about screening or good clinical care, we want to be thinking about everyone in clinical practice, and not just kind of who fits that old stereotype.

Christine Peat (she/her): For those of you that might be working with transgender communities, I think it's also important to note that these are individuals who might be at an increased risk for eating disorders. There was a study that was done a few years ago, looking at the prevalence of uh eating disorder uh behaviors in the in transgender teens and young adults, and this study estimated the prevalence around seven, although I think certainly that could be an underestimate for lots of reasons. Um! But one of the things I think is important to be thinking about is the extent to which folks are engaging in eating disorder behaviors in an attempt to try and address some of that gender dysphoria that they're already experiencing. This is particularly pronounced in teenagers and young adults who might be trying to suppress puberty so that they can suppress those secondary sexual characteristics. But many adults may also be engaging in eating disorder behaviors with a similar motivation of trying to prevent their body from appearing in a way that is discordant with their gender identity.

Christine Peat (she/her): Despite all of that, however, I do think uh, it's worth noting that eating disorders can also occur separately from body image concerns. It's not as though that's the only reason that trans individuals might be engaging in eating disorder behaviors. So, a few things to highlight there in terms of recognizing that these folks might be at increased risk. Particularly because some of the gender dysphoria has been appropriately addressed that the eating disorder will just magically go away. There are lots of folks that will continue to struggle even after being able to obtain gender-affirming care.

Christine Peat (she/her): Given that this presentation here is for those of you that work in the VA. I also wanted to highlight some information that's specific to this patient population. And these data are

actually in an infographic that is available on our website, and at the end of this presentation, but I just wanted to highlight a few things about the prevalence of eating disorder specifically in service members, veterans, and also their families. I went back a slide. There we go. So one of the reasons that we are particularly concerned about eating disorders and active duty folks, is the extent to which there are pressures to be engaged, and really high levels of physical activity. There are certain weight requirements for service members. And so, there can be pressures to engage in really risky dieting behaviors. Things like self-induce vomiting really significant caloric or dietary restriction. And so, we know that because of those demands. These folks are already at increased risk for eating disorders.

Christine Peat (she/her): But we also know that there are many conditions that are associated with eating disorders that are also more prevalent in active duty service members and veterans. So things like major depression, PTSD, a history of sexual trauma. All of these things we know in the general population can predispose folks to eating disorders.

Christine Peat (she/her): And one study found actually that there was a 26% increase in eating disorder diagnoses among military personnel in the years from 2013 to 2016. I think this was just a sort of cross sectional study that they were looking at, and I think it's also important to note that it's not just the service number or the veterans themselves might be struggling, but also their spouses and their children. There has been more robust study of eating disorders among spouses and children of service members and of the service members themselves.

Christine Peat (she/her): But, we know that these folks are experiencing eating disorders at three times the rates of their civilian peers. And you know there have been a number of reasons why this sort of thing might be happening, and I'm happy to talk about those towards the end of the presentation. But I don't have to tell many of you in this audience that these are folks that are experiencing really high degrees of stress, especially when they have a loved one who's deployed. These are folks that might not be, you know, living in a city for a particularly long period of time, and uprooting your life, but everything that that it entails. So in as much as stress might be an exacerbating factor for some of these things. We know that military families are certainly not spared from an onset of eating disorders.

Christine Peat (she/her): We also know that male veterans, with a history of military sexual trauma, are twice as likely to have an eating disorder compared with female veterans. And interestingly, veterans with bulimia nervosa. I'm sorry veterans experience bulimia nervosa at three times the rate of their civilian peers. And you know again, I think some of the reasons why this might be happening are certainly worth discussing as a larger group. But some of what we've heard from individuals is that as they transition out of active duty into being, you know, veteran. They may still be eating in a fashion that predisposes them to binge eating. So, maybe eating really quickly, not necessarily paying attention to hunger and satiety queues. But that physical activity requirement has now gone away, and so they may see rapid changes in their weight, and because of that weight gain, they may be vulnerable to engaging in some of those risky, dieting behaviors.

