



National Eating Disorders Association

Educator TOOLKIT



NEDA TOOLKIT for Educators

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The NEDA Educational Toolkits Story

The Background

Whether you know or simply suspect that a student has an eating disorder, it can create lots of worry and confusion. *How can such a bright student seem to sacrifice everything for the sake of being thin? How will he succeed if he's always missing class due to medical appointments? Is there anything I can do to make school easier for her?* Although these questions and concerns are the signs of a good and caring teacher, there are some simple steps that you can take to help support your student in his/her recovery and allow them to fulfill their academic potentials.

Myths and misconceptions surround eating disorders that can make it more difficult for you to provide effective help to your students who might be struggling with these issues. The National Eating Disorders Association created a series of toolkits for parents, educators, and coaches to help dispel myths and provide accurate, up-to-date information in an easy-to-use guidebook.

Some of the questions and issues that you will see addressed in the following pages are:

- What are eating disorders?
- What are some signs that one of my students may have an eating disorder?
- How do they affect academic performance?
- What type of support will a student need after returning to school post-treatment?
- How can I create a classroom environment that is conducive to recovery?

Of course, no toolkit, no matter how thorough, could possibly address the diverse range of issues that are unique to each individual and academic setting. Instead, our goal is to provide a comprehensive overview of eating disorders and treatment in one easy-to-use document. We have provided resources for more in-depth information that may address these unique issues.

A Brief History of the Toolkits

In September 2007 the NEDA Board of Directors officially approved the organization's new strategic priorities, listing educational toolkits as a new NEDA priority fitting the new mission: "To support individuals and families affected by eating disorders, and serve as a catalyst for prevention, cures and access to quality care."

The toolkits were initially developed to tie together existing information and create new materials to create a complete package to assist individuals in their search for information and help. They were meant to provide guidance, not create standards of care, and would be based on the best available information at the time of development.

The first toolkits were created with the assistance of the ECRI Institute, an organization known for its ability to translate complex healthcare research into accessible, usable information. After developing the first draft of the Educator Toolkit, NEDA and ECRI convened several focus groups of educators to review the document. NEDA's Board of Directors and other eating disorders experts performed a final review of the toolkit.

With the continuing advances in eating disorder research and treatment, NEDA recognized the need for a toolkit revision. Again, the input of educators, former eating disorder sufferers, and eating disorder experts was used to further refine the draft document. In 2015, the newest version of the Educator Toolkit was released.

We are currently seeking funding for the ongoing development of toolkits, as well as distribution and marketing. If you or anyone you know may be interested in contributing to, sponsoring or providing a grant to support these efforts, please be sure to contact our Development Office at 212-575-6200, ext. 307; development@nationaleatingdisorders.org.

We hope you'll find these toolkits useful and will share this resource with others.

Eating Disorder Information

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Frequently asked questions about eating disorders

What is an eating disorder?

Eating disorders are serious but treatable illnesses with medical and psychiatric aspects. The DSM-5, published in 2013, recognizes anorexia, bulimia, and binge eating disorder (BED) as diagnosable eating disorders. Some eating disorders combine elements of several diagnostic classifications and are known as “other specified feeding or eating disorder” (OSFED). Eating disorders often coexist with a mental illness such as depression, anxiety, or obsessive-compulsive disorder. People with an eating disorder typically become obsessed with food, body image, and weight. The disorders can become very serious, chronic, and sometimes even life-threatening if not recognized and treated appropriately.

Who gets eating disorders?

Males and females may develop eating disorders as early as elementary school. While it’s true that eating disorders are more commonly diagnosed in females than in males, and more often during adolescence and early adulthood than in older ages, many cases are also being recognized in men and women in their 30s, 40s, and older. Eating disorders affect people of all socioeconomic classes, although it was once believed that they disproportionately affected upper socioeconomic groups. Anorexia nervosa ranks as the third most common chronic illness among adolescent females in the United States. Recent studies suggest that up to 7% of US females have had bulimia at some time in their lives. At any given time an estimated 5% of the US population has undiagnosed bulimia. Current findings suggest that binge eating disorder affects 0.7% to 4% of the general population. (Smink, van Hoeken and Hoek, 2012)

Can eating disorders be cured?

Many people with eating disorders who are treated early and appropriately can achieve a full and long-term recovery. Some call it a “cure” and others call it “full remission” or “long-term remission.” Among individuals whose symptoms improve — even if the symptoms are not totally gone (called a “partial remission”) — the burden of the illness can be greatly diminished. This can encourage increased happiness and productivity, a healthier relationship with food, and an improved quality of life. Treatment must be tailored to the individual patient and family. Controversy exists around the term “cure,” which can imply that a patient does not have to be concerned with relapse

into the disorder. Many clinical experts prefer the term “remission” and look at eating disorders as a chronic condition that can be very effectively managed to achieve complete remission from signs and symptoms. Patients may, however, be at risk of a relapse in the future. Many patients in recovery agree that remission more accurately describes their recovery because they need to continuously manage their relationship with food, concepts about body image, and any coexisting mental condition, such as depression.

If someone I know intentionally vomits after meals, but only before big events — not all the time — should I be concerned?

Yes. Anyone who feels the need to either starve or purge food to feel better has unhealthy attitudes about one or more issues, such as physical appearance and body image, food, or underlying psychological factors. This doesn’t necessarily mean the person has a diagnosable eating disorder, but it does warrant expressing concern to the person about their behavior. If he or she denies the problem or gets defensive, it might be helpful to have information about what eating disorders actually are. Contact the National Eating Disorders Association’s Information and Referral Helpline for information and resources to help you learn how to talk to someone you care about. Call toll-free (1-800- 931-2237) or visit www.nationaleatingdisorders.org for a Click to Chat option.

I know someone who exercises for three or four every day. Is this considered a sign of an eating disorder?

Perhaps. If the person is not training for a rigorous athletic event (like the Olympics), and the compulsion is driven by a desire to lose weight despite being within a normal weight range, or by guilt due to bingeing, then, yes, the compulsion to exercise is a dimension of an eating disorder. If you know the person well, talk to him/her about the reasons he or she exercises so much. If you are concerned about their weight or the rationale behind the excessive exercise regime, lead the person to information and resources that could help.

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I'm noticing some changes in weight, eating habits, exercise, etc., with an athlete, but I'm not sure if it's an eating disorder. How can I tell?

Unless you are a physician or a clinician, you can't make a diagnosis, but you can refer the athlete to appropriate resources that might help. Keep in mind, however, that denial is typically a big part of eating disorder behavior and an athlete may be unreceptive to the suggestion that anything is wrong. Often it takes several conversations before the athlete is ready to listen to your concerns.

What if I say the wrong thing and make it worse?

Family, friends, school staff and coaches often express concern about saying the wrong thing and making the eating disorder worse. Just as it is unlikely that a person can say something to make the eating disorder significantly better, it is also unlikely that someone can say something to make the disorder worse. Saying nothing can be a bigger risk.

A group of athletes is dieting together. What should we do?

Seeing an athlete develop an eating issue or disorder can sometimes lead other athletes to feel confused, afraid, or full of self-doubt. They may begin to question their own values about thinness, healthy eating, weight loss, dieting, and body image. At times athletes may imitate the behavior of their teammates. Imitating the behavior may be a way of dealing with fear, trying to relate to the teammate with the eating disorder, or trying to understand the illness. In other cases, a group of athletes dieting together can create competition around weight loss and unhealthy habits. If dieting is part of the accepted norm of the team, it can be difficult for any athlete seeking peer acceptance to resist joining the behavior. Approaching an athlete who is imitating the behavior of a teammate with an eating disorder should be similar to approaching an athlete with a suspected eating problem.

What should be done when rumors are circulating about a student with an eating disorder?

If a student has an eating disorder and other students are talking about it to the point where the student with the eating disorder is uncomfortable coming to school, a strategy to deal with the gossip should be implemented. When a student is suspected of having or is diagnosed with an eating disorder, fellow students may have different reactions. Rumors often develop that further isolate the student experiencing the eating disorder and reinforce the stigma of mental illness, potentially discouraging those who are struggling from getting necessary help and support. Rumors can also be a form of bullying. Here are some suggested strategies:

- Assess the role of the rumors. Sometimes rumors indicate students' feelings of discomfort or fear.
- Demystify the illness. Eating disorders can sometimes become glamorized or mysterious. Provide accurate, age-appropriate information that focuses on several aspects of the illness such as the causes as well as the social and psychological consequences (not only the extreme physical consequences).
- Work privately with students who are instigating and/or perpetuating rumors: talk about confidentiality and its value. For example, promote the idea that medical information is private and therefore no one's business. Without identifying the students as instigators of the rumors, encourage them to develop strategies for dealing with the rumors by establishing a sense of shared concern and responsibility. For example, "Can you help me work out a way of stopping rumors about (student's name), as he/she is finding them very upsetting?"

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Are the issues different for males with an eating disorder? What do I say?

Some aspects may be different in males. Important issues to consider when talking to or supporting a male who may have an eating disorder include the following:

- Stigma. Eating disorders are promoted predominantly as a female concern. Males may feel a greater sense of shame or embarrassment.
- It may be even more important not to mention the term “eating disorder” in the discussion, but rather focus on the specific behaviors you have noticed that are concerning.
- Keep the conversation brief and tell him what you’ve directly observed and why it worries you.
- Eating disorder behavior presents differently in males. Although the emotional and physical consequences of eating disorders are similar for both sexes, males are more likely to focus on muscle gain, while females are more likely to focus on weight loss.

