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Rates and correlates of disordered eating among women veterans in primary care[☆]



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ABSTRACT

Rates of disordered eating may be higher among women veterans than civilians, and are associated with co-occurring mental health (MH) conditions, such as depression, post-traumatic stress disorder (PTSD), and alcohol misuse. Although evidence suggests that these conditions are common in primary care settings, limited research has examined symptoms of disordered eating among women veterans in primary care. This study used a cross-sectional design to examine rates and MH correlates of disordered eating among women veterans treated in a primary care setting. Participants ($N = 176$) completed self-report measures of disordered eating attitudes and behaviors, depression, anxiety, PTSD, alcohol misuse, and military sexual trauma. Results indicated that women veterans were likely to report objective (35.8%) and subjective binge episodes (29.5%), as well as shape and weight concerns (36.4% and 23.3%, respectively). While, anxiety and PTSD were strongly associated with disordered eating, restraint, eating concerns, weight concerns, and shape concerns, military sexual trauma was often unrelated to these outcomes. Further study is needed to improve the detection of disordered eating behaviors among women veterans, as well as to identify effective management strategies in primary care. Overall, these findings suggest that integrated primary care (IPC) may be a useful setting to improve the detection and treatment of eating disorders, particularly by targeting binge eating and body dissatisfaction among women veterans within these settings.

1. Rates and correlates of disordered eating among women veterans in primary care

Women veterans may report higher rates of disordered eating behaviors (Mitchell, Rasmusson, Bartlett, & Gerber, 2014; Rowe, Gradus, Pineles, Batten, & Davison, 2009) than women in the general population (Hudson, Hiripi, Pope Jr, & Kessler, 2007). The pressure to maintain strict weight requirements within the military (Bartlett & Mitchell, 2015; Bodell, Forney, Keel, Gutierrez, & Joiner, 2014), and high rates of mental health (MH) comorbidities (Maguen, Cohen, Cohen, et al., 2012) are thought to contribute to the increased risk for eating pathology among veterans. Trauma exposure, in particular, is a salient contributor due to the increased rates of eating disorders observed in women veterans with a history of military sexual trauma (MST;

Forman-Hoffman, Mengeling, Booth, Torner, & Sadler, 2012; Maguen, Cohen, Ren, et al., 2012), or a diagnosis of post-traumatic stress disorder (PTSD; Forman-Hoffman et al., 2012; Maguen, Cohen, Cohen, et al., 2012; Maguen, Cohen, Ren, et al., 2012). Other conditions, including mood disorders and substance use, have also been shown to increase the likelihood of an eating disorder diagnosis (Maguen, Cohen, Cohen, et al., 2012; Mitchell et al., 2014).

Though individuals with eating disorders are more likely to seek treatment in a medical setting than a traditional MH setting (Hudson et al., 2007; Mond, Hay, Rodgers, & Owen, 2007), they are not routinely detected by primary care providers (Hay, Marley, & Lemar, 1998; Johnson, Spitzer, & Williams, 2001). The movement toward integrated primary care (IPC) services (Kearney, Post, Pomerantz, & Zeiss, 2014), wherein MH professionals work collaboratively with primary care

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providers, offers an opportunity to more consistently identify and manage individuals with disordered eating (Buchholz, King, & Wray, 2017). Because IPC providers are likely to encounter patients with co-occurring MH and medical conditions that are associated with weight and/or eating concerns (e.g., hypertension, diabetes, and obesity; Gatchel & Oordt, 2003), they may serve a vital role in improving the identification of veterans with disordered eating.

However, only one study to date (Mitchell et al., 2014) has specifically examined rates of eating disorder diagnoses among veterans who use primary care, suggesting a need for further study. The majority of research to date has explored rates of eating disorders via electronic medical record review (EMR; Maguen, Cohen, Cohen, et al., 2012; Maguen, Cohen, Ren, et al., 2012; Mitchell et al., 2014). While EMR-based studies are helpful in exploring national base rates, this methodology may underestimate the number of individuals with disordered eating, given the lack of national guidelines within the Veterans Healthcare Administration (VHA) to identify individuals with eating disorders. Data from validated self-report measures may more accurately represent the prevalence and severity of disordered eating behaviors (Garner, 2002), but few studies have used this technique (Bodell et al., 2014). Further, to our knowledge, no prior research has examined subthreshold disordered eating among women veterans, which is problematic because they are more common than diagnosed eating disorders (American Psychiatric Association (APA), 2013).

The purpose of this study is to begin to address the aforementioned gaps in the literature by using a well-validated measure to evaluate the prevalence of eating disorder symptoms in a sample of women veterans enrolled in VHA primary care. Consistent with prior research, we hypothesized that depression, PTSD, anxiety, MST, and alcohol misuse would be associated with greater disordered eating among women veterans (Forman-Hoffman et al., 2012; Maguen, Cohen, Cohen, et al., 2012; Maguen, Cohen, Ren, et al., 2012; Mitchell et al., 2014). In order to better characterize the relationships between MH correlates and disordered eating behaviors, we also explored the relationships between these constructs and concerns related to weight, shape, eating, and dietary restraint.