Christine Peat (she/her): For example, we also know that, unfortunately for those individuals that are experiencing eating disorders, seeking care can be really tough. This is true in the general population, but also particularly for veterans. In fact, only 35% of eating disorder treatment centers across the country even accept tri-care, which is a major barrier to actually receiving the treatment that's needed. And, so when we think about some of those gaps in care. I think it's really important to be thinking about how we make sure that our veterans are receiving of care that they need either in the VA sytem, or thinking of other creative solutions that would allow them to access other specialty services.

Christine Peat (she/her): So then, when we think collectively about where we are when it comes to the state of affairs for eating disorders. We know that these are conditions that again are life threatening. In fact, they have the second highest mortality rate of any psychiatric illness, really secondary only to opioid use disorder. And unfortunately, many of this folks are going to die by suicide, and as much as we know that veterans are already at increased risk for suicide. Many times, I think we're talking about populations that overlap, and in more challenging sort of circumstances.

Christine Peat (she/her): We also know that those with eating disorders are um maybe only sort of at best, fifty percent likely to receive the treatment that they need. These numbers are based on civilian populations, but I think it certainly could be mirrored in a veteran population. And we just know that for many reasons, treatment seeking can be really challenging whether that's insurance status, geographical location, all of those sorts of things.

Christine Peat (she/her): So when it comes to the barriers to detection. What are some of the things that get in the way? Well, I think first and foremost, some of what we've already talked about those stereotypes about eating disorders um about who might be affected, who looks like they have an eating disorder. But I think that's also true on the health care Provider side. We, as providers oftentimes have images in our mind about who might be struggling with a particular condition, or who is at risk. But the reality is that when it comes to eating disorders, the vast majority of our folks are going to be asymptomatic, or they won't have up obvious signs or symptoms. They may not look like what sort of that stereotype has been. So, I think it behooves us to kind of challenge some of those long held beliefs that we've had.

Christine Peat (she/her): We also know in general, folks tend to be much more comfortable talking about their physical health symptoms than their mental health symptoms. If we're talking about anxiety or depression, for example, many individuals feel much more comfortable talking about having upset stomach, or headache, or difficulty sleeping, which are very common symptoms for anxiety and depression. But they're less likely to talk about feeling lonely or sad, or feeling as though they're in some state of despair. The same is certainly true for eating disorders where folks might be much more comfortable, especially in a primary care setting, saying, you know, “Listen, Doc, I just have been really

concerned about my weight or my relationship with food. And you know I'm wondering if we can talk about a medication, for example, versus talking about these intrusive thoughts about food, eating calories being unhappy with their weight and shape uh those sorts of things. And then also, as I've mentioned before, there's a real reluctance to disclose symptoms. Many individuals just don't feel comfortable talking about their eating habits or their body, and the eating disorder actually encourages that. It encourages secrecy and not talking about these symptoms. So again, lots of different barriers to be thinking about.

Christine Peat (she/her): Um. I think that for those of you that are engaged in this kind of work, whether you're screening folks or you have folks in your care who you're concerned about may have eating disorder symptoms. It's important for you to be aware that it is very common for folks that are struggling with these conditions to not have really good insight or awareness of their symptoms. So what may be a real red flag for you as a clinician may not even register for folks that are struggling with eating disorder symptoms.

Christine Peat (she/her): It's very common for those of us in specialty settings to hear things like, well, I probably don't have an eating disorder. I don't need to be in the hospital, right? It can't be that serious, or everyone is dieting all the time. How is what I'm doing any different from what everyone else is doing? Even on the more extreme end, we've heard people talk about having regular syncable episodes, or having, you know dizziness or other kinds of physical symptoms. And they say, well um that was yesterday. I'm, I'm feeling okay today. I'm sure this isn't an eating disorder. So, I think it's important that as a clinician, if you are identifying red, you're not necessarily buying into what the eating disorder is saying, but that you are recognizing.