What’s the difference between overeating and binge eating?

Binge eating is distinguished by eating an amount of food within a specified time that is larger than the amount that most people would consume during a similar time and circumstance, and a sense of loss of control, or inevitability of a binge, such that the individual feels that he or she could not have stopped it from happening, and afterwards experiences shame and guilt. Sometimes, detailing daily eating patterns can be helpful in decreasing food consumption. However, it may be insufficient in addressing the underlying emotional or psychological components of an eating disorder and consequences of binges. Anyone who suspects that they may be suffering from binge eating disorder should speak with a trained professional in order to identify and address any underlying components.

Can’t people who have anorexia see that they are too thin?

Most cannot. Body image disturbance can take the form of viewing the body as unrealistically large (body image distortion) or of evaluating one’s physical appearance negatively (body image dissatisfaction). People with anorexia often focus on body areas where being slim is more difficult (e.g., waist, hips, thighs). They then believe they have “proof” of their perceived need to strive for further weight loss. Short-term weight loss and shape-change goals are often moving targets that can lead to a slippery slope of unhealthy weight loss. Body image dissatisfaction is often related to an underlying faulty assumption that weight, shape, and thinness are the primary sources of self-worth and value. Adolescents with negative body image concerns may be more likely than others to be depressed, anxious, and suicidal.

I know someone who won’t eat meals with family or friends, both in and out of school. How can he/she not be hungry? Does he/she just not like food?

Most likely, the person is overwhelmingly preoccupied with food. A person with an eating disorder does not like to eat with others, does not like anyone questioning his/her food choices, and is totally consumed with refraining from eating. Is the person hungry? Yes! But the eating disorder controls the person.

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Common myths about eating disorders

Even for professionals who have been treating them for years, eating disorders can be baffling and confusing illnesses. Adding to this confusion is the fact that eating disorders are surrounded by a large number of myths and misconceptions. It can be difficult for some people to take an eating disorder diagnosis seriously. This section will help dispel some of the most common misunderstandings about eating disorders and those affected by them. You may wish to print out this section and share it with other teachers and educators.

Eating disorders are a choice. I just need to tell my student to snap out of it.

Eating disorders are actually complex medical and psychiatric illnesses that patients don't choose and parents don't cause. The American Psychiatric Association classifies five different types of eating disorders in the Diagnostic and Statistical Manual, 5th Edition (DSM-5): anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder (ARFID) and other specified feeding and eating disorders (OSFED). Several decades of genetic research have shown that eating disorders are strongly heritable and frequently co-occur with other mental illnesses like major depression, social anxiety disorder, and obsessive-compulsive disorder.

Doesn't everyone have an eating disorder these days?

Although our current culture is highly obsessed with food and weight, and disordered patterns of eating are very common, clinical eating disorders are less so. Those with disordered eating behaviors may engage in similar behaviors as those with clinical eating disorders, but disordered eating is distinguishable from a clinical eating disorder by the lower frequency and severity of the disordered behavior and symptoms. However, disordered eating behaviors should not be taken lightly; disordered eating is problematic, can be a source of distress, and may lead to a clinical eating disorder.

When researchers followed a group of 496 adolescent girls until they were 20, they found that 5.2% of the girls met criteria for DSM-V anorexia, bulimia, or binge eating disorder. When the researchers included OSFED criteria, a total of 13.2% of the girls had suffered from a DSM-V eating disorder by age 20. The consequences of eating disorders can be life-threatening, and many individuals find that stigma against mental illness (and eating disorders in particular) can obstruct a timely diagnosis and adequate treatment.

Eating disorders are a sociocultural disease.

The causes of an eating disorder are complex. Current thinking holds that eating disorders are caused by a combination of biological, psychological, sociocultural, and environmental factors. Sociocultural factors, such as an emphasis on a thin body ideal, can create a culture in which disordered eating attitudes and behaviors are reinforced. Environmental factors, such as bacterial and viral infections and childhood teasing and bullying, may also play a role. Additionally, there may be a genetic component, as there are biological predispositions that make individuals vulnerable to developing an eating disorder. Eating disorders are complex diseases with multifaceted causes; anyone struggling with an eating disorder should be treated by a trained professional in order to ensure that all causal factors — biological, psychological, sociocultural and environmental — are appropriately addressed.

It's just an eating disorder. That can't be a big deal.

Eating disorders have the highest mortality rate of any psychiatric illness. Up to 20% of individuals with chronic anorexia nervosa will die as a result of their illness. Community studies of anorexia, bulimia, and other specified feeding and eating disorders (OSFED) show that all eating disorders have similar mortality rates. Of the causes of death for individuals with eating disorders, suicide is one of the most common. Other causes include medical complications from binge eating, purging, starvation, and over-exercise. People who struggle with eating disorders also have a severely impacted quality of life, oftentimes leaving sufferers friendless and absent from a real life for many years.

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Anorexia is the only serious eating disorder.

When researchers looked at the death rates of individuals with any eating disorder diagnosis who were being treated as outpatients, they found that individuals with bulimia and OSFED were just as likely to die as those with anorexia. During the study, roughly 1 in 20 people with eating disorders died as a result of their illness. Individuals who take laxatives or diuretics or force themselves to vomit are at significantly higher risk of sudden death from heart attacks due to electrolyte imbalances. Excessive exercise also can increase the risk of death in individuals with bulimia. The psychological and social consequences of eating disorders, including isolation, stigma, and shame, can also be extremely dangerous to the sufferer's mental health and social wellbeing.

If my student insists they are fine, I should believe them.

One of the symptoms of an eating disorder can include a difficulty understanding the presence or severity of the eating disorder. Thus, your student may genuinely believe they are fine when they are acutely ill. The effect of malnutrition on the brain can make it difficult for the sufferer to think rationally and perceive the seriousness of the behavior. Other people may insist they are fine even when they know they are not because they are afraid of treatment. And in many instances the child is terrified to surrender the one coping skill they have found to be effective for them. Regardless of the reason, it is important to insist on regular medical follow-up with a physician who is well-versed in eating disorders. Keep in mind that medical tests do not always reveal a need for treatment, but it is important for anyone struggling with disordered eating to have their health monitored by a professional.

Strict dieting or fad eating isn't a problem.

What appears to be a strict diet on the surface may actually be an eating disorder in disguise, or the beginnings of one. Even if it isn't a clinical eating disorder, disordered eating can nonetheless have serious medical consequences. Individuals dealing with serious disordered eating (eating behaviors that negatively impact one's life but do not meet the criteria for an eating disorder) may benefit from intervention and treatment to address their concerns. Chronic dieting has been associated with the later development of an eating disorder, so addressing these issues right away may prevent a full-blown eating disorder; early

intervention for disordered eaters has been shown to dramatically improve outcomes.

As long as someone isn't emaciated, they are not that sick.

You can't diagnose an eating disorder just by looking at someone. Although most people with eating disorders are portrayed by the media as emaciated, they don't represent the vast majority of eating disorder sufferers, most of whom are not underweight. These perceptions can allow eating disorders to remain untreated for years, and can cause distress in eating disorder sufferers, who may feel that they are not "sick enough" to deserve treatment.

The main eating disorder symptom I have to worry about in my student is weight loss.

Although anorexia nervosa and other restrictive eating disorders are characterized by weight loss, many people with eating disorders don't lose weight and may even gain weight as a result of their disorder; weight is not always an identifying factor for having or not having an eating disorder. There are many physical and behavioral symptoms of an eating disorder; weight change is one of many possible effects.

Eating disorder behaviors only focus on food.

Individuals with eating disorders generally have an unhealthy focus on food and weight, but the symptoms of an eating disorder can extend far beyond food. Genetic research has shown links between eating disorders, perfectionism, and obsessiveness, which can lead to a fixation on grades or sports performance. As well, the malnutrition caused by eating disorder behaviors has been shown to increase depressed mood and anxiety that can affect all aspects of life.

My student doesn't claim to feel fat. Can they still have an eating disorder?

Absolutely. While body image and weight concern are common in eating disorders, some individuals develop eating disorders without concern about weight. Younger children are less likely to indicate concerns about weight or shape in spite of engaging in disordered eating behaviors, and some teens and adults also do not report weight concern as a symptom. Body image issues are not required for an eating disorder diagnosis.

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Since eating disorders are linked to biology, my student doesn't have much hope for recovery.

Biological factors can make someone more vulnerable to an eating disorder, but the disorder is neither untreatable nor predestined. There is always hope for recovery; individuals can recover from eating disorders at any age or at any point in their illness. Although their vulnerability to turn to eating disordered behaviors when under stress may never disappear entirely, there are lots of good techniques that individuals with eating disorders can learn to help manage their emotions and keep behaviors from returning. The goal of recovery is to learn effective coping strategies that help individuals maximize emotional wellbeing, physical health, and quality of life.

I don't have to worry about eating disorders in male students because they're a "girl thing."

Although eating disorders are believed to be more common in females, researchers and clinicians are becoming aware of a growing number of males who are seeking help for eating disorders. A 2007 study by the Centers for Disease Control and Prevention found that up to one-third of all eating disorder sufferers are male. It's currently not clear whether eating disorders are actually increasing in males or if more males who are suffering are seeking treatment or being diagnosed. Because physicians don't think of eating disorders as occurring in males, their disorders have generally become more severe and entrenched at the point of diagnosis. There may be subtle differences in eating disorder thoughts and behaviors in males, who are more likely to be obsessed with building muscle than weight loss. They are also more likely to purge via exercise and misuse steroids than females. Gay, bisexual, and transgender males are more likely to develop an eating disorder than are straight males.

