

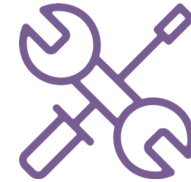
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Disordered Eating and Body Image Disturbance in the Military

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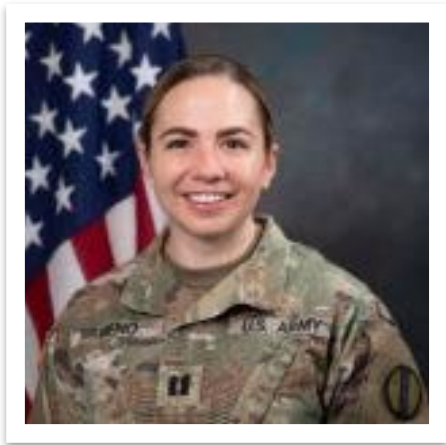


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Readiness. Knowledge. Network.

This material is based upon work supported by the National Institute of Food and Agriculture,
U.S. Department of Agriculture, and the Office of Military Family Readiness Policy,
U.S. Department of Defense under Award Number 2019-48770-30366.

Today's Presenters



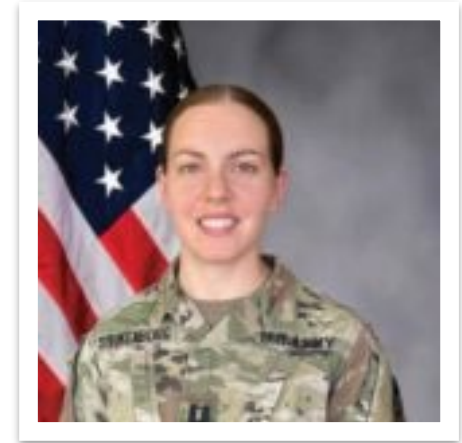
**CPT Stephanie Meno,
MS, RD, CSSD**

Nutrition Domain Lead
Holistic Health and Fitness (H2F)
Center for Initial Military Training



**Priscilla Rumph,
MS, RD, CSSD, CEDRD**

Registered Dietitian
Holistic Health and Fitness (H2F)
Joint Base Lewis-McChord



**CPT Maria Stukenborg,
MS, RDN**

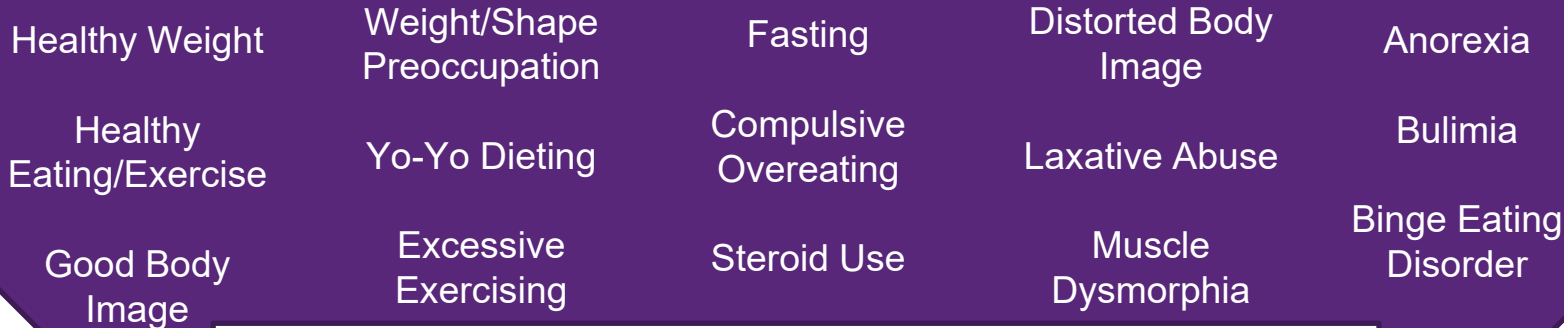
Nutrition Program Director
Holistic Health and Fitness (H2F)
Joint Base Lewis-McChord

Learning Objectives

- Describe the prevalence of disordered eating and body image disturbance in a military population.
- Identify common signs and symptoms of disordered eating and body image disturbance.
- Explain the impact of disordered eating on individual readiness and performance.
- Give two examples of assessment tools and two examples of intervention strategies for service members experiencing disordered and body image disturbance.

The Spectrum

Disordered Eating vs. Eating Disorders “Continuum of Eating Disturbance”

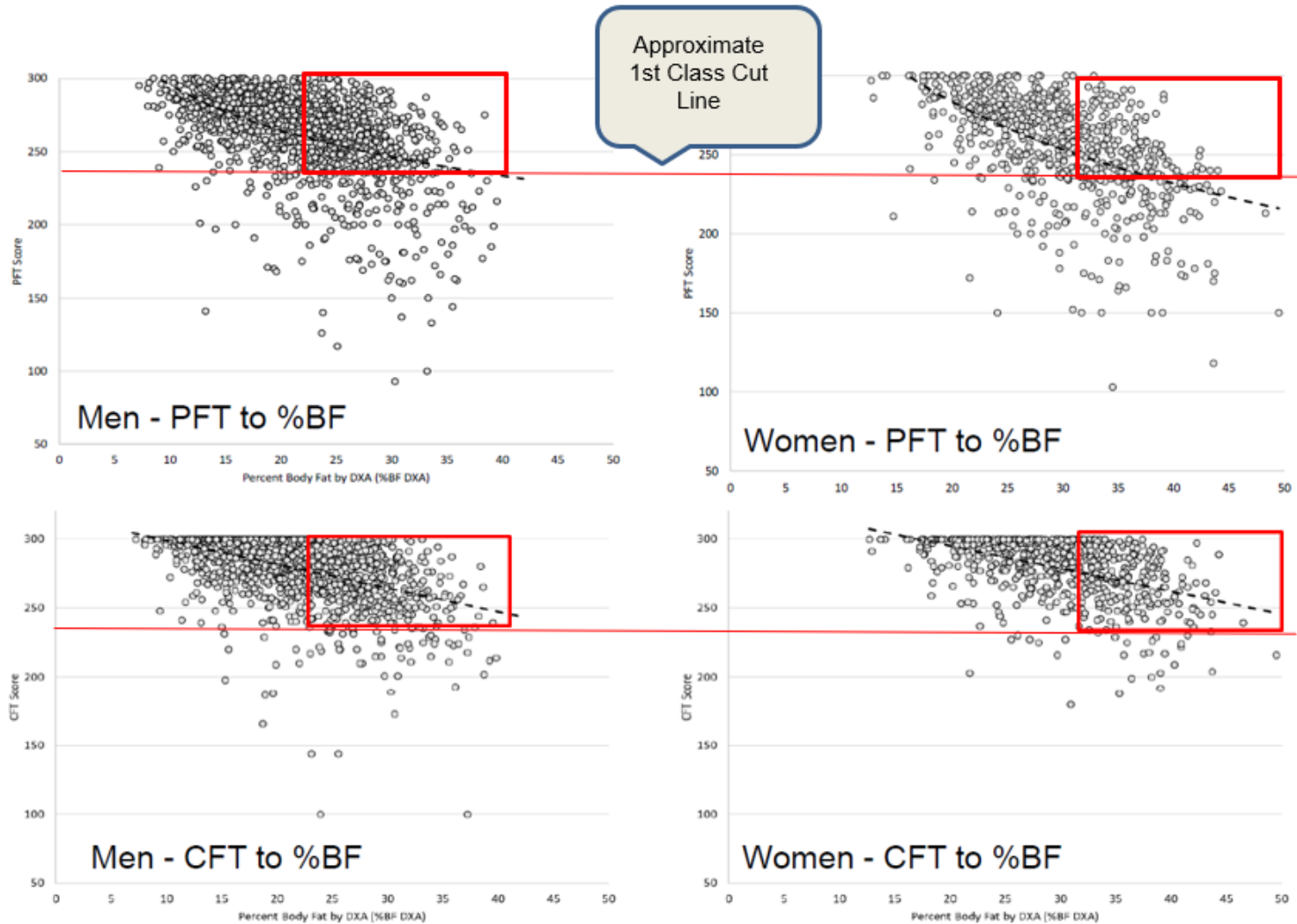


Healthy attitudes and behaviors

Sub-clinical issues (disordered eating)