Christine Peat (she/her): Listen. This is a warning sign. I'm concerned about this, and here's why I'm concerned. One of the really tricky things, however, is that oftentimes when you're working with these folks, and if you draw their labs, their labs are going to be perfectly stable. This is a common problem with folks with eating disorders. Because they'll look at those lab values and say, well, everything is within normal limit. So, I must be fine. But the real challenge, of course, is that there isn't a lab value for eating disorder, right. There isn't a way for us to tell based on a blood draw, whether or not, you have one of these conditions above and beyond that. Even if you're engaging in some behaviors that could throw off some of those lab values. A lot of times they don't end up getting picked up on the labs because the body is incredibly resilient, and it's designed to kind of provide homeostasis. So again, I just provided some of this context here, so that you are prepared that even if you identify signs and symptoms that are concerning it may not necessarily be concerning to the patient that you are working with.

Christine Peat (she/her): The good news, however, is that if you are especially working in a primary care setting. There's some real opportunities to make an impact on that course of someone's illness, because we know that the early detection is key. It's really rare for patients to wake up one morning and say, I

have anorexia nervosa. I'm going to go to you and seek and get treatment. It's much more likely that they're going to be discussing with you as their primary care doc, problems with their weight or concerns about. You know their dietary intake, those sorts of things.

Christine Peat (she/her): And so, given that you're already a part of that care team and you have an existing relationship. You can really leverage that relationship to open the door to this conversation, to really help kick, start treatment. And as with most things, we know that the earlier we can diagnose and provide treatment for an eating disorder, usually the better the prognosis.

Christine Peat (she/her): So some of you may be wondering how we can screen for these conditions. What are some of the evidence-based screeners that we have that are appropriate for use in a primary care setting. I've listed three of those here. So the SCOFF, the eating disorder screen for primary care, and the Binge Eating Disorder 7. The first two are designed to provide screening across all eating disorder diagnoses. The last is specific to binge eating disorder. Just as I'm sure it was clear from the name. The SCOFF items are represented here, and what you can see it is the five item measure that is designed to assess specific eating disorder behaviors that might flag an eating disorder condition. So, things like making yourself throw up, losing significant amounts of weight in a relatively short amount of time. And the typical scoring convention is, that if a patient says yes to two or more of these items that would be considered a positive screen.

Christine Peat (she/her): The same is true for the eating disorder screen for primary care. But if you're looking closely at the questions here, you can see that these items are actually a little bit more broad. They're less symptom specific. So questions like, Are you satisfied with your eating patterns? Does your weight affect the way that you feel about yourself? There's kind of a nod to a past personal history of an eating disorder, or a family history of an eating disorder. Similar though, to the SCOFF, if a patient says yes to two or more of these questions that would be a considered a positive screen.

Christine Peat (she/her): You can see that there are two questions that have an asterisk next to them. And these indicate which items are the most sensitive of these five. There was a study that was done a handful of years ago, looking at you know sort of the overall sensitivity of this measure, and which items kind of gave you the most bang for your buck, and it's that first one and the third one. So, really thinking about these two as the most sensitive at picking up eating disorders in a primary care population.

Christine Peat (she/her): The questions for the Binge Eating Disorder 7 are presented here. I'm not going to go through and read each of these to you. But suffice it to say, the questions here are designed to determine whether or not someone is experiencing those recurrent binge eating episodes that we talked about. So, having that sense of loss of control, feeling as though you can't stop yourself. How often those episodes having happened. Those sorts of things.