My student is too young to develop an eating disorder.

People who treat eating disorders are reporting increasing numbers of young children being diagnosed, some as young as five or six. Although eating disorders typically develop during adolescence and young adulthood, it is possible to develop an eating disorder at any age. Often, the thoughts and behaviors that precede the eating disorder begin much earlier than the onset of the disorder itself. Many eating disorder sufferers report that their thoughts and behaviors

started much earlier than anyone realized, sometimes even in early childhood. Recognition of these early warning signs allows for more effective intervention. It is not clear whether people are actually developing eating disorders at younger ages or if an increased awareness of eating disorders in young children has led to improved recognition and diagnosis.

Since I teach older students, I don't have to worry about an eating disorder. They'll grow out of it.

The research literature has identified a subset of people with eating disorders who seem to recover spontaneously, without treatment. However, many people who struggle with eating disorders and disordered eating in their teens continue to struggle into adulthood unless they receive treatment. Increasing numbers of older men and women are being treated for eating disorders, either due to a relapse or because their disorder was never adequately treated. One should be careful not to assume that their students will spontaneously recover. It is important to encourage your student to seek help from professionals with experience treating eating disorders.

If my student has bulimia, I don't have to worry about him developing another eating disorder.

Many with eating disorders will suffer from more than one disorder before they ultimately recover. Roughly half of all people with anorexia will go on to develop bulimia. Some individuals show signs of both anorexia and bulimia simultaneously, regularly binge eating and purging while at a low weight (this is technically known as anorexia, binge/purge type). Still others transition from one diagnosis to another, a process known as diagnostic cross-over.

Purging only involves self-induced vomiting.

Purging includes any method of removing food from the body before it is fully digested. Many times, an individual is driven to purge to compensate for what was perceived as excessive food intake. While self-induced vomiting is one of the most common ways that an individual will purge, it's far from the only method. Individuals can also use laxatives and enemas, as well as non-purging compensatory behaviors, such as abusing insulin, fasting, and excessive exercise. An individual can purge through more than one method. Each method carries its own particular risks, but all involve potentially life-threatening electrolyte imbalances.

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Once my student with anorexia gains weight, she will be fine.

Weight and nutritional restoration are only the first steps to anorexia recovery. Malnutrition compromises cognitive abilities, so once anorexia sufferers return to a weight that is healthy for them, they can usually participate more fully and meaningfully in psychotherapy. Other psychological work usually

needs to be done so individuals can manage thoughts, emotions, and behaviors without resorting to anorexic behaviors. Weight recovery alone does not mean the eating disorder is cured. In fact, post-weight restoration is a very difficult period for those seeking recovery due to the added anxiety of potential appearance changes and physical discomfort, among many other factors. An outpatient treatment team and support in school is essential after weight restoration.

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Eating disorder signs and symptoms specific to a school setting

During adolescence, young people often experience sudden variations in height and weight. For example, girls can gain an average of 40 pounds (lb.) from age 11 to 14—and that’s normal. A girl or boy who puts on weight before having a growth spurt in height may look plump, while a student who grows taller but not heavier may appear rather thin.

The points outlined below are not necessarily definitive signs or symptoms of an eating disorder — only an expert can make that diagnosis. Although many individuals with eating disorders are perfectionistic and appear to be “perfect” students, it’s not a universal trait. Also be aware that perfectionism can be expressed by what looks like apathy — if a student can’t reach the impossibly high standards s/he sets for her- or himself, they may opt not to try. Perfectionistic individuals might feel that disappointing themselves or others would be too upsetting, so they opt to avoid the possibility instead.

Eating disorders are marked by a variety of emotional, physical, and behavioral changes. While some of the behaviors may appear to be little more than teenage dieting and body dissatisfaction, taken together they can indicate a serious, life-threatening eating disorder. If a student consistently shows one or more of the signs or symptoms listed below, it is cause for concern.

Emotional

- Changes in attitude/performance
- Expresses body image complaints/concerns: being too fat even though normal or thin; unable to accept compliments; mood affected by thoughts about appearance; constantly compares self to others; self-disparaging; refers to self as fat, gross, ugly; overestimates body size; strives to create a “perfect” image; seeks constant outside reassurance about looks
- Incessant talk about food, weight, shape, exercise, cooking, etc.
- Displays rigid or obsessive thinking about food, eating, exercise: labels foods as good/bad; on/off limits for no actual reason; appears uncomfortable or unwilling to share food; inflexible about diet without reason
- Appears sad/depressed/anxious/ashamed/embarrassed/expresses feelings of worthlessness
- Emotions are flat or absent
- Intolerance for imperfections in academics, eating, social life, etc.
- Is target of body or weight bullying currently or in the past
- Spends increasing amounts of time alone; pulls back from friends
- Is obsessed with maintaining unhealthy eating habits to enhance performance in sports, dance, acting, or modeling
- Overvalues self-sufficiency; reluctant to ask for help
- Unable or unwilling to acknowledge recent changes

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Physical

- Sudden weight loss, gain, or fluctuation in short time
- Complaints of abdominal pain
- Feeling full or “bloating”
- Feeling faint, cold, or tired
- Dark circles under the eyes or bloodshot eyes/ burst capillaries around eyes
- Calluses on the knuckles from self-induced vomiting
- Dry hair or skin, dehydration, blue hands/feet
- Lanugo hair (fine body hair)
- Fainting or dizziness upon standing; frequent fatigue
- Thinning, dry hair

Behavioral

- Diets or chaotic food intake; pretends to eat, then throws away food; skips meals
- Creates rigid dietary rules or observes strict diet without medical or religious reason
- Exercises for long periods and with obsessional attitude; exercises excessively every day (can't miss a day)
- Constantly talks about food; unwilling to share food; hoards food; refuses to eat food prepared by others or without knowing exact ingredients
- Difficulty sitting still: hovers over chair instead of sitting, constantly jiggles legs, gets up from desk at every opportunity, offers to run errands
- Makes frequent trips to the bathroom
- Makes lists of foods and calories eaten
- Wears very baggy clothes to hide a very thin body (anorexia) or weight gain (binge eating disorder) or to hide a “normal” body because of concerns about body shape/size
- Avoids cafeteria, works through lunch, eats alone
- Shows some type of compulsive behavior (e.g., compulsive hand washing; hoarding; repetitive movements/speech; need for constant reassurance)
- Denies difficulty with food or body image despite evidence that it is an area of concern

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Medical problems that can arise from specific eating disorders

Although the following medical complaints may not all affect an individual at once, they are further signs that a student may be suffering from an eating disorder and is in a compromised medical state.

Anorexia Nervosa

- Heart failure (can be caused by slow heart rate and low blood pressure; the use of drugs to stimulate vomiting, bowel movements, or urination; or starvation, which can also lead to brain damage)
- Brittle hair and nails; dry skin (skin may dry out and become yellow, and the affected person can develop a covering of soft hair called lanugo)
- Mild anemia
- Swollen joints
- Reduced muscle mass
- Long-term constipation
- Osteoporosis

Binge Eating Disorder

- High blood pressure
- High cholesterol
- Fatigue
- Joint pain
- Type II diabetes
- Gallbladder disease
- Heart disease

Bulimia Nervosa

- Erosion of tooth enamel from the acid produced by vomiting
- Inflammation of the esophagus (the tube in the throat through which food passes to the stomach)
- Enlarged glands near the cheeks (giving the appearance of swollen cheeks)
- Stomach damage from frequent vomiting
- Irregular heartbeat
- Heart failure
- Electrolyte imbalances (loss of important minerals like potassium) that can lead to sudden death
- Peptic ulcers
- Pancreatitis (inflammation of the pancreas, which is a large gland that aids digestion)
- Long-term constipation

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Impact of eating disorders on cognitive ability and functioning in school

Eating disorders can profoundly affect a child's ability to learn. Understanding some of the ways an eating disorder can affect cognitive function may help educators to recognize that a student may be at risk for an eating disorder. Listed below are key ways that an eating disorder can affect a child's cognitive functioning because of poor nutrition. A child's cognitive function will also be affected by the mental disorders that often coexist with an eating disorder, which may include anxiety, depression, and obsessive-compulsive disorder.

A review of the research on the impact of under-nutrition found that unhealthy dietary patterns:

- Can have detrimental effects on cognitive development in children
- Has a negative impact on student behavior and school performance
- Makes students feel irritable, may cause nausea, headache, and makes students feel fatigued and have lack of energy
- Individuals who are actively dieting have a reduced ability to concentrate and focus, and do less well at listening to and processing information
- Negatively affects students' task performance
- Leads to deficiencies in specific nutrients, such as iron, which has an immediate effect on students' memory and ability to concentrate
- Causes people to focus on the details at the expense of the big picture, which may affect a student's ability to synthesize information and understand broader concepts
- Increases perfectionism and obsession with good grades
- Can increase anxiety and depression, which further amplifies the negative effects of unhealthy dietary patterns
- Can make students become less active and more apathetic, withdrawn, and engaged in fewer social interactions
- Can impair the immune system and make students more vulnerable to illnesses
- Increased absenteeism in affected students because of the above impairments

Despite malnourishment, the perfectionist attitude of those who suffer from anorexia and bulimia may compel them to maintain a high level of academic performance. Thus a student with a life-threatening eating disorder may continue to earn all A's, despite being acutely ill. For individuals with eating disorders, functioning can be asymmetrical; some areas, such as schoolwork, may be less affected, while others, such as health and social functioning, are affected greatly. Academic performance is not a good measure of an eating disorder's severity.