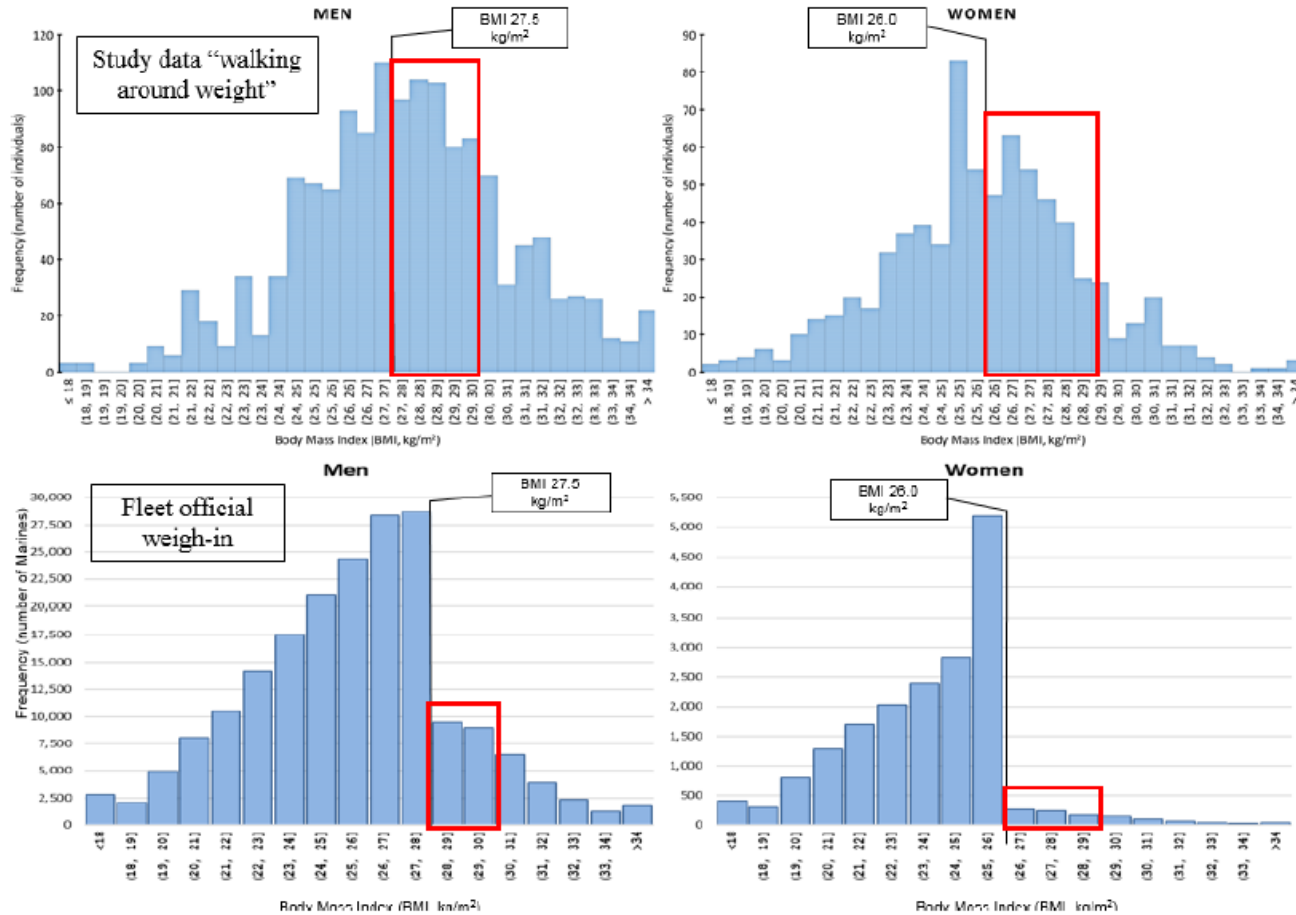
Clinical issues (eating disorders)

Performance vs. %Body Fat

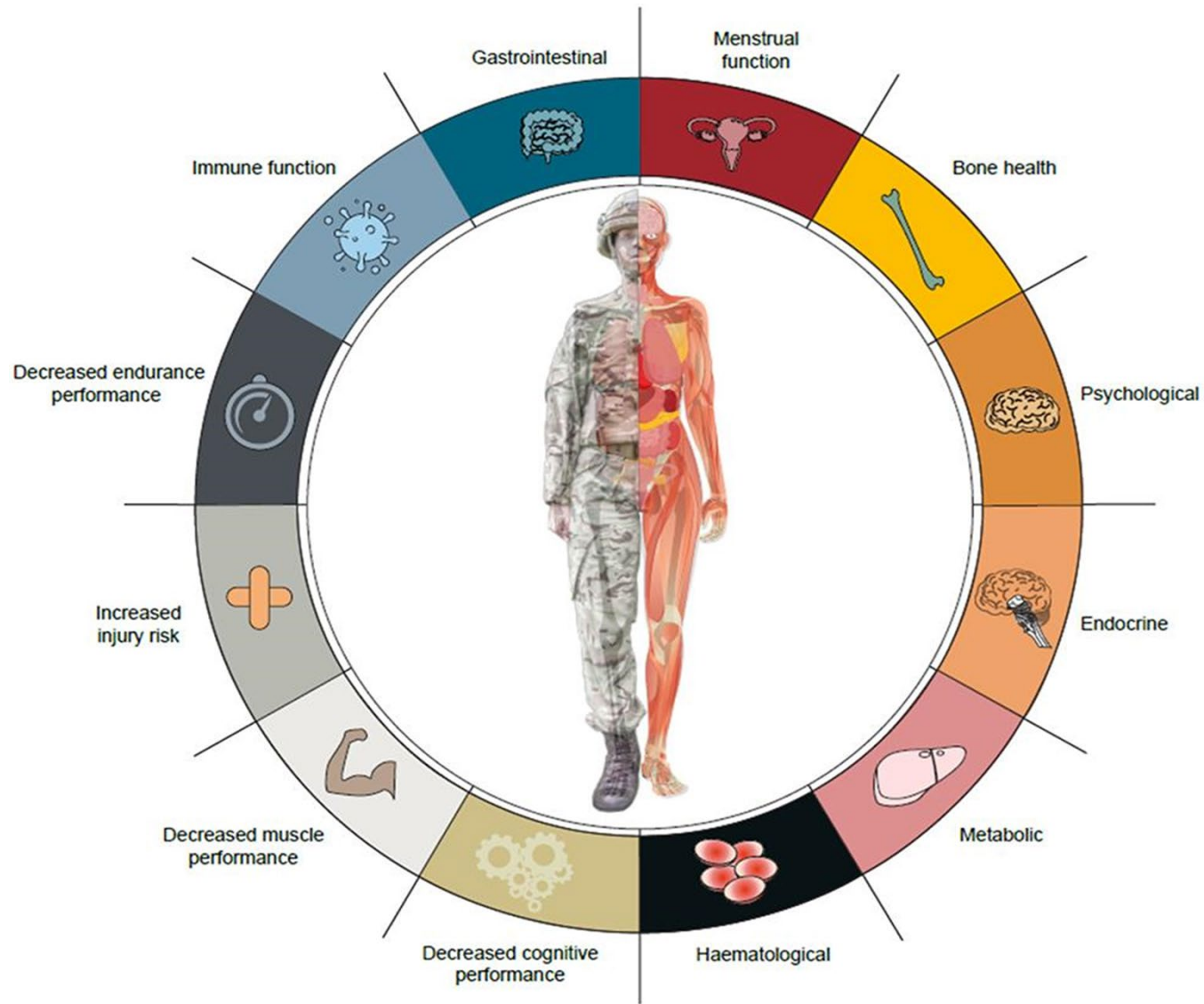


Weight Cycling

Figure 12. Body mass index (BMI) distribution for Marine men and women in this study (upper graphs) and BMI for Marine men and women from official weigh-in data (lower graphs). Red callouts indicate individuals that are within 10 pounds of exceeding the weight screen. Note these illustrations are presented as integers; male BMI limit is 27.5 kg/m².