Christine Peat (she/her): The good news is that for those of you that are interested in doing more regular screening among your patients, the National Center of Excellence for Eating Disorders has developed an entire protocol that within two to three clicks will give you everything you need to screen. Briefly intervene, and then refer patients to treatment. Many of you here may already be familiar with the SBIRT framework, you know, screening brief intervention and referral to treatment, as it is commonly used in substance use disorders. It was actually originally developed for alcohol use disorder, and it gave clinicians a way to screen. For these folks, provide kind of a brief intervention, but then get them referred to the specialty care that they might need. So, we've taken that existing evidence-based framework and simply swapped out the content, so that it's relevant for eating disorders. So at the website that you see listed there at the bottom of the screen, you will get access to the SCOFF, which is an evidence-based screener that has been deemed appropriate for use in primary care. We have given you brief intervention in the form of basically brief counseling that you might do with a patient. And then giving you everything that you might need to get folks referred to treatment. Again, I want to highlight that Amy will be talking here at the end of the presentation to give you some VA specific ways to get folks referred. But, in the absence of that the SBIRT for eating disorders protocol really gives you everything that you might need to get a patient referred to the type of specialty care that might be indicated based on their geographic location, their insurance status, all of those sorts of things.

Christine Peat (she/her): I do also want to note that we developed this protocol in collaboration with our primary care colleagues. We're eating disorder specialists, I'm not in primary care to often. So, we wanted to make sure that as we were building this, it made sense for your scope of practice and the type of work that you do.

Christine Peat (she/her): So, one of the things we commonly heard from our PCP’s was that they're perfectly happy to screen. This is something that they do on a regular basis. But if they're gonna screen, they need to be able to demonstrate that they've done something if a patient screens positive. And so, that's kind of where that referral to treatment mechanism came in. Where, basically it would prevent clinicians from having to Google search for options, or look for things that you know might not be as up to date or something like that. And so, we've taken all the guess work out and given you access to a searchable database.

Christine Peat (she/her): The other thing that we often heard from our PCP’s was sort of a desire of what to say in the room, and I don't know how to have this conversation. I'm worried if I say something, it's going to make them feel worse. So that brief intervention component is where we've given you basically conversation, snippets, or scripted prompts of how you might start this conversation with your patient, based on which questions they said Yes to in that screener. So again, this is designed to kind of be a comprehensive protocol that within a couple of clicks, gives you everything you might need to screen and then get folks referred or get that specialty care.

Christine Peat (she/her): So when you're thinking about how you might detect some of this in primary care practice you know, in in collaboration with the screening tools, folks that are discussing any frank concerns about their weight or shape would certainly be folks that you'd want to be thinking about. If you have patients that are telling you sort of out of the blue that they've decided to go vegan, or vegetarian in a way that is inconsistent with the way that they typically have been eating again; these are not sort of sufficient criteria to diagnose an eating disorder. But you might want to show some degree of curiosity here. If you're showing if a patient is demonstrating any changes in their weight, either weight up or down, irrespective of their starting weight. It would also be a reason to sort of lean in and say, listen, I notice your weight has changed here from the last visit. Tell me a little bit about what's going on there. Right?

Christine Peat (she/her): We've talked some already about considering these comorbid diagnoses in terms of folks that might be at greater risk for eating disorder development.

Christine Peat (she/her): Of course, if you talk to any of us who are specialists, and you ask who should be screened for eating disorders, we're going to say everyone. But we know that that isn't, always feasible, depending on the scope of practice and sort of the nature of the practice. But, uh, we thought it'd be worth highlighting a few high risk groups in case you're thinking about specific individuals that you might want to be screening. So, for any of you that are working with adolescents. Certainly, we know that there are increased risk for eating disorder onsets, patients and key transition periods. So, if you've got folks that are graduating high school, getting their first job, maybe moving to a new state. All of these things can be really happy, really exciting times for individuals. But, they can also be really stressful. And we know that stress just makes the ground really fertile for eating disorder development. So, you want to think about those folks in particular.

Christine Peat (she/her): Also, any patients with medical morbidity, the list that's here is not exhaustive. But thinking about some of these folks that increase as folks with increased risk. Particularly folks with type, one and type two diabetes. We know that they are at risk for engaging in eating disorder behaviors if you're working with athletes. Certainly anybody with a family history of eating disorders. Patients that are explicitly seeking help for weight loss, and we know that one of the major risk factors for eating disorder development is a history of being overweight, history of obesity, history of any kind of dieting. So, given the overlap there, as we're thinking about screening that group in particular.