In addition to the effects described above, preoccupation with food often dominates the life of a student with an eating disorder. According to Dan W. Reiff and Kathleen Kim Lampson Reiff in *Eating Disorders: Nutrition Therapy in the Recovery Process*, individuals with eating disorders self-report an overwhelming preoccupation with food:

“In our clinical practice we surveyed over 1,000 people with clinically diagnosed eating disorders. We found that people with anorexia nervosa report 90 to 100 percent of their waking time is spent thinking about food, weight and hunger; an additional amount of time is spent dreaming of food or having sleep disturbed by hunger. People with bulimia nervosa report spending about 70 to 90 percent of their total conscious time thinking about food and weight-related issues. In addition, people with disordered eating may spend about 20 to 65 percent of their waking hours thinking about food. By comparison, women with normal eating habits will probably spend about 10 to 15 percent of waking time thinking about food, weight, and hunger.”

Strategies for Schools and Educators

NEDA TOOLKIT for Educators

School strategies for assisting students with eating disorders

Teachers, administrators, and staff

- Develop a student assistance program (SAP) and protocol, if one is not already in place (see *sample SAP information form*), for students, faculty, and staff to channel nonacademic concerns about a student. This should create an appropriate pathway that adheres to the local laws and regulations governing communications among teachers/parents/students/outside healthcare.
- Designate a subgroup (of at least two members) of the SAP to learn about eating disorders and share their knowledge and expertise with other school personnel and plan an in-service, if possible. This should include learning about effective strategies for identifying, preventing and supporting students with eating disorders.
 - When assembling the subgroup, consider including the school nurse, school psychologist, guidance counselor, and other individuals who are well-situated for early identification of disordered eating in students.
- If a full training program is not possible, plan some time at a faculty meeting to discuss eating disorders or hand out basic information to staff on signs and symptoms of eating disorders, addressing concerns with students and/or parents, and coach and teacher tip sheets.
- Create specific guidelines on referrals for students suspected of having an eating disorder. Be prepared to refer students and families to appropriate local counseling resources and medical practitioners who are familiar with eating disorders, if available. Also obtain options for individuals with limited or no insurance coverage.
- Update school anti-harassment and anti-discrimination policies to ensure they include provisions about physical appearance and body shape. Ensure that a protocol is in place for students to report teasing, bullying, or harassment based on weight or appearance. Consequences for bullying behavior should be clearly outlined and communicated to students.
- Decide which staff will take responsibility for monitoring and communicating changes in a student's well-being through appropriate channels to concerned parties (and in accordance with confidentiality, laws, and SAP protocols). That teacher or staff person should take on the role of "checking in" with the student each week for a few minutes to see how he/she is. This may involve an informal chat during lunch, recreation time, or before or after school as appropriate.
- Use checklists of typical physical, social, behavioral, and psychological signs and symptoms of eating disorders to facilitate monitoring changes that could signal progression to a more serious condition so that a student can be referred to specialist support as warranted.
- Work towards the elimination of student weighing and BMI measurements in health, PE, and other classes. If you can't, make it a policy not to weigh students publicly or in close proximity to fellow students. Consider eliminating weigh-in policies for sports programs as well.
- Advocate for a wide range of tasty and nutritious foods in school cafeterias, and vending machines with a variety of snacks and beverages.
- Consider offering a community outreach program on eating disorders; invite experts in your area to speak on the topic.
- Review posters/books/materials in the school to ensure they include a broad variety of body shapes, sizes, and ethnicities.
- Ensure that students of all sizes are encouraged to participate in school activities such as band, cheerleading, student government, theater groups, etc. Ensure that students are not typecast by appearance in drama roles.

NEDA TOOLKIT for Educators

Assist the student

- If a student discloses a personal problem, consider the setting in which the disclosure has occurred. If, for example, it is during a class or another setting where others are present, practice protective interrupting (e.g., “Thank you for sharing that... I’d really like to follow this up with you after [class; recess; gym].”)
 - Be aware that a student who has divulged very personal concerns has chosen the particular teacher or staff person to divulge to for a reason. Acknowledge to the student how difficult disclosing personal concerns can be.
 - Ask the student with the eating disorder privately how he/she would like teachers (and others) to respond when asked about how the student is doing.
 - Contact the student’s parents or guardians to assure appropriate medical and psychological follow-up.
 - Remain mindful that the student may not have disclosed the full extent of his/her problems and the situation may be more serious than either of you realizes.
- Support friends and fellow students by providing information and opportunities to talk about:
 - Emotions they may be experiencing
 - Coping with the changes in their friend (for example, behavioral and social changes such as increased agitation or social isolation)
 - Strategies to support their friend
 - Strategies to support themselves (e.g., practicing self-care; taking time-outs)
 - Strategies to help create a positive environment for friend and others (e.g., eliminating “fat talk”)
 - Their responsibility as a friend (to provide friendship and stay mindful of their friend’s overall well-being)
 - The ineffectiveness of focusing on food, weight, or appearance with their friend
 - The friends of the student with an eating disorder can be supportive by learning basic information about eating disorders and encouraging a culture of body positivity within their social circles. Such information could be integrated into health education or lifestyle classes, if those classes are available for students.
 - Ways to encourage body positivity include abstaining from “fat talk”; discussing others in terms of their accomplishments and character, rather than focusing on appearance; and modeling healthy, balanced, and flexible dietary and exercise patterns.

Assist friends of students with an eating disorder

- When supporting the student’s classmates, protect confidentiality and privacy by providing generic information about how to be supportive to a friend who is experiencing an eating disorder.
- Remind friends that they are not responsible for their friend’s eating disorder or recovery.
- Encourage the students’ friends to continue usual activities with the person experiencing the eating disorder.
- Consider the needs of the student’s immediate friendship group. They may be feeling a loss in their friendship circle or confusion about how to relate to their friend.
- Be mindful of other students’ reactions to the eating disorder; for example, provide age-appropriate, selected information.
- Encourage classmates and friends to discuss their concerns with you, a fellow teacher, or another adult.

NEDA TOOLKIT for Educators

Sample Student Assistance Program information form

Please check the appropriate responses in each section and add comments when needed to clarify on the reverse side of this form. The more specific (including dates) the information, the more useful it is to the study.

School Staff Note: Only observable behaviors should be discussed. Please be aware that under the Federal Educational Rights and Privacy Act, parents have the right to review the SAP file as part of their child's school record. List the types of interventions you have previously tried with this student on the reverse side of this form. Also please provide any other appropriate information concerning this student.

Would you like to speak directly to a member of the SAP team? Yes No

Date:

Course:

Student:

Period/Time of Day:

Teacher:

A. Class Attendance

- # Days absent
- # Days tardy
- # Classes cut
- Repeated requests to visit restrooms; health office; and/or counselor

B. Academic Performance

- Present grade
- Decrease in participation
- Failure to complete homework
- Cheating
- Drop in grades
- Failure to complete in-class assignments
- Does not take advantage of extra assistance offered/available
- Unprepared for class
- Short attention span, explain specific behaviors

- Difficulty retaining new or recent information
- Verbalized disinterest in academic performance
- Easily frustrated
- Verbalized anxiety/fears regarding academic achievement
- Perfectionism in completing assignments

C. Disruptive Behavior

- Verbally abusive
- Fighting
- Sudden outburst of anger
- Obscene language, gestures
- Hits, pushes others
- Disturbs other students
- Denies responsibility, blames others
- Distractible
- Repeated violation of rules
- Constantly threatens or harasses

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D. Atypical Behavior

- Older/younger social group
- Expresses openly alcohol & other drug use
- Expresses desire to punch or gain revenge via harmful or deadly means
- Easily influenced by others
- Unwilling to change attire for PE
- Disliked by peers
- Withdrawn/loner
- Difficulty making decisions
- Expresses hopelessness, worthlessness, helplessness
- Expresses fear, anxiety of _____
- Expresses anger toward parent
- Dramatic/sudden change in behavior
- Lying
- Criticizes others/self
- Seeks constant reassurance
- Change in peer group/friends

E. Illicit Activities

- Carrying weapons
- Involvement in theft (student reported)
- Vandalism (student reported)
- Carries large amounts of money
- Selling drugs (student reported)

F. Physical Symptoms

- Noticeable change in weight
- Sleeping in class
- Complains of nausea (student reported)
- Glassy, bloodshot eyes
- Unexplained physical injuries
- Poor motor skills
- Frequent cold-like symptoms
- Smells of alcohol/marijuana
- Slurred speech
- Self-abuse
- Change in hygiene
- Frequently expresses concern w/personal health
- Fatigue
- Disoriented
- Food issues

Explain: _____

G. Co-Curricular Activities

- Loss of eligibility
- Missed practice
- Quit team

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H. Home/School/Family Indicators

- Refusal to go home
- Hangs around school for no apparent reason
- Runaway
- Absence of caregiver (student reported)
- Other family stresses (student reported)

Explain: _____

I. Crisis Indicators

- Expresses desire to die (student reported)
- Expresses desire to join someone who has died
- Suicide threat, gesture
- Recent death of family member or close friend

J. Student Strengths and Resiliency Factors

- Can work independently
- Participates in extracurricular activities
- Enthusiastic
- Works well in a group
- Demonstrates desire to learn
- Displays good logic/reasoning
- Leader
- Creative
- Can accept redirection (criticism)
- Considerate of others
- Good communication skills
- Cooperative
- Support system available to student
- Demonstrates good problem solving skills

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Guidance for schools on an education plan for a student in treatment

Recovering from an eating disorder is a long-term process. Students may miss significant amounts of time from school due to treatment and ongoing appointments. Here are some suggested strategies for helping students during and after treatment.

