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Addressing Eating Disorders in Middle and High Schools

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Eating disorders, including anorexia nervosa and bulimia nervosa, are serious mental illnesses with onset commonly during the early teen years. They have serious medical consequences, are notoriously difficult to treat, and in many cases require specialized treatment.

Middle schools and high schools have an obligation to provide resources to support children with eating disorders as well as aid in their prevention. Charged with the care of children who may be suffering from these disorders for the majority of their waking day, schools need to be aware of the needs of children in treatment. In many cases schools may be an important partner in treatment. Through the power of the social milieu, they can also play a significant role in prevention.

Common eating disorders and their prevalence

Anorexia nervosa is characterized by a failure to maintain a healthy body weight, intense fear of gaining weight, and distorted body image. Bulimia nervosa is characterized by recurrent and frequent episodes of eating unusually large amounts of food (e.g., binge-eating), and feeling a lack of control over the eating. This binge eating is followed by a type of behavior that compensates for the

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binge, such as purging (e.g., vomiting, excessive use of laxatives or diuretics), fasting and/or excessive exercise.

Unlike people with anorexia who usually bear the obvious physical marks of their disorder, people with bulimia can have weight within the normal range for their height and age. For this reason, bulimia nervosa in student populations is often under-reported and under-diagnosed.

Prevalence rates of eating disorders are increasing worldwide. Anorexia nervosa is the third most common chronic illness among adolescents. The prevalence of eating disorders among adolescents in America is estimated to be 3.4% for girls and 1.5% for boys. In one study of American adolescents in the 5th through 12th grades, 13% of girls and 7% of boys reported engaging in both binge eating and purging behavior. However, a far higher proportion of youth report less severe symptoms of disordered eating and shape and weight concerns. US studies have reported that 50% of girls 11 - 13 see themselves as overweight and 80% of 13-year-olds have attempted to lose weight.

Eating disorder risk factors

It is now recognized that between 50 and 80 percent of a person's risk of an eating disorder is due to genetic factors. Previous theories of etiology focused primarily on family dynamics and sociocultural causes. We now know that families do not cause eating disorders. We also know that anorexia nervosa existed long before the current cultural ideal of thinness, so sociocultural explanations for anorexia are only one piece of the puzzle. Personality traits of anxiety and perfectionism are associated with or believed to contribute to eating disorders.

Regardless of contributing factors, in almost all cases of eating disorders dieting or caloric restriction (intentional or not) is usually the trigger. If someone genetically predisposed to an eating disorder never diets, they likely will never develop an eating disorder. Therefore an appropriate target for primary prevention is the prevention of dieting.

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Warning signs

The following behaviors might indicate that a student has an eating disorder. However, not all students with eating disorders will display these behaviors; and even though a student displays some of these symptoms, he or she might not have a disorder – so be careful when applying this as a guide.

- Skipping lunch
- Seeking out snacks frequently
- Avoiding high fat foods, eating only health foods, or consuming a very narrow variety of foods
- Throwing away food
- Avoiding food in social situations
- Playing with or taking apart foods (e.g., removing cheese from pizza)
- Secrecy around eating
- Using the restroom immediately after eating
- Weight loss, weight gain, or fluctuation in weight
- Frequent attempts at dieting
- Obsession with maintaining low weight to enhance performance in sports, dance, acting, or modeling
- Excessive exercise in physical education class, sports, dance, etc.
- Continually talking about food, weight, and body image or disparaging comments about their appearance
- Preoccupation with dieting or exercise
- Fatigue or dizziness
- Wearing baggy clothing
- Calluses or scars on the knuckle (from sticking their fingers down their throat)

Importance of Early Intervention

Eating disorders must be addressed from both a medical and a mental health perspective for full recovery to occur. Early intervention is crucial. The sooner one gets help, the greater the likelihood that they will get better. Without early intervention eating disorders may become chronic, or even fatal.

Research on people with bulimia nervosa showed a better recovery rate if they receive treatment early in their illness. If treated within the first 5 years, the recovery rate is 80%. If not treated until after 15 years of symptoms, recovery falls to 20%. Among those patients with anorexia nervosa who do not get early

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intensive treatment, a portion will remain chronically ill; of this portion, up to 20% may die of the disorder.

Treatment Recommendations

The malnutrition caused by an eating disorder dramatically alters mood, behavior, and thinking. Research shows that normalization of eating habits and weight restoration are the crucial first steps towards recovery. Those who are underweight must gain weight. Those who eat erratically must resume regular daily consumption and digestion of three meals and two to three snacks. Those who purge must stop.

For adolescents with eating disorders, the best-researched and most successful treatment is **Maudsley Family Based Therapy** or **FBT**. This approach focuses on using the strength of the entire family working together to beat the eating disorder. Parents are charged with re-nourishing their child during family meals. FBT offers a number of advantages over traditional treatments. FBT allows the child in treatment to remain in their home with the support of their family. With some exceptions, children receiving FBT are able to continue to attend school. By teaching the family skills in confronting eating disordered behaviors, FBT creates a more consistent treatment environment than an inpatient treatment program that eventually returns the child to a family not equipped to deal with relapse. FBT is also cost-effective compared to inpatient or residential treatment. FBT is supported by a number of resources to make it available even in communities where there may not be a specialist available. There are FBT manuals for both parents and therapists to learn the approach. There is an international support network and numerous resources for parents doing FBT.

RECOMMENDATIONS FOR MIDDLE AND HIGH SCHOOLS

Two organizations in the United States, the National Association of Anorexia Nervosa and Associated Disorders (ANAD) and the National Eating Disorders Association (NEDA) have published guidelines for schools in dealing with eating disorders. The following recommendations have been largely culled from the guidelines by ANAD and NEDA.