Low Energy Availability



The Readiness Threat

"Except for athletes in severely abusive situations, soldiers confront more extreme, multi-stressor environments arising from unpredictable and hostile physical and psychological challenges (e.g., severe sleep deprivation, extended periods of physical effort without proper recovery, prolonged periods of mental stress, lack of food and dehydration)."

The Readiness Threat

Considerations:

- Insufficient validated screening tools—especially for men.
- REDs Clinical Assessment Tool (REDs CAT) will eventually be adapted to assist clinicians in the military field.
- Military setting makes it harder to measure energy expenditure.
- "It is fundamental that the military medical community acknowledge RED-M and have the clinical skills to recognize its signs and symptoms.

Editorial

Relative energy deficiency in military (RED-M)

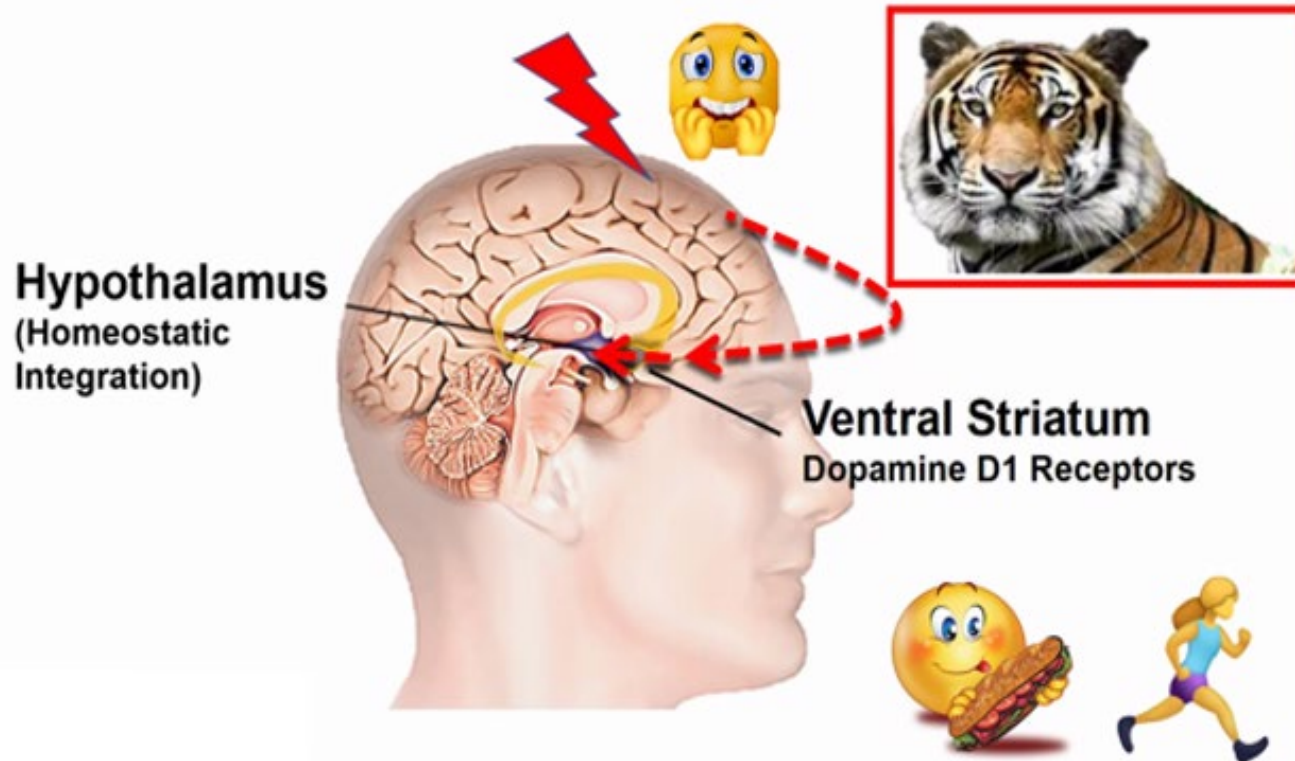
Naama W Constantini,^{1,2} E Alves ,³ M L Mountjoy,^{4,5}
K E Ackerman^{6,7}

The human body needs adequate energy availability (EA) to maintain proper physiological functioning. EA is defined as the difference between energy intake (EI) and exercise energy expenditure (EEE) relative to fat-free mass (FFM).¹ Prior work in active women suggests an optimal EA range of 40–45 kcal/kg FFM/day and a low EA (LEA) below 30 kcal/kg FFM/day, although there is individual variability.² It is widely acknowledged that LEA is the main factor triggering the unfavourable health and performance consequences

state of prolonged LEA in military populations is associated with reduced LH, FSH, oestradiol, testosterone, thyroid hormones (T3 and T4), insulin, insulin-like growth factor-1 (IGF-1) and leptin, and increased cortisol, growth hormone (GH) resistance, sex hormone binding globulin (SHBG), ghrelin, cholesterol and bone resorption.⁷⁻⁹ These changes lead to reduced muscle strength, bone mineral density, endurance, aerobic capacity and glycogen stores, impaired thermogenesis, higher injury risk, impaired judge-

male preponderance is expected due to exclusion of women from elite combat units in many countries (USA until 2016) and from most investigations. Recently, in a group of 28 women and 17 men soldiers, Chapman *et al* concluded that all consumed less than the military dietary reference values,¹⁴ that men consumed greater amounts of macronutrients and micronutrients, and that women were at greater risk for inadequate intake relative to recommended daily allowances for some micronutrients.¹⁴ However, when data were expressed relative to body mass, there were no statistical differences between sexes.¹⁴ Also, Edwards *et al* reported no apparent differences in EA between males and females.¹⁵ In addition, significant menstrual dysfunction prevalence (maximum range of 68–90%) has been reported among female soldiers and cadets.¹⁶ In a group of 21 male elite soldiers, an EA range of 1 to 44 kcal/kg

Genetic Risk



Anorexia Nervosa (AN) & Atypical Anorexia Nervosa (AAN)