- Meet with the student and parents before the student returns to school to discuss the support needed
- Work with treatment team and school to ensure the reintegration plan takes the student's medical, psychological, and academic needs into account (upon re-entry, student may need supportive counseling, medical monitoring, release from physical education classes, meal monitoring, and ongoing communication between treatment team and family)
- Be aware of the effects of eating disorders on cognitive abilities, so your expectations are realistic
- Be flexible while balancing realistic workloads, deadlines, and the need to fulfill important learning goals
- Consider the timing of potentially stressful decisions (i.e., discussing if the student needs to repeat the grade)
- Try to minimize the long-term impact on the student's career choice
- When making decisions about workload, consider the student's medical, psychological, academic, and developmental needs
- Stay up to date on the latest changes to the student's 504 plan or IEP
- Reduce homework load and alter deadlines where appropriate
- Recognize that the student's reconnecting with friends may be difficult and stressful
- Provide extra academic support, especially after a long absence
- Work with the student and the parents to successfully re-integrate the child into full-time schooling
- Understand the potential long-term need for missed school for medical and therapeutic appointments and management of ongoing eating disorder symptoms
- Refrain from discussing food, weight, exercise, and dieting in the classroom
- Help school devise reduced workload for student, alternative assignments for physical education requirements, extended time on assignments/tests, peer tutoring, copies of class notes from missed days, and access to a quiet study location, as needed
- Advocate for the student (e.g., help student and/or his/her parents negotiate scheduling conflicts between school and doctor appointments)
- Work with administrators to create a healthy school environment (e.g., zero-tolerance of appearance-based teasing and bullying, adequate time to eat lunch, reducing or eliminating in-school weighing and BMI measurements)
- Promote alternatives to class activities that may trigger eating disorder behaviors (e.g., weigh-ins, co-education swim class, calorie counting in nutrition class)
- Facilitate a manageable reintegration into extracurricular and social activities, which may have become marginalized during the illness

Please note that your professional rights and responsibilities may vary by state and school system; please consult your school administration as well as any relevant local and professional organizations for information on regional guidelines.

Why parent-school communications may be difficult

This information is intended to help both parents and school staff understand each other's perspectives about communication and the factors that affect their communications.

Parents of children with an eating disorder (diagnosed or undiagnosed) sometimes express frustration about what they perceive as a lack of communication about their child's behavior from school teachers, coaches, guidance counselors, and other school administrative personnel. From the parents' perspective, feelings have been expressed that "my child is in school and at school activities more waking hours a day than they are home. Why didn't the school staff notice something was wrong? Why don't they contact us about our child to tell us what they think?"

From a teacher's perspective, feelings have been expressed that "eating disorders can be difficult to spot, especially when someone may be going to great lengths to hide the problem. Also, it's often the case that a given teacher sees a student less than an hour a day in a class full of kids. So no school staff person is seeing the child for a prolonged period, and they often have a hard time getting a good baseline from which to detect changes."

It is important to keep in mind that rules vary by state, city, and district, and to educate yourself on your locality's confidentiality and communication regulations. Some schools may be bound by strict protocols generated by state regulations about how teachers and staff are required to channel observations and concerns, while in many districts teachers can and do contact parents directly about concerns they have over a student, whether directly related to academic performance or other behavior observed at school. Teachers can also address issues directly with the student. Parents are often grateful for the communication from the teacher and open and responsive to concern and feedback, although there are exceptions to this.

Although a parent can request that a teacher not disclose certain issues to the student, and students can ask that the teacher not contact their parent, there are few laws prohibiting or requiring this disclosure except in cases of suspected abuse. Eating disorders can have serious and even deadly consequences so both parents and teachers must keep the overall well-being of the student in the forefront of their minds as they make decisions about what to disclose and to whom.

However, in some areas, school districts may be required to have a "student assistance program" team to handle student nonacademic issues. Guidance counselors may also be involved, given the nature of eating disorders. Some guidance counselors may ask that a teacher be responsible for all parent communication so that the student will continue to share their concerns openly and honestly with the counselor.

Guidance counselors may have slightly different ethical concerns and obligations to the student and his or her parents than teachers do. The American School Counselor Association's (ASCA) position statement on confidentiality (www.schoolcounselor.org) states the professional responsibilities of school counselors, emphasizing rights to privacy, defining the meaning of confidentiality in a school setting, and describing the role of the school counselor. The position statement underscores that an atmosphere of trust and confidentiality is vital to the student-counselor relationship; a counselor's primary obligation is to their students, but that obligation should be balanced by mindfulness of the family's legal and inherent rights in their child's life.

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Tips for communicating with parents/guardians

After a student has been referred for follow-up to a school's student assistance program or appropriate school staff, here are some suggestions for implementing successful communications between the school and student and the school and parents.

Before you approach the family

- Consider the family dynamics and any cultural or social issues that may make it difficult for the parents/families to discuss issues.
- When approaching parents/families, always ask if it is a convenient time to talk, and then schedule a time if it isn't convenient at that moment.
- Be prepared for resistance from the student about talking to his/her family and reassure them that you are concerned for their health and you would be negligent if you didn't do something.
- Be prepared for pushback from the family about the presence of potential mental health problems in their child.
- If the parents are not open to help but the student is, ask him/her privately what type of support you can provide during the school day (a quiet place to eat lunch, someone to talk to, etc.).

When you start the conversation with the family or guardians

- Show empathy and support. Listen to what the family member says without interrupting, judging, or making pronouncements or promises.
- Balance supportive and empathetic concern with a serious tone.
- Aim to establish and maintain a positive, open, and supportive relationship with parents/families. Be mindful that the parents may feel guilty, blamed, or in some way responsible for the eating issue or disorder.
- Begin by telling the parents/families that you are concerned about the student AND offer specific, factual observations about the student's behavior to illustrate your concerns. Don't interpret what the behavior could mean — just state the facts of the observed behaviors.
- Don't make or suggest a diagnosis.
- Stay calm and stay focused on the goal of the conversation: to help the family help your

student with his/her problems and improve academic performance and quality of life.

- Encourage the family to access support, information, or treatment from external agencies, and have resources available to which to refer them.
- Don't persist with a conversation that isn't going well. This may damage future communication.

Here are some examples:

- We are concerned about (student's name) because of some behaviors we've noticed recently. Specifically, he/she has been keeping to himself/herself a lot and has been [distracted, fidgety, agitated, unfocused] in class. I was wondering if you had any concerns or noticed anything recently.
- We are concerned about (student's name) because of some comments we've heard him/her make about himself/herself recently. We've heard [student] make a lot of comments about feeling unhappy about his/her appearance, weight. I was wondering if you had any concerns or noticed anything recently.
- We are concerned about [student's name] because of some behaviors we've noticed recently. We've noticed [student] does [not eat lunch; eats very little; throws lunch away; always requests a restroom pass immediately after eating and becomes very agitated or upset if not given a pass at that moment]. I was wondering if you had any concerns or noticed anything recently.

To end a conversation that isn't going well

- Acknowledge that you sense it must be difficult to talk about.
- Reassure the family that it's okay if they don't want to talk about this with you personally, but encourage them to follow up with someone else, such as another teacher, counselor, or physician.
- Reiterate the school's concern for their son/daughter.
- Leave the door open by reassuring them that you are available to talk anytime.
- Let them know that you will contact them again soon to check in.
- You may also want to let them know about the school's duty of care to its students.

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The school and student of concern

- If appropriate, involve the student in conversations with his/her parents/families.
- If possible, negotiate an agreement with the student to enable open communication with parents/families.
- Consider what steps you are able and willing to take in relation to duty-of-care if a student requests that parent(s) not be informed.
- Consider what action you are permitted to take if parents/ families deny there is a problem and you feel the student is in crisis.
- Specify who at the school will be a family liaison so that the family has the opportunity to develop a supportive relationship with a school staff member. The school psychologist, counselor, or equivalent is generally the most appropriate person to communicate with parents/families.
- Be clear about the support the school can offer and the services available through the school.
- Follow up oral conversations with a written summary of the conversation and action steps agreed upon, and send the summary to the parent/family member to check mutual understanding of what was discussed.
- Follow up on the agreed-upon action steps within an established timeframe.
- Focus on the general wellbeing of the student, rather than concerns about an eating disorder, if the topic appears to be sensitive.
- Ask the family member what kind of support would be helpful. This may provide useful information about how to proceed, and it may also facilitate a sense of trust and safety with the family.
- Try to decide collaboratively on the next steps the school will take with the student and family.