Christine Peat (she/her): So, if you're a clinician and you suspect that there's an eating disorder in one of your patients, what are you gonna do next? We've talked a little bit about that screening piece. One of the other really key roles that, I think, is um important to highlight for those of you that are working in primary care is your ability to kind of help increase motivation for seeking that kind of specialty care. We know that when physicians and other medical professionals are expressing concerns that are about their physical health oftentimes this can be a little bit of a wake-up call.

Christine Peat (she/her): If you have a patient who is abusing laxatives, or misusing in them in some way. And you explain, listen, this is actually really risky for your health, and this is part of why I'm concerned. Sometimes that in, and of itself is enough for someone to say. I had no idea it was that dangerous. I didn't realize that using laxatives in this way could be challenging for my health. Or if you're talking about over exercise, for example, or under eating, with the amount of exercise you're doing; expressing some of those concerns in a way consistent with the other care that you're providing can oftentimes really help increase motivation.

Christine Peat (she/her): We also know that you may be involved in um sort of the ongoing management of this patient, if they do end up seeking specialty care. So, this doesn't mean that you are the care provider for the eating disorder. But one of the things that is crucial in eating disorder treatment, is the ongoing medical monitoring of a patient which you may end up playing a role in.

Christine Peat (she/her): So, when it comes to making those referrals to a specialty care center. I provided you again with the hyperlink to our screening tool, which will give you access to that same sort of searchable database. If you are that referring provider, though, I think it's important that you're prepared for some degree of ambivalence, or maybe even reluctance, to accept that type of referral. Because, folks may just not be ready to address the eating disorder. They're still really entrenched in those behaviors, and they're not quite ready to seek specialty care for that. And as we've discussed before for access to eating disorders, care can be really challenging. So, I think, having some degree of patience and perseverance is well worth it in these circumstances.

Christine Peat (she/her): Also, when it comes to making those referral to specialty care, there are a few other things to be aware of. There may be not only patient or parent resistance to seeking this kind of care. But depending on where you live, it may require coordinating out of state care. And that's a whole other sort of nuance and wrinkle that can make things more challenging. In the wake of the pandemic, that availability has been a real crisis. And so, we have incredibly long waiting list, especially at those higher levels of care.

Christine Peat (she/her): And insurance coverage, as I mentioned at the beginning, can be a real challenge, especially for folks that are covered by Tricare. I hate to sort of paint such a negative picture, but I wanted to make sure this information was in front of you. So, that you're prepared for some of the hoops that you may end up having to jump through to get your patients connected with the care that they need.

Christine Peat (she/her): The one piece of good news here, however, is the SERVE Act was passed as part of the fiscal year, 2022 National Defense Authorization Act. This bill allows military families to

receive residential eating disorder treatment up to age 65, instead of capping it at age 20. Prior to this time there was a real difficulty in getting services for the families, or for the children of military members, or for a veteran when it came to their eating disorder treatment. So there has been at least some good news in terms of increasing access to care. Of course, this mostly focuses on the family members of those who are serving. But, there are other legislative efforts that are happening to help increase access to care for the actual service member or the veteran when it comes to the levels of care and what treatment might look like.

Christine Peat (she/her): I just wanted to kind of give you a quick, rundown. It's very similar to other mental health conditions where there's everything from outpatient care all the way through, inpatient and kind of everything in between. And really, this depends on the patient symptomatology in terms of where they land in this mix.

Christine Peat (she/her): The treatment itself, however, tends to be highly, psychologically based. There really aren't many medications. When it comes to treating eating disorders, there are a couple of notable exceptions at the bottom of the screen. But, treatment is largely psychological interventions. So cognitive behavioral therapy, which I'm sure many of you are familiar with, has been adapted for a trans diagnostic eating disorder treatment for children and adolescents with eating disorders, is something called family based therapy is really the gold standard.