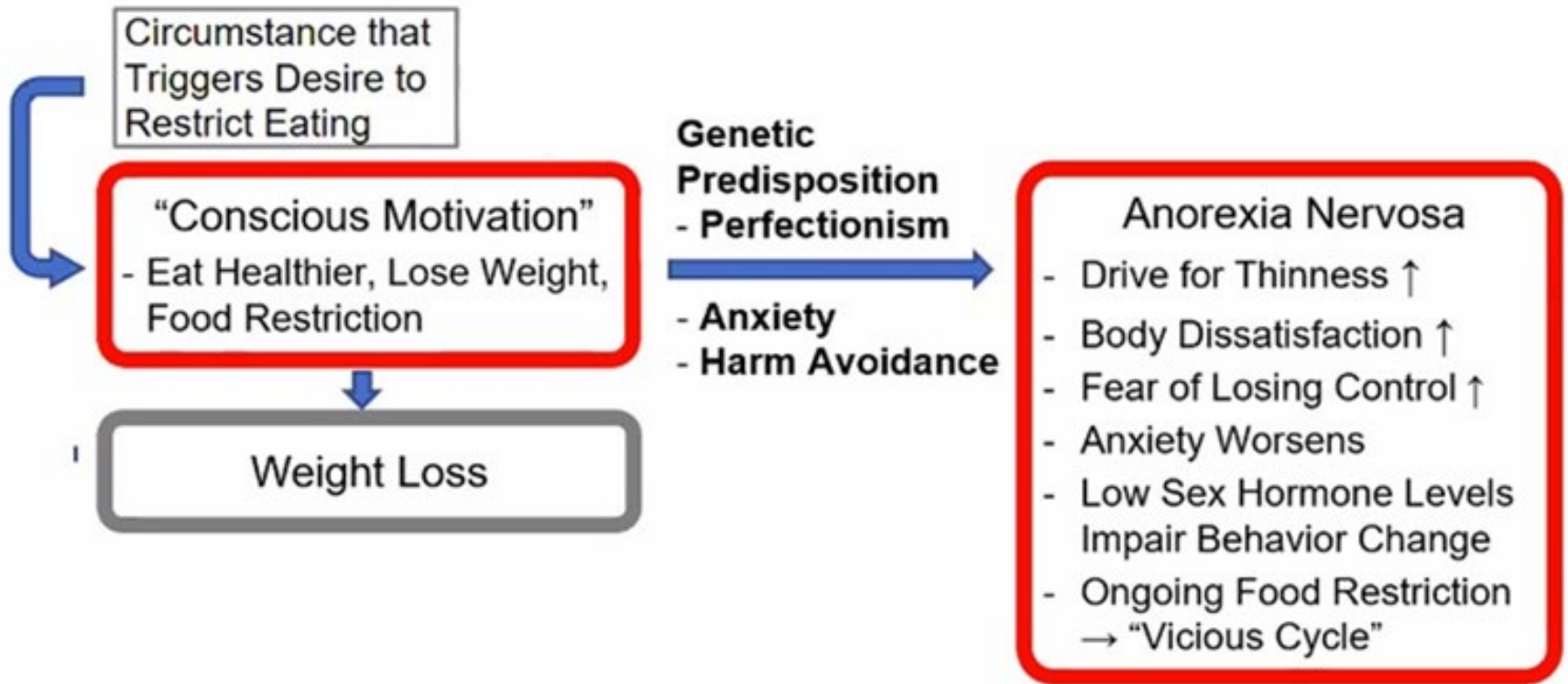
Anorexia Nervosa (AN):

- Specific DSM-5 criteria regarding intense fear of gaining weight despite weight that is less than biologically appropriate
- Disturbance in the experiencing of one's body weight and shape with overvaluation of weight/shape on self-worth

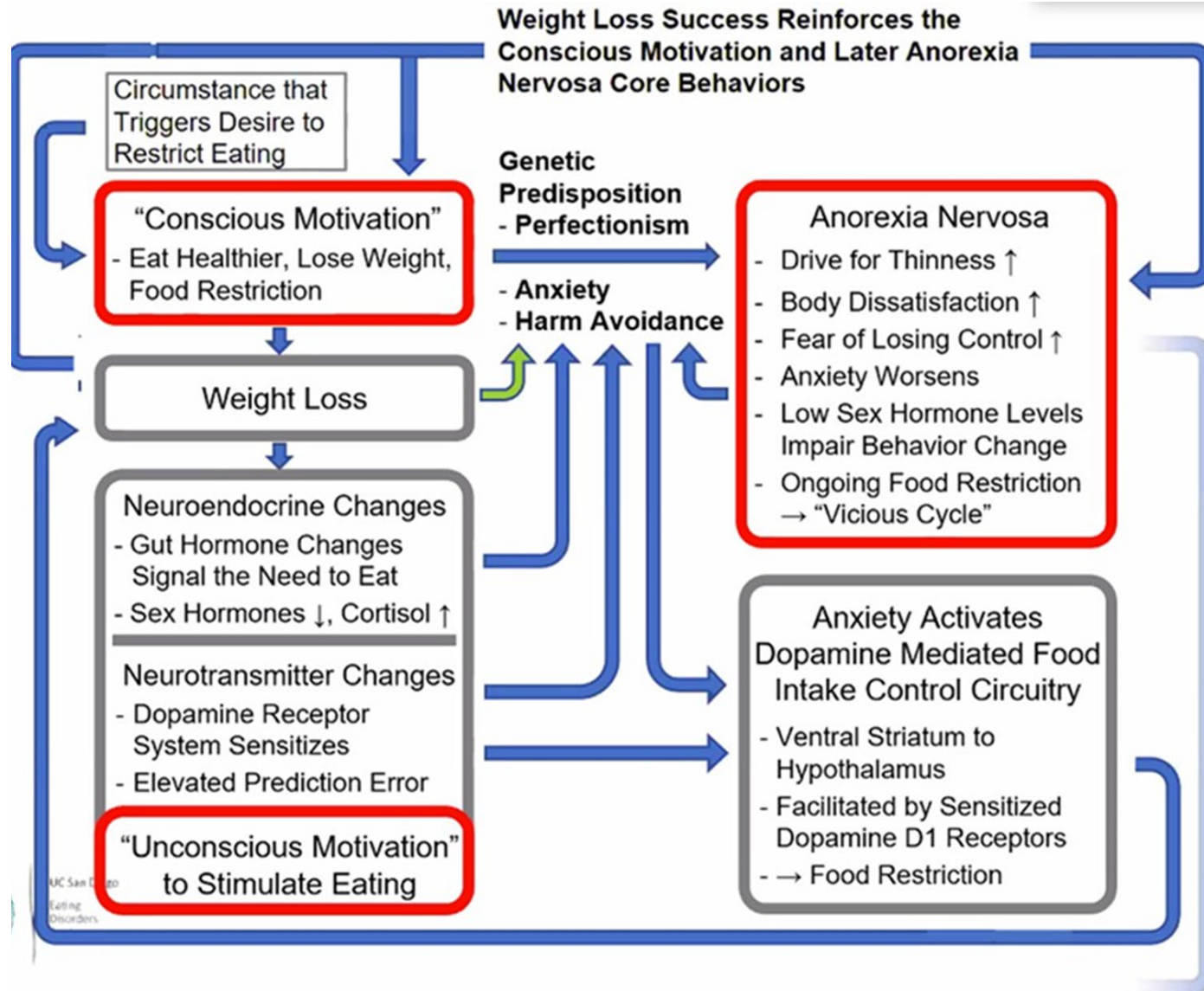
Atypical Anorexia Nervosa (AAN):

- Same symptoms as current definition of AN but can occur in any body shape/size
- Diagnosis is based on the symptoms that the individual is experiencing and does not require low body weight for diagnosis
- Currently would be diagnosed under Other Specified Feeding and Eating Disorders (OSFED)
- AAN in post-9/11 Veterans: 14% of women and 5% of men (Masheb, 2021)

The Dangers of Dietary Restriction



Dangers of Dietary Restriction



AKC San Diego
Eating Disorders

Bulimia Nervosa (BN) & Binge Eating Disorder

Bulimia Nervosa:

- Recurrent episodes of binge eating that consist of larger than average quantities of food and feel out of control
- Compensatory behaviors, such as vomiting, overexercise, fasting, and misuse of laxatives, diuretics or other medications
- Overvaluation of weight/shape