NEDA TOOLKIT for Educators

Tips for school psychologists

According to the National Association of School Psychologists (NASP), school psychologists should:

- Model healthy attitudes (balanced and flexible eating and exercise for health rather than appearance)
- Know how to approach individuals at risk for or in the early stages of an eating disorder
- Refer at-risk students for screening and evaluation to clinicians in the community
- Have a plan for communicating about medical and psychological concerns about a student to parents/guardians
- Be knowledgeable about appropriate community treatment resources and help for families without adequate health insurance or other resources
- Learn about the current best practices for eating disorders to support the student and family during the recovery process
- Be aware of the medical complications associated with eating disorders
- Provide support to students in recovery returning to the school setting. Act as a:
 - School contact for treatment team
 - Student advocate (e.g., help student negotiate scheduling conflicts between school and doctor appointments; educate teachers about side effects of student's medication)
 - Supportive in-school counselor (e.g., relaxation techniques, supportive and reflective listening, safe place to eat meals and snacks, short-term solutions focused on problem solving techniques for in-school issues)
 - Consultant to faculty, administrators, and staff
- For students in recovery, work with treatment team and school to ensure the reintegration plan takes the student's medical, psychological, and academic needs into account. Upon re-entry, student may need:
 - Supportive counseling
 - Medical monitoring
 - Release from physical education classes
 - Meal monitoring
 - Communication with treatment team and family
- Help the school devise a reduced workload for student, alternative assignments for physical education requirements, extended time on assignments/tests, peer tutoring, copies of class notes from missed days, and access to a quiet study location, as needed
- Work with administrators to create a healthy school environment (e.g., zero-tolerance of appearance-based teasing and bullying, elimination or reduction of school-required calorie counting, weighing, and BMI measurements)
- Promote alternative assignments for class activities that may be triggers for an eating disorder student (weighing-in, co-education swim class, calorie counting in nutrition class)

(Guidelines adapted from "The Prevention and Treatment of Eating Disorders: An Overview for School Psychologists," www.nasponline.org)

Please note that your professional rights and responsibilities may vary by state and school system; please consult your school administration as well as any relevant local and professional organizations for information on regional guidelines.

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Tips for school nurses

“Mental health is as critical to academic success as physical well-being... School nurses are uniquely qualified to identify students with potential mental health problems. In addition, school nurses serve as advocates, facilitators, and counselors of mental health services both within the school environment and in the community.”—National Association of School Nurses (NASN)

Actions the school nurse can undertake to reduce the interference of mental health problems on school performance:

- Provide mental health promotion activities at school to enhance self-esteem, problem-solving techniques, positive coping skills, and anger and nonviolent conflict management
- Educate school staff to enable them to identify the signs and symptoms of mental health problems
- Provide on-going assessment, intervention, and follow-up of the physical and mental health of the school community
- As a trusted professional, school nurses can help families acknowledge and begin to address mental health issues
- Act as liaison between students and families to assess the family’s ability and willingness to seek services for a student at risk
- Act as a liaison between family and mental health providers in the community
- Actively engage in school committees including curriculum committees, child-study teams, student assistance teams, and crisis intervention teams
- School nurses, along with school psychologists, counselors, social workers, and other support staff should be part of the mental health treatment service team

Participate in health education or physical education lesson planning, and facilitating classes on the following topics:

- Healthy, balanced, and flexible nutrition
- Finding fun ways to move your body and risks of over-exercise
- Adequate hydration and nourishment during sports activities
- Body changes associated with puberty and adolescence (including weight gain)
- Health and legal risks associated with anabolic steroids

Body mass index (BMI) guidelines for school nurses

If a school is weighing all students to calculate BMI, the following protocol is recommended. BMI charts for children are available online at the U.S. Centers for Disease Control and Prevention. Be aware that weighing students with an eating disorder can exacerbate the situation. Consider excusing those students from weigh-ins.

- Inform parents or guardians in writing (letter, email, school note) that you will be weighing and measuring each student. Let parents know that they may opt out of the weigh-in by providing a physician’s health examination from the child’s physician.
- Respect student privacy by weighing and measuring each student individually in a private location.
- Do not comment on any student’s height or weight, because these are sensitive issues for almost anyone.
- Mail or email all letters containing height and weight measurements to the parents’ home. Do not give the letter to the student to deliver or place it in a student’s backpack. Send reports home on all students, not only to students who scored below the 5th percentile or above the 95th percentile for BMI. Children who are smaller or larger in size should not be made to feel as though something is wrong with their bodies.
- Include with all letters, if possible, educational information to parents about nutrition and exercise, as well as tips on recognizing potential problems.

Please note that your professional rights and responsibilities may vary by state and school system; please consult your school administration as well as any relevant local and professional organizations for information on regional guidelines.

NEDA TOOLKIT for Educators

Tips and information for coaches

Disordered eating and full blown eating disorders are common among athletes. For example, a study of Division 1 NCAA athletes found that more than one-third of female athletes reported attitudes and symptoms placing them at risk for anorexia nervosa. Though most athletes with eating disorders are female, male athletes are also at risk — especially those competing in sports that tend to emphasize diet, appearance, size, and weight.

The benefits of sport are well-recognized: building self-esteem, staying in good physical condition, and setting a foundation for lifelong physical activity. Athletic competition, however, can also cause severe psychological and physical stresses. When the pressures of athletic competition are added to societal norms that emphasize thinness or a certain body type, the risks increase for athletes to develop disordered eating. Listed below are some recognized risk factors for developing an eating disorder as an athlete.

Although increased risk of eating disorders in specific sports like gymnastics, running, swimming, diving, dancing, rowing, bodybuilding, and wrestling that require athletes “make weight” or maintain a certain body size to stay competitive has been documented, the fact is that any athlete in any sport can develop an eating disorder. No one is immune.

Personal factors that may create risk for an athlete

- Inaccurate belief that lower body weight will improve performance. In fact, under-eating can lead the athlete to lose too much muscle, resulting in impaired performance.
- Imbalance between energy input and output resulting in weight loss. This is especially a risk for athletes who burn high levels of energy in their sport, such as distance runners.
- Family history of eating disorders, addiction, and other mental health disorders.
- Personal history of anxiety and perfectionism.
- Coaches who focus only on success and performance rather than on the athlete as a whole person.
- Performance anxiety, fear of failure. Athletes who feel they are not performing at their peak capability may increase training and/or decrease food intake to bridge the gap. If no improvement in performance results, they may believe they didn’t lose enough weight or body fat they may step up their efforts even more.

- Social influences, including family and peer pressure about athletic ability and performance.

Concerns specific to female athletes

The Female Athlete Triad (the Triad), a term coined in 1993 by the American College of Sports Medicine, refers to a syndrome commonly seen in athletic women. It involves the interrelated symptoms of disordered eating, menstrual irregularity and low bone mass. Although the exact prevalence of the Triad is unknown, studies have found that nearly three-quarters of female athletes have at least one sign of the Triad, according to a 2009 study in the Clinical Journal of Sports Medicine.

How do you detect the Triad?

The signs and symptoms of the Triad are very broad, and they involve all of its three components: eating and exercise habits, menstrual irregularity and poor bone health.

- Disordered eating
- Menstrual irregularity is not usually detectable by a coach, but it is important to let your athletes know that missing menstrual cycles is not normal and they should feel comfortable going to student health or a specialist to have this addressed. Missed cycles in athletes are not always an indication of the Triad, so it is important to have the athlete evaluated by a doctor for other medical problems that may cause amenorrhea (e.g., polycystic ovarian syndrome or a pituitary tumor). This evaluation involves various laboratory tests and sometimes imaging. Once other causes are ruled out, treatment can proceed with dietary and exercise adjustments.
 - Female athletes taking oral contraceptive pills (OCP) may be unaware of menstrual irregularities or think the artificial period created by the pills will protect her from decreased bone density. More recent studies show that this is not the case. Only natural menstruation produces the right hormones at the right levels to build bone mass.

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- Low bone mass may manifest as stress fractures or full fractures (e.g., in a long bone such as the tibia or fibula or as a compression fracture in the spine). Some stress fractures are secondary to overuse and sports technique (such as an uneven running gait), while others, such as lumbar and femoral stress fractures, are highly correlated with disordered eating. Fractures are often early signs of low bone density. Other low bone mass risks include a history of malabsorption (e.g., Crohn's disease, ulcerative colitis, celiac disease), low calcium and/or vitamin D intake, excessive alcohol consumption, steroid use, and those with either or both of the other two aspects of the Triad. Low bone density can be detected by a dual x-ray absorptiometry (DXA) scan.

These conditions are a medical concern, and taken together they create serious, potentially life-threatening health risks. While any female athlete can develop this triad, adolescent girls are most at risk because of the active biological changes and growth spurts, peer and social pressures, and rapidly changing life circumstances that accompany the teenage years.

Please note that your professional rights and responsibilities may vary by state and school system; please consult your school administration as well as any relevant local and professional organizations for information on regional guidelines.

Resources

NEDA TOOLKIT for Educators

Glossary

This eating disorders glossary defines terms you may encounter when seeking information and talking with care providers about diagnosis and treatment of all types of eating disorders. It also contains some slang terms that may be used by individuals with an eating disorder.

Alternative Therapy In the context of treatment for eating disorders, a treatment that does not use drugs or bring unconscious mental material into full consciousness. For example, yoga, guided imagery, expressive therapy, and massage therapy are considered alternative therapies.

Amenorrhea The absence of at least three consecutive menstrual cycles. Amenorrhea was a DSM-IV diagnostic criterion for anorexia, but was removed as a criterion in the DSM-5.

Ana Slang. Anorexia or anorexic.

ANAD (National Association of Anorexia Nervosa and Associated Disorders) A nonprofit corporation that seeks to alleviate the problems of eating disorders, especially anorexia nervosa, bulimia nervosa, and binge eating disorder.

Anorexia Nervosa (AN) A disorder in which an individual refuses to maintain minimally normal body weight, intensely fears gaining weight, and exhibits a significant disturbance in his/her perception of the shape or size of his/her body.

Anorexia Athletica The use of excessive exercise to lose weight.

Anticonvulsants Drugs used to prevent or treat convulsions.

Antiemetics Drugs used to prevent or treat nausea and vomiting.

Anxiety A persistent feeling of dread, apprehension, and impending disaster. There are several types of anxiety disorders, including: panic disorder, agoraphobia, obsessive-compulsive disorder, social and specific phobias, and posttraumatic stress disorder. Anxiety is a type of mood disorder.