Christine Peat (she/her): I will note that this is different from family therapy. It's really an eating disorder. Specific family based therapy that we're talking about here. Um, but there are a couple of medications that have been indicated for use for eating disorders. So, with lisdexamfetamine is on label FDA approved as a monotherapy for binge eating disorder and fluoxetine has been FDA approved for the treatment of bulimia nervosa as well.

Christine Peat (she/her): One of the silver linings of the pandemic has been an increased access to virtual care. So, in the way that we're engaging here, this has also been the landscape for many patients over the last couple of years. And several eating disorder groups now provide eating disorder treatment entirely virtually so Equip Health, Arise, and Within Health, are three groups that have kind of popped up in the last couple of years that are providing evidence based eating disorder, multidisciplinary care. But, in an entirely virtual format which does help to really increase access to care, especially if you don't live in a really resource rich area. So, I've hyperlinked all of those here for you all to take a look, and again you will have the slides. After today's presentation, you'll have access to all of this information.

Christine Peat (she/her): But, when we think about eating disorder treatment as a whole. We really think about it as a four legged stool where folks need psychotherapy. They need medical nutrition therapy. Sometimes psychotropic medications for either the eating disorder itself, or for comorbid conditions. But they also need primary care, because they need their physical health monitored on a

regular basis. So, that's part of why we really see our primary care colleagues as crucial to the treatment of an eating disorder.

Christine Peat (she/her): So if you are in a position where you're working with a specialty team, there are a few things to keep in mind. So, one really making sure that there is good and consistent communication with the specialty team. I can't underscore this enough. If one treatment provider is saying something like, it's fine to exercise no big deal, go ahead. And the other treatment providers are saying, absolutely not. You're not at a place that's ready for that split between the team. This just allows the eating disorder to continue to flourish. So, it's important that there's regular and cons assistant communication between team members, so that we're giving a unified message to the patient.

Christine Peat (she/her): Also making sure that you're understanding the difference between referring to a special team for evaluation versus treatment. So, you may end up referring a patient thinking, okay, this team is going to pick my patient up for ongoing care. But, that team may not necessarily have the bandwidth to keep that patient on an ongoing pre-treatment program. But instead, may be able to simply do the evaluation to rule in or rule out a meeting disorder diagnosis and then get them referred to other community partners, for example.

Christine Peat (she/her): So, for those of you that are interested in learning more, I mentioned at the top of the presentation that our website has a variety of resources, one of which is this filterable resource library that you can use at that will. This is all available on demand. We have recommendations from you know, the American Academy of Pediatrics. We have treatment guidelines, and you can filter these based on your stakeholder type. We also have a variety of free online courses that you can access again on demand. We have a number that are focused specifically on primary care. If you visit our website, you can get easy access to those.

Christine Peat (she/her): I also wanted to leave you with a few QR codes, one specifically to the SBIRT for eating disorders protocol and that infographic that I mentioned with all of the data about eating disorders among service members, veterans and their families. Again, you'll have these QR codes in the slides later.

Christine Peat (she/her): With that I do want to transition over to Amy, who, I know, has a few slides to share with you with respect to how you might get somebody referred over in the VA. So, Amy over to you.

Amy Kienow-Paychek: Great. Thank you so much, Dr. Peat. I really appreciate you being here, and really such a lovely, comprehensive overview of the scope of the challenge of eating disorders and treatment. So I'm going to share my screen here and line up. You should be able to see the Jesse Brown eating

disorder treatment team. Could one of the panelists unmute themselves to let me know if you see that. Okay, yeah. Now we've got it. We got it now. Okay, great, great.

Amy Kienow-Paychek: So, this is our team at Jessie Brown. I am the Eating Disorder Treatment Coordinator as well as a Women's Health Clinic Social Worker. We also have Dr. Hazeghazam on the team as the psychiatrist, Hannah Doelling, is the clinical dietitian, Dr. Bonnie Yap, one of our psychologists, and Dr. Sarah Catanese.