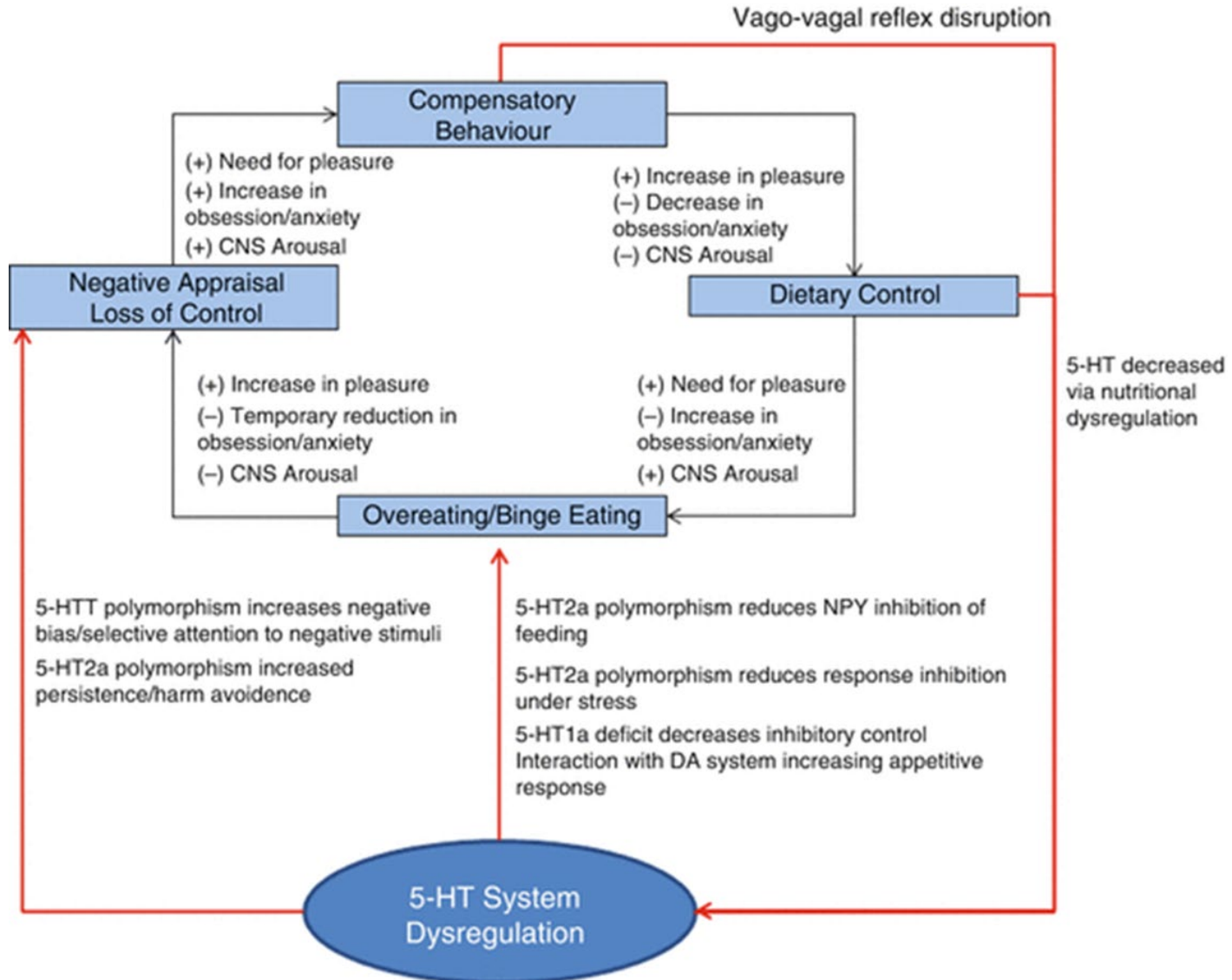
Binge Eating Disorder:

- Eating definitely larger amounts of food than the average person in similar period of time
- Sense of lack of control over the eating episode
- Absence of compensatory behaviors

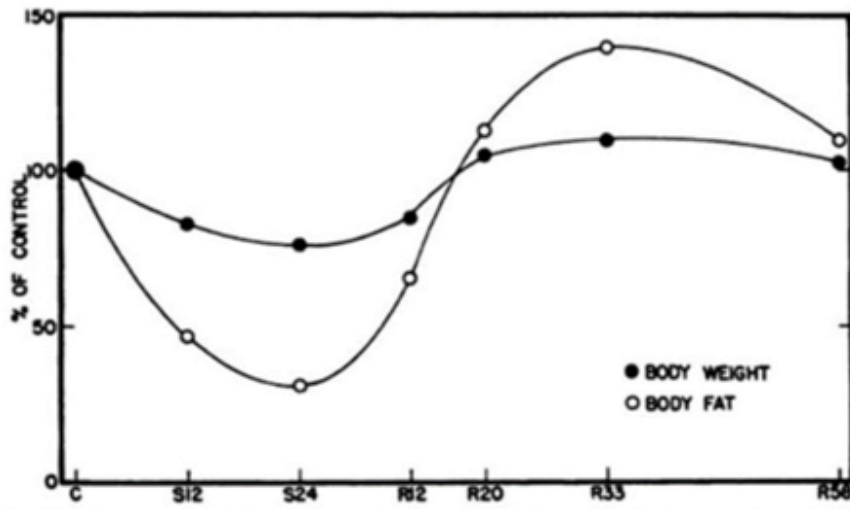
Binge Eating Neurobiology

- Potentially chronic low serotonin levels in those who experience binge eating symptoms which may contribute to binge eating in an attempt to relieve the depressed mood (Haedt-Matt & Keel, 2011)
- Variants in serotonin transporter gene were associated with increased binge eating severity (Haedt-Matt & Keel, 2011)
- Association between impulsivity and strict dieting with serotonin receptor genes and binge eating (Racine et al., 2009)
- Alterations in dopamine response may be related to hyper-responsiveness to rewards (such as food) and lead to continuation of compulsive overeating (Davis, 2012; Bello & Hajnal, 2010)

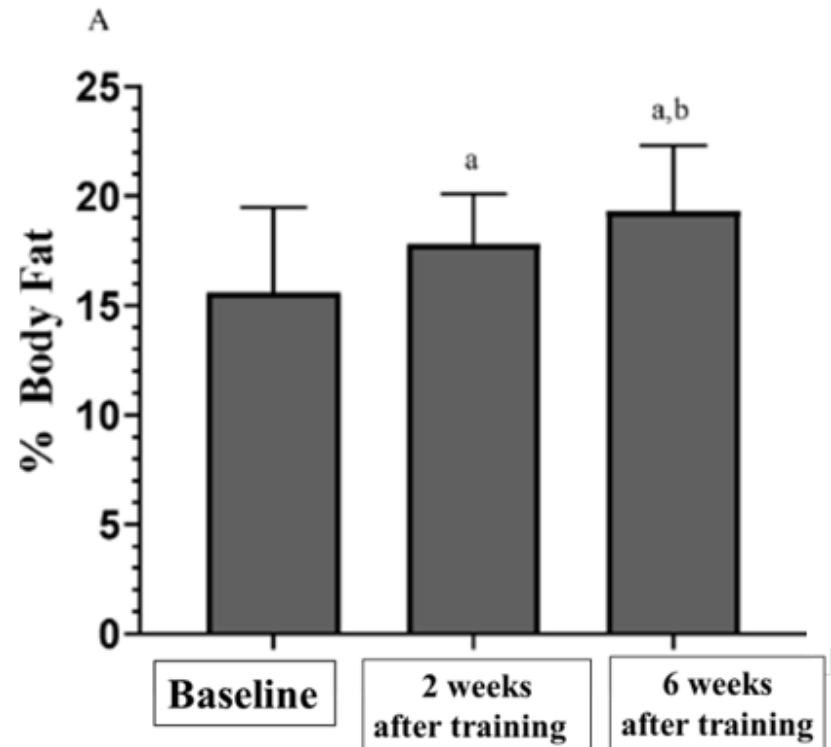
The Restriction/Binge Cycle



Impact of Cyclic Dietary Restriction on %Body Fat



(Keys, 1950)



(Conkright et al., 2019)

