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Women Veterans' Treatment Preferences for Disordered Eating

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A B S T R A C T

Objective: Disordered eating, which includes subclinical and clinical maladaptive eating behaviors, is common among women, including those served by the Veterans Health Administration (VA). We used qualitative methods to determine whether and how women veterans want to receive treatment for disordered eating.
Method: Women veterans participated in one of seven focus groups/interviews and completed in-person demographic and psychological questionnaires. We used thematic analysis of focus groups/interviews to understand preferences for disordered eating treatment.
Results: Participants ($n = 20$) were mostly women of color (55%); mean age was 48 (SD = 15) and 65% had significant psychological symptoms. Few participants described being assessed for disordered eating, but all thought VA should provide treatment for disordered eating. Through thematic analysis, we identified six preferences: 1) treatment for disordered eating should be provided in groups, 2) treatment for disordered eating should provide concrete skills to facilitate the transition out of structured military environments, 3) treatment for disordered eating should address the relationship between eating and mental health, 4) disordered eating can be treated with mindfulness and cognitive–behavioral therapy, 5) disordered eating treatment providers should be experienced and take an interactive approach to care, but can come from diverse disciplines, and 6) referrals to treatment for disordered eating should be open ended, occur early, and allow for ongoing, flexible access to treatment.
Conclusions: Women veterans are interested in treatment for disordered eating. Preferred treatments align with existing treatments, could be offered in conjunction with weight loss or primary care services, and should provide social support and interactive learning.

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Clinical eating disorders are relatively rare among women in the general population; rates range from 0.9% to 3.5% (Hudson, Hiripi, Pope Jr, & Kessler, 2007). Disordered eating is more common, affecting between 5.9% and 27.7% of women (Hilbert, de Zwaan, & Braehler, 2012; Mangweth-Matzek, Hoek, & Pope, 2014). Disordered eating is more common than clinical eating disorders because it represents a spectrum of maladaptive eating behaviors, ranging from infrequent binge eating, purging, and/or dietary restriction to behaviors associated with clinical eating disorder diagnoses (e.g., weekly bingeing, purging, and/or dietary restriction).

Disordered eating is particularly common among individuals who are overweight or obese (Spitzer et al., 1993). Given that more than two-thirds of the U.S. population is overweight or obese (Ogden, Carroll, Kit, & Flegal, 2014), treating disordered eating, as opposed to solely focusing on clinical eating disorders, is a public health concern (Puhl, Neumark-Sztainer, Austin, Luedicke, & King, 2014). Treating disordered eating is of special importance to veterans served by the Veterans Health Administration (VA). A recent systematic review found prevalence estimates of disordered eating among veteran and military men and women to be comparable to or higher than prevalence

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estimates for the general population (Bartlett & Mitchell, 2015). At the extreme end of the spectrum, one included study found that almost 80% of the thousands of participants in VA's weight loss program report disordered eating (Higgins et al., 2013).

There are several evidence-based treatments for clinical eating disorders, including cognitive–behavioral therapy (CBT) and interpersonal therapy, that show promise for treating subclinical eating disorders (a form of disordered eating; Kass, Kolko, & Wilfley, 2013). There is also evidence from a recent systematic review that mindfulness-based treatments reduce disordered eating, including binge eating and emotional eating (Katterman, Kleinman, Hood, Nackers, & Corsica, 2014). The VA provides mental health care, which, depending on facility, may include these and other disordered eating-related treatments. In addition, roughly 20 VA residential programs provide inpatient eating disorder treatment secondary to treatment for other conditions (personal communication, Dr. Deleene S. Menefee, March 18, 2016). However, there are no national data available on how many VA clinicians specialize in disordered eating.