Amy Kienow-Paychek: So there's a couple of different ways to reach us. If you do suspect that your patient is struggling with an eating disorder, and you've done screenings and tools, you can place the consult. They're available on multiple menus where the outpatient eating disorder treatment console is the name of the consult, and you can place it on the mental health menu. It's available on that menu as well as the women's health on the Jesse Brown, main, outpatient conflict menu and the nutrition consult menu.

Amy Kienow-Paychek: And then this is a little bit about our treatment referral process. So once you send over the consult to me, I can then screen the veteran, discuss the different program options, engage their interest and motivation to working with us, specifically on reducing eating disorder behaviors where you will come in is a medical event. Evaluation with labs needed to ensure medical stability for outpatient care, but also to see if we're not missing something else. That might be a miss.

Amy Kienow-Paychek: Then the eating disorder and nutritional assessments need to be completed by myself and Hannah, and then treatment recommendations will be made by the team. Now, if a person's eating, this sort of behaviors are very challenging, very severe, I will work with that person to get them to a higher level of care outside of the VA, by using community care.

Amy Kienow-Paychek: This is a slide that outlines the different types of labs that will be required for the person as outlined by the Joint Commission.

Amy Kienow-Paychek: So you may see that request from me, and you might see that request in a person's chart uh for you to order labs as the primary care provider. And then here is an outline of really the types of treatment we can provide at Jesse Brown.

Amy Kienow-Paychek: So, initially, when I first began my time here about a year and a couple of months ago, I was able to provide individual therapy. But over this past year, eating disorder encounters have nearly quadrupled facility wide. So, that means there is a huge need. So we really have to transition over to group based programming, with the exception of some individual therapy sessions being able to

occur for some folks. So nutritional therapy is another aspect of the multi-disciplinary treatment that's being provided.

Amy Kienow-Paychek: The goals may be to regain weight for anorexia, to stabilize weight for bulimia and binge eating, and to create a healthy relationship with food and then psychiatry, so veterans may be evaluated for psychiatric medications if needed or we may work with the person's existing psychiatrist.

Amy Kienow-Paychek: So, no need to switch providers. We can work with whoever the veteran is working with already. But, really this is in addition to what they're already receiving. There's no need for them to change providers all the way around. And then to circle back to the evidence based care, the types of classes that we do offer our DBT and CBT for binge eating. A intuitive eating, there is an eating disorder alumni group, and then soon there's going to be a self-hypnosis for the hungry heart specifically for working with binge eating.

Amy Kienow-Paychek: And those are my references. So thank you so much for allowing me to present, and I really look forward to the Q&A session.

Christine Peat (she/her): Wonderful. Thanks so much Amy. If I could steal back screen sharing from you, I'm just going to share one slide here in case folks have questions, or if they're looking for additional information from our website. But yes, we have plenty of time for questions. And if you do have questions, please use the Q&A feature in the zoom controls that you have. I'll have some assistance from our team in case there are things that come through.

Christine Peat (she/her): I do see one from Michael Mccarthy. I’m wondering if there's any knowledge of this research who presented recently. He believes the factors in developing anorexia nervosa is a lack of interception. Certainly. Yeah, I took a look at that link Michael, and it's a great question. The lack of interceptive awareness is actually something that has been posited as a sort of risk factor or even maintenance factor for many individuals across eating disorders, not just anorexia nervosa. In fact, many of the more in depth questionnaires, or assessments of eating disorder behaviors.

Christine Peat (she/her): There's actually a sub scale in one of them called in receptive awareness, because many folks find that it's not just sort of a lack of body awareness in terms of hunger, satiety, those sorts of things. But there's also some deficits with respect to interceptive awareness of emotional states, how to attend to some of those more challenging emotions that might be coming up. So, certainly receptive awareness is something that has been studied for a number of years. Sort of a cross eating disorder diagnoses.

Christine Peat (she/her): I think it's a great point. I see another question that's come in. I believe it was mentioned that people of color are less likely to be a diagnosed. Is it screening that isn't happening, or are there different screening questions that we should consider? Yeah. So you know, I think it's an empirical question. I think that when it comes to being less likely to be diagnosed. We think that some of this is simply not screening individuals who don't fit that stereotype. I don't know that I've seen any more sort of granular examinations of why those rates might be lower. We don't believe it's because they aren't experiencing eating pathology. In fact, we have data in the opposite.