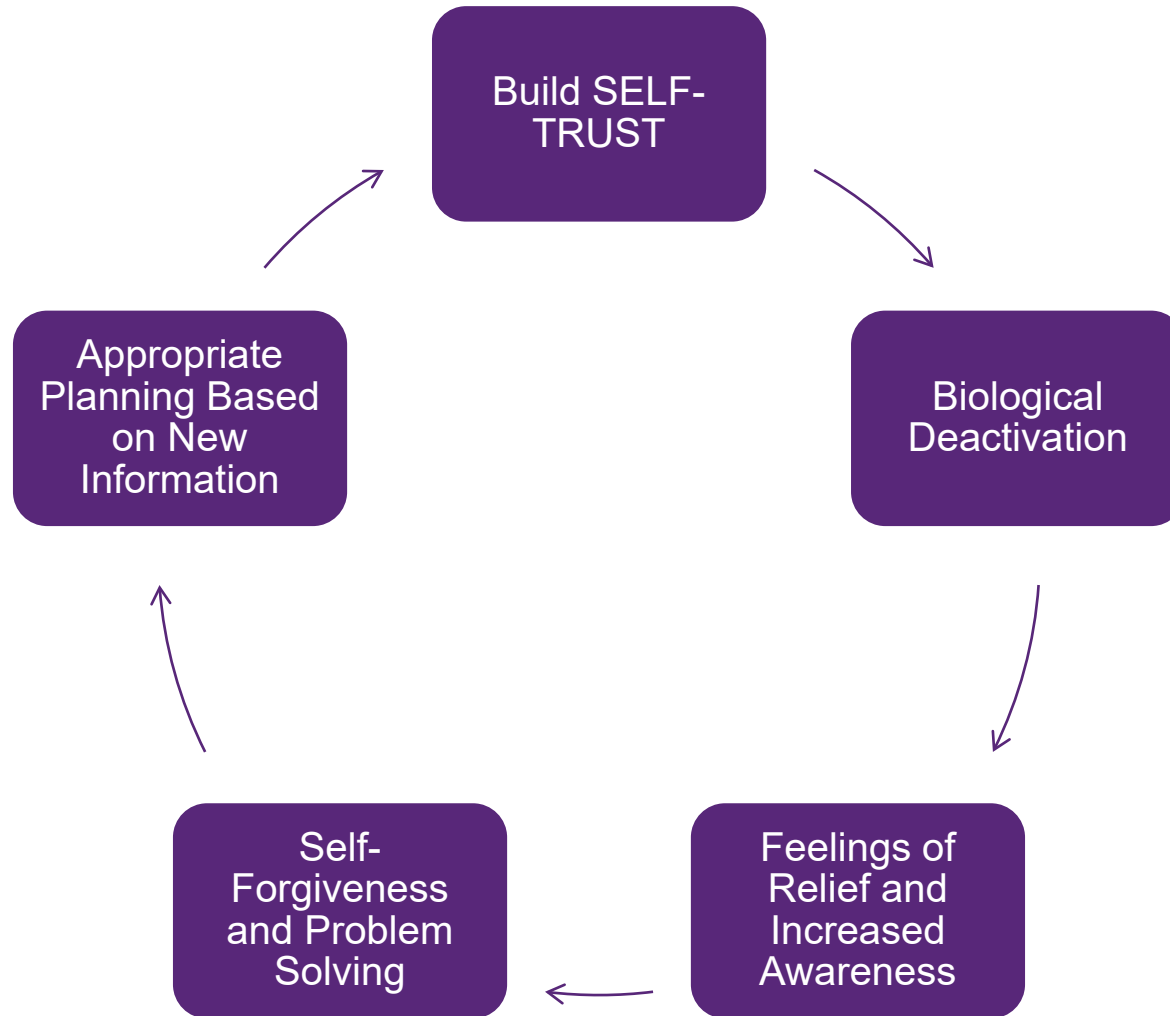
Differences in Response to Dietary Restriction

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/m² 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).

(Friedl, 1994)

- Individuals respond differently to dietary restriction (Friedl, 1994; Peitilainen, 2011; Fothergill, 2016; Jeffrey, 200)
- Variability in Nonexercise Activity Thermogenesis (Levine, 1999; Bouchard, 1990)

Breaking the Restriction/Binge Cycle



Question Break

Body Image



Predictors of Poor Body Image

- Body weight and BMI
- Weight cycling
- Gender
- Race
- Peer and family influence
- Social media
- Participation in weight class sports, independent of BMI

Signs and Symptoms of Body Image Disturbance

- Preoccupation with weight, shape, and/or appearance
- Compensatory behaviors to control body size (e.g., skipping meals, over exercising, laxative use)
- Comparison of self to a perceived ideal body image
- Feeling self-conscious or ashamed of body size and/or shape
- Taking steps to avoid seeing body, such as avoiding photos or mirrors
- Frequent weighing and/or measuring body
- Concealing perceived flaws (e.g., wearing loose fitting clothing)
- Feelings of depression and/or anxiety related to body size/shape
- Avoidance of social activities

Diagnosing Body Dysmorphic Disorder

Body Dysmorphic Disorder (BDD) is a mental health condition classified under the DSM-5 chapter of "Obsessive-Compulsive and Related Disorders"

DSM-V diagnostic criteria:

- **Preoccupation** with perceived flaw(s) not observable to others
- **Repetitive** behaviors in response to perception of flaw(s)
- **Clinically significant distress** related to perceived flaw(s)
- **Differentiation** from eating disorder diagnosis

Muscle Dysmorphia is a subgroup of BDD where an individual has concern that their body is "too small" or lacking enough musculature despite a relatively normal, or even muscular physique (predominately seen in males)

Body Image Disturbance in the Military

Prevalence in military vs civilian population

- **13% and 21.7%** prevalence of BDD in male and female service members (Campagna, 2016)
 - **5-10x higher** than the general population (Koran, 2008; Rief, 2006)
- **12.7% and 4.2%** prevalence of MD in male and female service members (Campagna, 2016)
 - **2.5-7.5x** higher than the general population (Leon, 2005)

The results of a 2021 study by Stukenborg et al revealed:

- Soldiers who fail to meet body composition standards have higher concern about conforming to a military image
- Soldiers who expressed having negative body image had greater odds of weight cycling
- ~1/3 of Soldiers classified as a healthy BMI reported weight cycling

Service Specific Body Composition Programs

DoDI 1308.03 directs each service to assess body composition "**using either BF calculations, waist-to-height ratio, abdominal circumference, height-weight screening, or any combination thereof**"

➤ **Army: AR 600-9, Army Body Composition Program**

Semi-annual – 100% height and weight ➔ 1-site tape test for individuals who fail screening tables

➤ **Navy: OPNAVINST 6110.1K, Physical Readiness Program**

Semi-annual – 100% height and weight ➔ 1-site tape test (AC) for individuals who fail screening tables ➔ 2-site or 3-site tape test for individuals who fail AC

➤ **Marines: MCO 6110.3A, Marine Corps Body Composition and Military Appearance Program**

Semi-annual – 100% height and weight ➔ 2-site or 3-site tape test for individuals who fail screening tables (*Marines who PASS body composition testing can still be placed in the MAP*)

➤ **Air Force/Space Force: Body Composition Program**

Annual - 100% waist-to-height ratio measurement

Weight Stigma in the Military

- **49%** of overweight or obese service members report experiencing stigma related to their weight and/or body shape (Schevy, 2016)
 - **19%** reported being mocked or given a weight-related nickname
 - **21%** reported they were told they simply need “more willpower”
 - **24%** reported experiencing punitive measures such as mandated additional PT sessions
 - **32%** reported they were assumed to be lazy and out of shape
 - **Nearly 1/3** reported coping with unhealthy weight control methods
 - Sauna use, laxative pills, purging, fasting, body wraps, surgical intervention

Harms of Weight Stigma



Increased stress → Increased cortisol



Increased compensatory behaviors



Decreased self-esteem



2.5x more likely to experience mood and anxiety disorders



Predicted future weight gain/weight cycling

Effects of Military Weight Stigma

An overweight Soldier with the same qualifications as a normal weight Soldier is viewed as:

- A worse role model for junior Soldiers
- Less likely to succeed in a promotion board
- A worse team member
- Having less will power and self-control
- Less active
- Less self-sacrificing
- Less physically fit