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Prevention

Schools should provide an environment that promotes and models healthy behaviors and healthy body image. The school cafeteria should provide nutritious food and unhealthy foods should be removed from vending machines.

Schools should provide a curriculum that promotes healthy flexible eating and size acceptance. An excellent curriculum for schools is *Healthy Body Image: Teaching Kids to Eat and Love Their Bodies Too* by Kathy Kater (2005). The curriculum should discourage dieting and counting of calories. There should be no anti-obesity messages and no rigid rules about nutrition. The school should provide education and awareness about eating disorders.

There should be a policy in place for students to report teasing, bullying, or harassment based on weight or appearance. Ideally, the school should review all materials in the school (books, posters, etc.) to ensure they include all body shapes, sizes, and racial groups. Students of all sizes should be encouraged to participate in school activities such as band, cheerleading, student government, theater groups, etc. Children should never be weighed in public nor should they be told their BMI or told to lose weight. In the event of a obesity-related health risk, the concern over unhealthy eating behaviors should be expressed by a physician, not the school.

Being Prepared

It is important that schools are responsive in dealing with eating disorders. Children spend a majority of their time in school and teachers have the opportunity to observe and interact with students in a variety of social, academic, and eating-related contexts. School personnel may become aware of a problem before the family.

In order for schools to identify and support children who have a disorder, the school should be up to date on evidence-based treatments. Faculty should receive training in identifying eating disorders and early intervention. Staff should receive training in sensitively addressing students showing signs of eating disorders. Ideally, there should be a designated resource person such as the school counselor or team to guide interventions for eating disorders.

The school should have resources available to which to refer students with eating disorders.

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Early Intervention

Talking with the student and parents. If a teacher has concerns about a student, the designated resource person/team can help guide the intervention and decide who speaks to the child. They also need to determine when parents are informed about the concern. Sometimes eating disorders can develop very suddenly and parents may not be aware there is an issue. I believe parents need to be informed early because the cost of waiting can be severe when it comes to eating disorders.

Parents may react in many ways when a school brings the issue to their attention. Denial is often encountered when eating disorder behavior is confronted and a student (and sometime even parents) may be unreceptive to the suggestion that anything is wrong. The school needs to be sensitive to the feelings and concerns of the parents, which may include shame, feeling blamed, and concerns about confidentiality.

A school staff member should begin by telling the family they are concerned and offer specific information about the student's behavior. The family should be educated about eating disorders, the importance of early intervention, and available resources. It is best if the school is clear about what services they can provide and who at the school will be a family liaison so the family has the opportunity to develop a supportive relationship with a school staff member, usually the school counselor. The school should work with the parents to decide collaboratively on the next steps the school will take with the student and family. The goal of this is to try to get the parents to acknowledge the problem and accept the school as a partner in the treatment.

Working with a child in treatment. Once referrals to medical and mental health resources (locally and internationally) are provided, the student should receive supportive counseling and medical monitoring. The school needs to communicate with any outside team members that are providing treatment. The school should discuss with the parents who will monitor the child (the school or an outside treatment provider), what kind of monitoring will be involved, and how this information will be communicated among the school, parents, and treatment providers (in accordance with confidentiality, laws, and other school policies). It may be appropriate or convenient to have the school nurse conduct periodic assessments and follow-up such as weight checks and pulse and blood pressure checks.

Even in cases where the family minimizes or ignores the severity of the eating disorder, the school needs to both show its concern for the student's safety and protect itself from liability. The school should expect guidance from a treatment team on whether the student is safe to participate in PE, sports, field trips, and

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the like. It may be appropriate for the school to set hard limits on strenuous activities for children with eating disorders – intense athletic activity is not going to help a low-weight student recover.

Accomodations to the student. The designated person should work with the treatment team and school to ensure that the intertwined medical, psychological, and academic needs of a student in recovery are taken into account. The student may need a reduced course load, a shortened school day, time off for appointments, days off for bed rest, extra snacks, meal monitoring during school lunches, release from health and physical education classes, or other accommodations. In some cases, students may need to take a leave of absence from school to attend a residential or inpatient treatment program. In these cases the school may be able to provide lessons to the child in treatment. Children returning from residential treatment may need help reintegrating into school and getting caught up on work.

RESOURCES

NEDA (www.nationaleatingdisorders.org) provides a downloadable toolkit for educators on their website.

ANAD (www.anad.org) publishes school guidelines that they will make available via email.

Maudsley Parents (www.maudsleyparents.org). This website for parents of eating-disordered children provides support and a great deal of information about Family-Based Therapy.

Families Empowered and Supporting Treatment of Eating Disorders *(FEAST)* (www.feast-ed.org)**.** FEAST is an international nonprofit organization of parents and caregivers designed to help loved ones recover from eating disorders by providing information and mutual support, promoting evidence-based treatment, and advocating for research and education to reduce the suffering associated with eating disorders.

Around the Dinner Table (www.aroundthedinnnertable.org) is a support forum for parents and caregivers of anorexia, bulimia and other eating disorder patients.

Academy for Eating Disorders (www.aedweb.org). The AED is the main international scientific body for the study and prevention of eating disorders. It provides professional training to therapists as well as education and information

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about eating disorders research, prevention, and clinical treatments. It has recently published a guideline for medical management of eating disorders.

Help Your Teenager Beat an Eating Disorder, James Lock, M.D., Ph.D. and Daniel Le Grange, Ph.D. (2005). This book for parents includes a comprehensive overview of the Maudsley (family based therapy) approach to treatment.

Eating Disorders Guide to Medical Management, 2nd Edition. This brief set of guidelines is designed to enhance early recognition of eating disorders by front line professionals and improves the quality of the initial assessment and medical management of individuals with eating disorders.

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