Arrhythmia An alteration in the normal rhythm of the heartbeat.

Art Therapy A form of expressive therapy that uses visual art to encourage the patient's growth of self-awareness and self-esteem to make attitudinal and behavioral changes.

Atypical Antipsychotics A new group of medications used to treat psychiatric conditions. These drugs may have fewer side effects than older classes of drugs used to treat the same psychiatric conditions.

Avoidant/Restrictive Food Intake Disorder A DSM-5 diagnosis, the primary feature of which is the avoidance or restriction of food intake, without evidence of a disturbance in the way in which one's body weight or shape is experienced.

B&P An abbreviation used for binge eating and purging in the context of bulimic behavior.

Behavior Therapy (BT) A type of psychotherapy that uses principles of learning to increase the frequency of desired behaviors and/or decrease the frequency of problem behaviors. When used to treat an eating disorder, the focus is on modifying the behavioral abnormalities of the disorder by teaching relaxation techniques and coping strategies that affected individuals can use instead of not eating, or binge eating and purging. Subtypes of BT include dialectical behavior therapy (DBT), exposure and response prevention (ERP), and hypnobehavioral therapy.

Binge Slang. Binge eating episode or binge eating disorder.

Binge Eating (also Bingeing) Consuming an amount of food that is considered much larger than the amount that most individuals would eat under similar circumstances within a discrete period of time.

Binge Eating Disorder (BED) A type of eating disorder that is characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating.

Beneficiary The recipient of benefits from an insurance policy

Biofeedback A technique that measures bodily functions, like breathing, heart rate, blood pressure, skin temperature, and muscle tension. Biofeedback is used to teach people how to alter bodily functions through relaxation or imagery. Typically, a practitioner describes stressful situations and guides a person through using relaxation techniques. The person can

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see how their heart rate and blood pressure change in response to being stressed or relaxed. This is a type of non-drug non-psychotherapy.

Bipolar and Related Disorders A group of related mental disorders listed in the DSM-5. These disorders include bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance/medication-induced bipolar and related disorder, bipolar and related disorder due to another medical condition, other specified bipolar and related disorder, and unspecified bipolar and related disorder.

Body Dysmorphic Disorder (BDD) Formerly called dysmorphophobia. A mental disorder, defined in the DSM-5, in which the patient is preoccupied with one or more perceived appearance defects, which are not observable or appear slight to others. The appearance concerns manifest as repetitive behaviors or mental patterns (e.g., mirror checking; comparing oneself with others) and is a source of distress or impairs the sufferer's life.

Body Image The subjective opinion about one's physical appearance based on self-perception of body size and shape and the reactions of others.

Body Mass Index (BMI) A formula used to calculate the ratio of a person's weight to height. BMI is expressed as a number that is used to determine whether an individual's weight is within normal ranges for age and sex on a standardized BMI chart. The US Centers for Disease Control and Prevention website offers BMI calculators and standardized BMI charts.

Bulimia Nervosa (BN) A disorder defined in the DSM-5 in which a patient binges on food an average of twice weekly in a three-month time period, followed by compensatory behavior aimed at preventing weight gain. This behavior may include excessive exercise, vomiting, or the misuse of laxatives, diuretics, other medications, and enemas.

Case Management An approach to patient care in which a case manager mobilizes people to organize appropriate services and supports for a patient's treatment. A case manager coordinates mental health, social work, educational, health, vocational, transportation, advocacy, respite care, and recreational services, as needed. The case manager ensures that the changing needs of the patient and the family members supporting that patient are met.

COBRA A federal act in 1985 that included provisions to protect health insurance benefits coverage for workers and their families who lose their jobs. The landmark Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) health benefit provisions became law in 1986. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, and the Public Health Service Act to provide continuation of employer-sponsored group health coverage that otherwise might be terminated. The US Centers for Medicare & Medicaid Services has advisory jurisdiction for the COBRA law as it applies to state and local government (public sector) employers and their group health plans.

Cognitive Therapy (CT) A type of psychotherapeutic treatment that attempts to change a patient's feelings and behaviors by changing the way the patient thinks about or perceives his/her significant life experiences. Subtypes include cognitive analytic therapy and cognitive orientation therapy.

Cognitive Analytic Therapy (CAT) A type of cognitive therapy that focuses its attention on discovering how a patient's problems have evolved and how the procedures the patient has devised to cope with them may be ineffective or even harmful. CAT is designed to enable people to gain an understanding of how the difficulties they experience may be made worse by their habitual coping mechanisms. Problems are understood in the light of a person's personal history and life experiences. The focus is on recognizing how these coping procedures originated and how they can be adapted.

Cognitive Behavior Therapy (CBT) A treatment that involves three overlapping phases when used to treat an eating disorder. For example, with bulimia, the first phase focuses on helping people to resist the urge to binge eat and purge by educating them about the dangers of their behavior. The second phase introduces procedures to reduce dietary restraint and increase the regularity of eating. The last phase involves teaching people relapse prevention strategies to help them prepare for possible setbacks. A course of individual CBT for bulimia nervosa usually involves 16- to 20-hour-long sessions over a period of four to five months. It is offered on an individual, group, or self-managed basis. The goals of CBT are designed to interrupt the proposed bulimic cycle that is perpetuated by low self-esteem, extreme concerns about shape and weight, and extreme means of weight control.

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Cognitive Orientation Therapy (COT) A type of cognitive therapy that uses a systematic procedure to understand the meaning of a patient's behavior by exploring certain themes such as aggression and avoidance. The procedure for modifying behavior then focuses on systematically changing the patient's beliefs related to the themes and not directly to eating behavior.

Comorbid Conditions Multiple physical and/or mental conditions existing in a person at the same time.

Crisis Residential Treatment Services Short-term, around-the clock help provided in a nonhospital setting during a crisis. The purposes of this care are to avoid inpatient hospitalization, help stabilize the individual in crisis, and determine the next appropriate step.

Cure The treated condition or disorder is permanently gone, never to return in the individual who received treatment. Not to be confused with "remission."

Dental Caries Tooth cavities. The teeth of people with bulimia who using vomiting as a purging method may be especially vulnerable to developing cavities because of the exposure of teeth to the high acid content of vomit.

Depression or Major Depressive Disorder A condition characterized by one or more major depressive episodes consisting of two or more weeks during which a person experiences a depressed mood or loss of interest or pleasure in nearly all activities. It is one of the mood disorders listed in the DSM-5.

Depressive Disorders A group of mental disorders characterized by the presence of sad, empty, or irritable mood that affects the individual's ability to function normally. These disorders include disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder.

Diabetic Omission of Insulin A nonpurging method of compensating for excess calorie intake that may be used by a person with diabetes and bulimia.

Dialectical Behavior Therapy (DBT) A type of behavioral therapy that views emotional deregulation as the core problem in bulimia nervosa. It involves

teaching people with bulimia nervosa new skills to regulate negative emotions and replace dysfunctional behavior. A typical course of treatment is weekly two-hour group sessions lasting 20 weeks.

Disordered Eating Term used to describe any atypical eating behavior.

Drunkorexia Slang. Behaviors that include replacing food consumption with excessive alcohol consumption and/or consuming food along with sufficient amounts of alcohol to induce vomiting as a method of purging and numbing feelings.

DSM-5 The fifth (and most current, as of 2015) edition of the Diagnostic and Statistical Manual for Mental Disorders, published by the American Psychiatric Association (APA). This manual lists mental diseases, conditions, and disorders as well as the criteria established by the APA to diagnose them.

DSM-5 Diagnostic Criteria A list of symptoms in the Diagnostic and Statistical Manual for Mental Disorders 5 published by the APA. The criteria describe the features of the mental diseases and disorders listed in the manual. For a particular mental disorder to be diagnosed in an individual, the individual must exhibit the symptoms listed in the criteria for that disorder. Many health plans require that a DSM-5 diagnosis be made by a qualified clinician before approving benefits for a patient seeking treatment for a mental disorder such as anorexia, bulimia, or binge eating disorder.

Dual Diagnosis Two mental health disorders in a patient at the same time, as diagnosed by a clinician. For example, a patient may be given a diagnosis of both bulimia nervosa and obsessive-compulsive disorder or of anorexia and major depressive disorder.

Eating Disorders Anonymous (EDA) A fellowship of individuals who share their experiences with each other to try to solve common problems and help each other recover from their eating disorders.

Eating Disorders Not Otherwise Specified (EDNOS) A term previously used to describe any disorder of eating that does not meet the criteria for anorexia nervosa, bulimia nervosa or binge eating disorder. With the publication of the DSM-5, EDNOS is now referred to as Other Specified Feeding or Eating Disorder (OSFED).

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Eating Disorder Inventory (EDI) A self-report test that clinicians use with patients to diagnose specific eating disorders and determine the severity of a patient's condition. Originally created in 1984, the EDI has been revised twice. The EDI-3 was released in 2004, and, as of 2015, it is the most current edition.

Ed Slang Eating disorder.

ED Acronym for eating disorder.

Electrolyte Imbalance A physical condition that occurs when ionized salt concentrations (commonly sodium and potassium) are at abnormal levels in the body. This condition can occur as a side effect of some bulimic compensatory behaviors, such as vomiting.

Emetic A class of drugs that induces vomiting. Emetics may be used as part of a bulimic compensatory behavior to induce vomiting after a binge eating episode.

Enema The injection of fluid into the rectum for the purpose of cleansing the bowels. Enemas may be used as a bulimic compensatory behavior to purge after a binge eating episode.