Attitude Towards and Beliefs About Obese Persons

Survey of 117 Army leaders in FORSCOM units

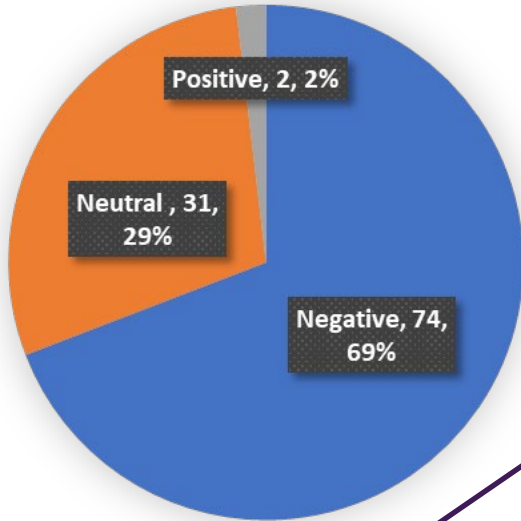
Attitudes Towards Obese Persons

- 59-point average (120 possible points)
 - <61 points indicates more negative attitude towards obese persons
- Indicates belief that obese persons lack confidence, are less happy, are ashamed of their bodies, and are less healthy than a non-obese person

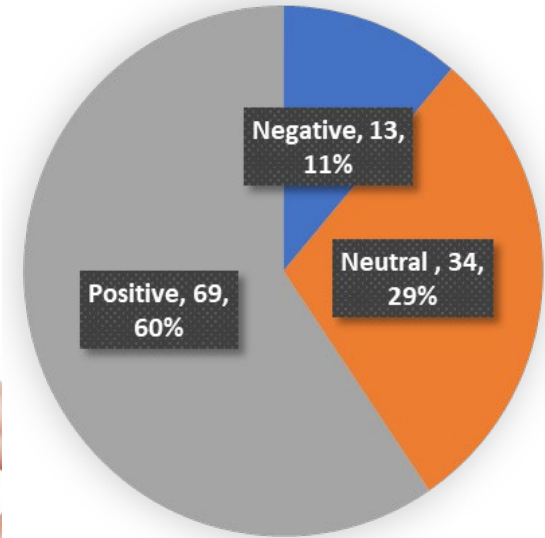
Beliefs About Obese Persons

- 14.6-point average (48 possible points)
 - <25 points indicates belief that obesity is caused by things within an individual's control
- Indicates a belief that obesity is caused by lack of willpower, overeating, and lack of physical activity

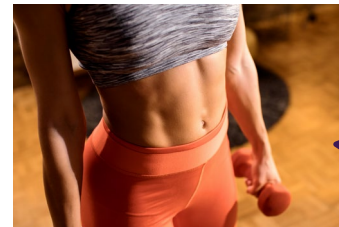
Perception of Different Body Types



"Good diet"
 "Athletic"
 "Disciplined"
 "Motivated"
 "Work ethic"



"Dad bod"
"Mom bod"
"Just had a baby"
"Post-baby muffin top"
"Poor eating habits"
"Slacker"
"Doesn't care"
"Lazy"
"Undisciplined"



"Workout too much"
"Drugs"
"Eating Disorder"
"Photoshopped"
"Unattainable"

Question Break

Screening Tools

- **Eating Disorder Examination Questionnaire – Short (EDE-QS)¹**
 - 12 self-report questions, score ranges from 0-36
 - Cut off score is 15 or higher indicates a probable eating disorder
 - 2 questions focused on body image
- **Eating Attitudes Test – 26 (EAT-26)²**
 - 26 self-report questions, score ranges from 0-78
 - Cut off score of 20 or above indicates a probable eating disorder
- **Eating Disorder Inventory - 3 (EDI-3)³**
 - 91 self-report questions, 12 separate scale scores, and 6 composite scores
 - Can be used for adolescents in the US and adults

Screening Tools

- **SCOFF¹**
 - 5 self-report questions
 - Not used to diagnose
 - A 'yes' to 2 or more questions indicates a more comprehensive assessment should be completed
 - Does not ask about restrictive eating behaviors
- **Screening, Brief Intervention, and Referral to Treatment for Eating Disorders (SBIRT-ED)²**
 - 5 questions based on the SCOFF
 - Currently not intended for use in adolescents
 - Does not ask about restrictive eating behaviors

Screening Tools

- **Muscularity-Oriented Eating Test (MOET)¹**
 - 15 self-report questions, score ranges from 0-60
 - Measures muscularity-oriented disordered eating
 - No cut off score, a higher score indicates a person engages in more muscularity-oriented disordered eating
- **Military Body Image Scale²**
 - 12 self-report questions, score ranges from 0-60
 - No cut off score, a higher score indicates a more negative body image
 - Does not ask about eating behaviors
 - Only validated for Service Members


Screening Tools

- New website and mobile app based on updated APA guidelines
- Aids providers with:
 - Screening
 - Assessment
 - Treatment
- <https://live.avomd.io/dashboard/8506c158-349e-41e6>

Eating Disorders (APA)

Updated Wed, Aug 2, 2023

This tool will cover screening, assessment, and treatment for potential eating disorders.

 Funding note  APA Practice Guideline on Treatment of Patients with Eating Disorders

 Additional resources for clinicians, patients, and families  How to use this algorithm

Do you wish to screen the patient for an eating disorder, do a detailed assessment of eating disorder features, or select a treatment for a specific eating disorder?

Screening

Assessment

Treatment

Multidisciplinary Team Approach

- Dietitian
- Behavioral Health Provider
- Doctor/Physician Assistant
- Nurse Case Manager
- Occupational Therapist
- Physical Therapist
- Athletic Trainer
- Strength and Conditioning Coach

Levels of Care

- Outpatient
- Intensive Outpatient (IOP)
- Partial Hospitalization (PHP)
- Residential
- Inpatient

TRICARE Policy Manual 6010.63-M, April 2021,
Chapter 11, Section 2.4, Eating Disorders Program

Levels of Care

- Outpatient
 - Weekly or biweekly appointments with providers
 - Medically stable
 - Least amount of support day to day
 - Tricare typically will not cover treatment at this level off post
- Intensive Outpatient (IOP)
 - Tricare will cover two to five days per week for at least 3 hours *
 - Medically stable
 - Provides some additional support
 - Can continue to work and/or attend schools as needed

*You need to check with the specific facility to make sure they accept Tricare.

Levels of Care

- Partial Hospitalization (PHP)
 - Five days per week for six to eight hours
 - Returns home in the evenings
 - Medically stable with more day-to-day monitoring
 - Structured programs and meals to provide more support
 - All services are provided at one location and can include:
 - Individual therapy
 - Nutrition counseling
 - Group therapy
 - Family therapy
 - Supported meals
 - Tricare does cover PHP*

*You need to check with the specific facility to make sure they accept Tricare.

Levels of Care

- Residential
 - 24-hour care/supervision
 - Medically stable with additional monitoring
 - All meals and snacks are supervised
 - Services provided include:
 - Individual therapy
 - Nutrition therapy
 - Group therapy
 - Family therapy
 - Psychiatric care
- Inpatient
 - Support for individuals who are not responding to lower levels of care and/or require medical stabilization and monitoring
 - Medical management and intensive treatment are provided

*You need to check with the specific facility to make sure they accept Tricare.