Despite the high prevalence of disordered eating among veterans and existing and viable treatment options, to our knowledge, no research describes veterans' disordered eating treatment preferences. Such information is important given the millions of veterans treated within and outside VA. Treatment preferences in non-veteran clinical populations seem to be related to individual understandings of disordered eating; in one study, individuals who viewed their primary problem as an eating disorder were more likely to be interested in CBT for eating disorders whereas those who conceptualized their problem as being overweight were equally interested in a behavioral weight loss treatment or CBT for eating disorders (Brody, Masheb, & Grilo, 2005). However, veterans' disordered eating treatment preferences may differ from the general population's because veterans have different life experiences and comorbid conditions. For example, posttraumatic stress disorder (PTSD) prevalence is higher in veteran than civilian populations (Norris & Slone, 2013), and both trauma (Hoerster et al., 2015; Mason et al., 2014) and combat exposure (Jacobson et al., 2009) are associated with disordered eating.

The aim of this study was to describe women veterans' disordered eating treatment preferences. Although women and men engage in disordered eating, we focused on women because military and veteran women are often more likely to be diagnosed with and report disordered eating (Bartlett & Mitchell, 2015; Frayne et al., 2014). Given the nascent nature of this research, we used qualitative methods to identify treatment preferences and to provide context for why participants preferred certain treatments.

Materials and Methods

Research Team

The research team consisted of six women with experience conducting women's health research in VA: 1) a bachelor's-level research assistant, 2) two doctoral candidates in clinical psychology (one military veteran), 3) an anthropologist, and 4) two psychologists (one senior psychologist and one postdoctoral fellow). The latter three had experience with qualitative methods. Both psychologists had experience treating disordered eating. No study staff had prior relationships with participants.

Recruitment and Consent

We used homogeneous sampling, a common strategy to improve the comfort level of participants during focus group discussions (Morgan, 1996) to recruit women veterans between the ages of 18 and 70 who reported changing their eating habits in response to stress, recent weight gain, and/or interest in healthier eating habits. Participants were recruited though a combination of flyers at the local VA and at local colleges, and referrals from mental health clinicians who provided researchers with contact information for potential participants who agreed to be contacted by study staff. We excluded women diagnosed with serious mental illness (i.e., schizophrenia, psychosis) because they likely have different needs that were outside the scope of this study (Goldberg et al., 2013); however, preferences of women with serious mental illness is an important area of inquiry for future work.

Women who called and were interested in the study verbally consented to a phone screen (conducted by the doctoral candidates) to assess eligibility. Eligible women participated in focus groups or dyadic interviews after signing written consent forms that informed them that the purpose of the study was to learn how experiences during deployment can impact a person's eating behaviors and that results would be used to improve the evaluation and treatment offered to veterans. To obtain naturalistic responses and to avoid stigmatizing women who did not consider themselves eating disordered, participants were not educated about disordered eating at any point during phone screens, focus groups, or interviews. Women were paid $30 for their participation. All procedures were approved by an institutional review board and a VA Human Research Protection Program.

Data Collection

This study was designed mainly as a qualitative study; however, we used quantitative measures to provide descriptive information about participants and to stimulate discussion during focus groups/interviews (participants completed all measures during a break, before answering focus group/interview questions related to treatment preferences).

Qualitative Measures

Focus groups and dyadic interviews

Between April 2013 and October 2014, two researchers (the senior psychologist and a doctoral candidate) moderated five focus groups at an urban VA medical center. The research assistant was also present to take notes, but did not speak. Focus group size ranged from three to five participants. The same staff also conducted two dyadic interviews in the same location, which were the result of only two participants attending scheduled focus groups. Dyadic interviews share many factors with focus groups (e.g., participant interaction), while at the same time allowing for more data collection from each participant (Morgan, Ataie, Carder, & Hoffman, 2013). Although dyadic interviews were not part of the original research plan, they enhanced data by allowing participants to provide more in-depth responses to questions. Focus groups and interviews were populated on a first-come, first-served basis.

The same semistructured interview guide was used for focus groups and interviews. Topics included military service and eating, stress and eating, early eating habits, and disordered eating treatment preferences related to treatment format, treatment content, preferred providers and the referral process (Appendix A lists the questions related to treatment preferences,