Christine Peat (she/her): I think it's more that these individuals might be folks that slip through the cracks, because they don't look like someone with an eating disorder. So again, I think that's part of our recommendations as a center to be really thinking about screening broadly. Your perspective of sort of the type of patient population that you might be working with. And in fact, I was just looking at the second part of your question.

Christine Peat (she/her): Are there different screening questions? We should consider. You know it's a good question. Unfortunately, we don't have anything that is sort of specific to underrepresented groups or minoritized groups. But in the absence of that what I would say is that, if you're screening broadly, it would give you the opportunity to kind of rule in rule out any sorts of folks that you might have concerns about in the scope of your practice. So again, good question. Would you also suggest over eaters anonymous for folks looking for peer support, you know.

Christine Peat (she/her): Michelle, it's sort of a mixed bag. You know we have some patients who have done really well with sort of that twelve step kind of model. And, other folks have found it to be really, iatrogenic just based on sort of the millieu of the group, or sort of the facilitators that might be present. What I would recommend is that if you have folks that you're concerned about, making sure that they've had a thorough assessment to rule in or rule out an eating disorder diagnosis.

Christine Peat (she/her): And then typically that's done by a specialist. And then, based on you know that presentation, the specialists might be able to indicate, okay, I think you're going to be a good candidate for individual psychotherapy. Here's what we might recommend, or I think you'll need a higher level of care, some of what Amy was talking about. But I you know, I think, that it's such an individual kind of experience. But what I will say is that the sort of twelve step model is not something that has been well supported in the literature for the treatment of eating disorders. But again, I don't want to rule out the idea that some individuals may find that to be a benefit to them.

Christine Peat (she/her): I see a question from Rachel Lynch's work around radically open DBT and use in the treatment AN with respect to the interceptive deficit and receptive deficits mentioned.

Christine Peat (she/her): Rachel, if you wouldn't mind providing a little bit of a clarification in your question. I while you're doing that I will. I will note, however, that radically open DVT. For those of you that are familiar with that as an intervention, certainly has a growing evidence base behind it. With respect to the treatment of eating disorders, I know that there are actually lots of higher levels of care. So, inpatient residential programs that are actually in using RO DBT as one of their primary strategies. And so, thinking a little bit about that, and in the course of really responding to those in a receptive deficits. Perhaps that's what Rachel was highlighting. Is that that kind of approach may help allow people to better tap into some of their emotional experiences, develop a greater awareness and be able to kind of manage some of those more challenging emotions. Let's see here.

Christine Peat (she/her): Uh, I see. So Rachel's wondering if I could provide some context with respect to the use of that intervention for interceptive deficits. Yeah, um. So again, I'm not somebody who I would claim to be an expert in a RO DBT. But I will say that in as much as DBT as a core intervention, that's something that helps people develop greater awareness of mindfulness of their own sort of internal states, and also giving them concrete tools to manage some of that negative effect we know has been really beneficial, particularly in things like binge eating disorder, bulimia nervosa. There's a growing evidence base there for sure.

Christine Peat (she/her): Let's see here, just taking a look at any other questions that might be coming in. I also want to be sensitive to time, knowing that I'm sure lots of you have very busy days. Let's see here, taking a look at any other questions that might come in.

Christine Peat (she/her): Alright. Well, in the absence of any other questions coming in, I just want to take this opportunity to say thank you so much for coming and for your attention this afternoon. We know that you have lots of things to do with your time and any given day. We appreciate you taking the time to really learn more about eating disorders and the way in which you might have impact. Um, particularly in a primary care setting. My email address is here, and our website is available for those of you that are looking for more information. So please, don't hesitate to reach out if you have any additional questions or ways in which we can be helpful.

Christine Peat (she/her): Thank you so much for your time and attention. Everybody take care.