TABLE 5. Considerations in determining an appropriate level of care

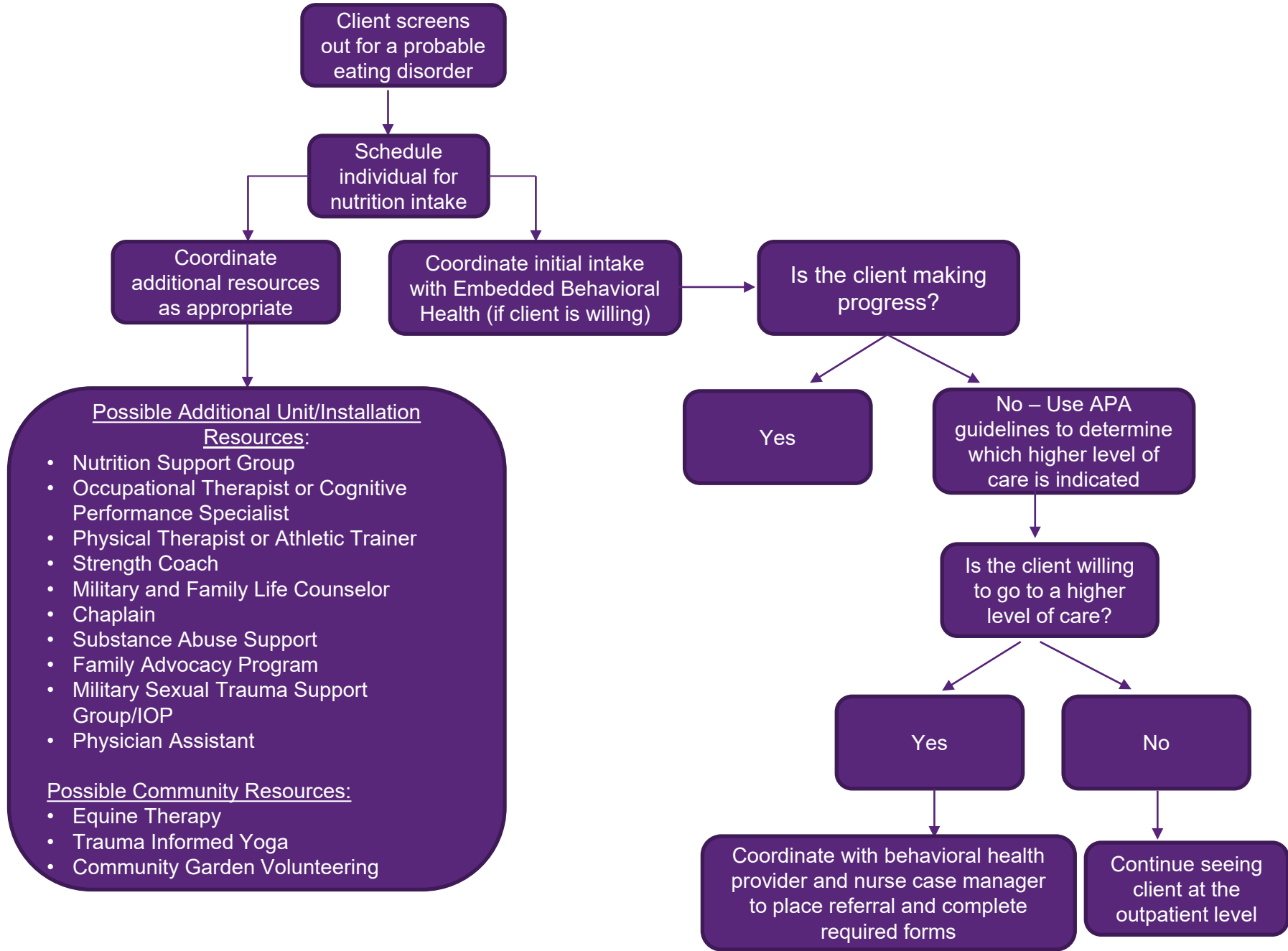
- Factors that suggest significant medical instability, which may require hospitalization for acute medical stabilization, including need for monitoring, fluid management (including intravenous fluids), electrolyte replacement, or nutritional supplementation via nasogastric tube feeding (see [Table 6](#))
 - Factors that would suggest a need for inpatient psychiatric treatment (e.g., significant suicide risk, aggressive behaviors, impaired safety due to psychosis/self-harm, need for treatment over objection or involuntary treatment)
 - Co-occurring conditions (e.g., diabetes, substance use disorders) that would significantly affect treatment needs and require a higher level of care
 - Lack of response or deterioration in patient's condition in individuals receiving outpatient treatment
 - Extent to which the patient is able to decrease or stop eating disorder and weight control behaviors (e.g., dietary restriction, binge eating, purging, excessive exercise) without meal support or monitoring
 - Level of motivation to recover, including insight, cooperation with treatment, and willingness to engage in behavior change
 - Psychosocial context, including level of environmental and psychosocial stress and ability to access support systems
 - Extent to which a patient's access to a level of care is influenced by logistical factors (e.g., geographical considerations; financial or insurance considerations; access to transportation or housing; school, work, or childcare needs)
-

TABLE 6. One or more factors supporting medical hospitalization or hospitalization on a specialized eating disorder unit

	Adults	Adolescents (12–19 years)
Heart rate	<50 bpm	<50 bpm
Orthostatic change in heart rate	Sustained increase of >30 bpm	Sustained increase of >40 bpm
Blood pressure	<90/60 mmHg	<90/45 mmHg
Orthostatic blood pressure	>20 mmHg drop in sBP	>20 mmHg drop in sBP
Glucose	<60 mg/dL	<60 mg/dL
Potassium	Hypokalemia ¹	Hypokalemia ¹
Sodium	Hyponatremia ¹	Hyponatremia ¹
Phosphate	Hypophosphatemia ¹	Hypophosphatemia ¹
Magnesium	Hypomagnesemia ¹	Hypomagnesemia ¹
Temperature	<36°C (<96.8°F)	<36°C (<96.8°F)
BMI	<15	<75% of median BMI for age and sex
Rapidity of weight change	>10% weight loss in 6 months or >20% weight loss in 1 year	>10% weight loss in 6 months or >20% weight loss in 1 year
Compensatory behaviors	Occur frequently and have either caused serious physiological consequences or not responded to treatment at lower level of care	Occur frequently and have either caused serious physiological consequences or not responded to treatment at lower level of care
ECG	Prolonged QTc >450 or other significant ECG abnormalities	Prolonged QTc >450 or other significant ECG abnormalities
Other conditions	Acute medical complications of malnutrition (e.g., seizures, syncope, cardiac failure, pancreatitis)	Acute medical complications of malnutrition (e.g., seizures, syncope, cardiac failure, pancreatitis), arrested growth and development

Note. BMI=body mass index; bpm=beats per minute; ECG=electrocardiogram; sBP=systolic blood pressure.

¹Reference ranges for potassium, sodium, phosphate, and magnesium and numerical thresholds for values that determine hypokalemia, hyponatremia, hypophosphatemia, and hypomagnesemia depend upon the clinical laboratory.



Question Break

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Upcoming Event



The Importance of Nutrition in Breast Cancer Survivorship Wednesday, October 25, 2023

11AM-12PM EST

This webinar provides information on nutrition and lifestyle issues that can arise during breast cancer treatment and survivorship.

Continuing education credit will be available for this session!

Upcoming Event



Diabetes Management for Patients Experiencing Food Insecurity

Tuesday, November 7, 2023

11AM-12PM EST

This presentation provides practical ways to apply the American Diabetes Association 2023 Standards of Care in Diabetes and reviews strategies to reduce food insecurity for patients with diabetes.

Continuing education credit will be available for this session!

Continuing Education



This webinar has been approved for the following continuing education (CE) credits:

- 1.5 CPEUs from the **Commission on Dietetic Registration (CDR)** for RDNs and NDTRs.
- 1.5 CEs from **UT Austin, Steve Hicks School of Social Work** for Social Workers, LPCs and LMFTs.
- 1.5 clock hours from the **Commission for Case Manager Certification** for Case Managers.
- 1.5 CEs from the **National Council on Family Relations (NCFR)** for CFLEs.
- 1.5 CEs from the **American Association for Family & Consumer Sciences (AAFCS)** for CFCS.
- 1.5 CEs from **The Patient Advocate Certification Board** for Board Certified Patient Advocates
- OneOp **Certificate of Attendance** available.

Evaluation Link

Go to the event page for the evaluation and post-test link.

[Continuing Education](#)

Questions?

Email Bethany Daugherty:
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