2. Methods

2.1. Participants

Participants were recruited within the Upstate New York VHA system. Study candidates were women between the ages of 18 and 65 who attended at least one primary care or primary care MH appointment in Fiscal Year 2015 (i.e., October 1, 2014–September 30, 2015). Veterans with a chart history of a psychotic-related disorder, or inpatient/residential medical or MH treatment at the time of mailing were excluded. A total of 5134 women were deemed eligible for the study.

Each eligible candidate ($N = 5134$) was assigned a unique identification number using a random number generator. Then, a random sampling procedure extracted 520 (10.1%) cases to contact for participation. The total number of cases to contact for participation i.e., 520 participants, was based on several factors. First, based on the results of a power analysis (PASS software, 2017), we estimated that a minimum of 117 participants would be required to detect a medium effect for the relationships between each of the proposed predictors (i.e., depression, PTSD, MST, or alcohol misuse) and eating pathology, after including the covariate effects for BMI and self-esteem. Using available data from ongoing studies in our region at the time (R.L. Shepardson, personal communication, December 2016), we estimated a) a minimum cold mailing response rate of 27% and b) 20% of missing data on the survey items. To achieve the required number of individuals with complete data, we therefore selected 520 candidates for participation (10.1% of the total eligible candidates).

Overall, 51 (9.8%) declined participation, 273 (52.5%) did not

respond, and 196 (37.7%) returned study surveys. Of individuals who returned surveys, 176 (89.8%) provided complete data on all variables of interest.¹ Response rates (41.8%) for our study were similar to other research within our region (P.R. King, personal communication, February 2018).

Participants were, on average 51.4 years old ($SD = 10.48$; range = 23–65), with a mean BMI of 29.4 ($SD = 6.40$; range = 18.5–52). The sample predominantly self-identified as non-Hispanic Caucasian ($n = 136$, 77.3%), followed by Black/African American ($n = 16$, 9.1%), Hispanic/Latina ($n = 10$, 5.7%), multi-racial ($n = 5$, 2.8%), Asian ($n = 1$, 0.6%), Native American/Pacific Islander ($n = 1$, 0.6%), and other ($n = 6$, 3.4%). One participant (0.6%) declined to report her ethnicity. Fewer than half (39.8%) reported that they had deployed at least once during their military service; of those who had deployed, 57.1% reported combat exposure.

2.2. Design and procedure

Eligible candidates were sent an informational packet describing the study and the informed consent process (including procedures to opt-out). For those who opted to participate, instructions to complete study measures (see below) were also included. Candidates who did not return their surveys were contacted by phone approximately one week after the initial mailing to address any questions and gauge their interest in participation. Two weeks after the initial mailing, a reminder letter was sent to candidates who neither declined nor returned study measures by mail. Candidates who opted-out or did not respond to contact were considered to decline participation in the study. Participants were compensated \$20 for their participation. This study was approved by the local Institutional Review Board.

2.3. Measures

2.3.1. Demographic variables

Demographics included age and ethnicity. Self-reported height and weight were used to calculate BMI, using the Centers for Disease Control and Prevention (CDC) (2015): $BMI = [weight (lb) / height (in^2)]$.

2.3.2. Eating disorder examination questionnaire (EDE-Q)

The EDE-Q is a 28-item self-report measure of eating disorder symptomatology over the past 4 weeks (Fairburn & Beglin, 2008). Individuals rate items on a 7-point Likert-type scale from 0 to 6, with higher scores indicative of greater disordered eating. Behavioral items represent the frequency of each behavior within the past month. The EDE-Q is comprised of a Global Scale, and four subscales: Restraint, Shape Concern, Weight Concern, and Eating Concern. This measure has strong psychometric properties (Berg, Stiles-Shields, et al., 2012), and has been used to evaluate the presence of eating disorder symptoms in primary care settings (Mond et al., 2008). According to Luce, Crowther, and Pole (2008), a mean ≥ 4.0 on the total scale or an individual subscale indicates a greater severity of disordered eating among women. For this sample, the Cronbach's α estimates were 0.90 for the EDE-Q Global Scale; 0.82 for the EDE-Q Restraint subscale; 0.91 for the EDE-Q Shape Concern subscale; and 0.80 for the EDE-Q Weight Concern and the EDE-Q Eating Concern subscales, respectively.

¹ Two cases were removed from analysis due to missing data on the variables used to calculate body mass index (BMI), while eight additional cases were removed due to missing data on the variables used to identify MST. One complete survey was coded as missing due to data lost from a clerical error. In addition, 8 participants were excluded due to substantial missing data on the constructs of interest (i.e., > 10% of total items; $n = 5$ for the RSES; $n = 2$ for the EDE-Q; $n = 1$ for the PCL-5; $n = 1$ for the AUDIT-C), resulting in a final analytic sample of 176 women veterans.

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