Equine/Animal-Assisted Therapy A treatment program in which people interact with horses and become aware of their own emotional states through the reactions of the horses to their behavior.

Exercise Therapy An individualized exercise plan that is written by a doctor or rehabilitation specialist, such as a clinical exercise physiologist, physical therapist, or nurse. The plan takes into account an individual's current medical condition and provides advice for what type of exercise to perform, how hard to exercise, how long, and how many times per week.

Exposure and Response Prevention (ERP) A type of behavior therapy strategy that is based on the theory that purging serves to decrease the anxiety associated with eating. Purging is therefore negatively reinforced via anxiety reduction. The goal of ERP is to modify the association between anxiety and purging by preventing purging following eating until the anxiety associated with eating subsides.

Expressive Therapy A nondrug, non-psychotherapy form of treatment that uses the performing and/or visual arts to help people express their thoughts and

emotions. Whether through dance, movement, art, drama, drawing, painting, etc., expressive therapy provides an opportunity for communication that might otherwise remain repressed.

Eye Movement Desensitization and Reprocessing (EMDR) A nondrug and non-psychotherapy form of treatment in which a therapist waves his/her fingers back and forth in front of the patient's eyes, and the patient tracks the movements while also focusing on a traumatic event. It is thought that the act of tracking while concentrating allows a different level of processing to occur in the brain so that the patient can review the event more calmly or more completely than before.

Family Therapy A form of psychotherapy that involves members of a nuclear or extended family. Some forms of family therapy are based on behavioral or psychodynamic principles; the most common form is based on family systems theory. This approach regards the family as the unit of treatment and emphasizes factors such as relationships and communication patterns. With eating disorders, the focus is on the eating disorder and how the disorder affects family relationships. Family therapy tends to be short-term, usually lasting only a few months, although it can last longer depending on the family circumstances.

Guided Imagery A technique in which the patient is directed by a person (either in person or by using a tape recording) to relax and imagine certain images and scenes to promote relaxation, promote changes in attitude or behavior, and encourage physical healing. Guided imagery is sometimes called visualization. Sometimes music is used as background noise during the imagery session.

Health Insurance Portability and Accountability Act (HIPAA) A federal law enacted in 1996 with a number of provisions intended to ensure certain consumer health insurance protections for working Americans and their families, establish standards for electronic health information, and protect the privacy of individuals' health information. HIPAA applies to three types of health insurance coverage: group health plans, individual health insurance, and comparable coverage through a high-risk pool. HIPAA may lower a person's chance of losing existing coverage, ease the ability to switch health plans, and/or help a person buy coverage on his/her own if a person loses employer coverage and has no other coverage available.

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Health Insurance Reform for Consumers Federal law has provided to consumers some valuable — though limited—protections when obtaining, changing, or continuing health insurance. Understanding these protections, as well as laws in the state in which one resides, can help with making more informed choices when work situations change or when changing health coverage or accessing care. Three important federal laws that can affect coverage and access to care for people with eating disorders are listed below. More information is available at www.cms.hhs.gov

- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Mental Health Parity Act of 1996 (MHPA)

Health Maintenance Organization (HMO) A health plan that employs or contracts with primary care physicians to write referrals for all care that covered patients obtain from specialists in a network of healthcare providers with whom the HMO contracts. The patient’s choice of treatment providers is usually limited.

Hematemesis The vomiting of blood.

Hypnbehavioral Therapy A type of behavioral therapy that uses a combination of behavioral techniques, such as self-monitoring to change maladaptive eating disorders, and hypnotic techniques intended to reinforce and encourage behavior change.

Hypoglycemia An abnormally low concentration of glucose in the blood.

In-network benefits Health insurance benefits that a beneficiary is entitled to receive from a designated group (network) of healthcare providers. The “network” is established by the health insurer that contracts with certain providers to provide care for beneficiaries within that network.

Indemnity Insurance A health insurance plan that reimburses the member or healthcare provider on a fee-for-service basis, usually at a rate lower than the actual charges for services rendered, and often after a deductible has been satisfied by the insured.

Independent Living Services Services for a person with a medical or mental health-related problem who is living on his/her own. Services include therapeutic group homes, supervised apartment living, monitoring

the person’s compliance with prescribed mental and medical treatment plans, and job placement.

Intake Screening An interview conducted by health service providers when a patient is admitted to a hospital or treatment program.

International Classification of Diseases (ICD-10) The World Health Organization lists international standards used to diagnose and classify diseases. The listing is used by the healthcare system so clinicians can assign an ICD code to submit claims to insurers for reimbursement for services for treating various medical and mental health conditions in patients. The code is periodically updated to reflect changes in classifications of disease or to add new disorders.

Interpersonal Therapy (IPT) A type of therapy designed to help people identify and address their interpersonal problems, specifically those involving grief, interpersonal role conflicts, role transitions, and interpersonal deficits. In this therapy, no emphasis is placed directly on modifying eating habits. Instead, the expectation is that the therapy will enable people to change as their interpersonal functioning improves. IPT usually involves 16 to 20 hour-long, one-on-one treatment sessions over a period of four to five months.

Ketosis A condition characterized by an abnormally elevated concentration of ketones in the body tissues and fluids, which can be caused by starvation. It is a complication of diabetes, starvation, and alcoholism.

Level of Care The care setting and intensity of care that a patient is receiving (e.g., inpatient hospital, outpatient hospital, outpatient residential, intensive outpatient, residential). Health plans and insurance companies correlate their payment structures to the level of care being provided and also map a patient’s eligibility for a particular level of care to the patient’s medical/psychological status.

Major Depressive Disorder or Major Depression A condition characterized by one or more major depressive episodes that consist of periods of two or more weeks during which a patient has either a depressed mood or loss of interest or pleasure in nearly all activities.

Mallory-Weiss Tear One or more slit-like tears in the mucosa at the lower end of the esophagus as a result of severe vomiting.

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Mandometer Therapy Treatment program for eating disorders based on the idea that psychiatric symptoms of people with eating disorders emerge as a result of poor nutrition and are not a cause of the eating disorder. A Mandometer is a computer that measures food intake and is used to determine a course of therapy.

Massage Therapy A generic term for any of a number of various types of therapeutic touch in which the practitioner massages, applies pressure to, or manipulates muscles, certain points on the body, or other soft tissues to improve health and well-being. Massage therapy is thought to relieve anxiety and depression in patients with an eating disorder.

Maudsley Method A family-centered treatment program with three distinct phases. The first phase for a patient who is severely underweight is to regain control of eating habits and break the cycle of starvation or binge eating and purging. The second phase begins once the patient's eating is under control, with a goal of returning independent eating to the patient. The goal of the third and final phase is to address the broader concerns of the patient's development.

Mealtime Support Therapy Treatment program developed to help patients with eating disorders eat healthfully and with less emotional upset.

Mental Health Parity Laws Federal and State laws that require health insurers to provide the same level of healthcare benefits for mental disorders and conditions as they do for medical disorders and conditions. For example, the federal Mental Health Parity Act of 1996 (MHPA) may prevent a group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower, or less favorable, than annual or lifetime dollar limits for medical and surgical benefits offered under the plan.

Mia Slang. Bulimia or bulimic.

Modified Cyclic Antidepressants A class of medications used to treat depression.

Monoamine Oxidase Inhibitors (MAOIs) A class of medications used to treat depression.

Movement/Dance Therapy The psychotherapeutic use of movement as a process that furthers the emotional, cognitive, social, and physical integration

of the individual, according to the American Dance Therapy Association.

Motivational Enhancement Therapy (MET) A treatment based on a model of change, with focus on the stages of change. Stages of change represent constellations of intentions and behaviors through which individuals pass as they move from having a problem to doing something to resolve it. The stages of change move from "pre-contemplation," in which individuals show no intention of changing, to the "action" stage, in which they are actively engaged in overcoming their problem. Transition from one stage to the next is sequential, but not linear. The aim of MET is to help individuals move from earlier stages into the action stage using cognitive and emotional strategies

Nonpurging Any of a number of behaviors engaged in by a person with bulimia nervosa in order to offset potential weight gain from excessive calorie intake from binge eating. Nonpurging can take the form of excessive exercise, misuse of insulin by people with diabetes, or long periods of fasting.

Nutritional Therapy Therapy that provides patients with information on the effects of their eating disorder. For example, therapy often includes, as appropriate, techniques to avoid binge eating and refeeding and advice about making meals and eating. The goals of nutrition therapy for individuals with anorexia and bulimia nervosa differ according to the disorder. With bulimia, for example, goals are to stabilize blood sugar levels, help individuals maintain a diet that provides them with enough nutrients, and to help restore gastrointestinal health.

Obsessive-compulsive Disorder (OCD) Mental disorder in which recurrent thoughts, impulses, or images cause inappropriate anxiety and distress, followed by acts that the sufferer feels compelled to perform to alleviate this anxiety. Criteria for obsessive-compulsive and related disorder diagnoses can be found in the DSM-5.

Opioid Antagonists A type of drug therapy that interferes with the brain's opioid receptors and is sometimes used to treat eating disorders.

Orthorexia Nervosa An informal term for a disorder in which a person obsesses about eating only "pure" and healthy food to such an extent that it interferes with the person's life. This disorder is not a diagnosis listed in the DSM-5.

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Osteoporosis A condition characterized by a decrease in bone mass with decreased density and enlargement of bone spaces, thus producing porosity and brittleness. This can sometimes be a complication of an eating disorder, including bulimia nervosa and anorexia nervosa.

Other Specified Feeding or Eating Disorder (OSFED) Formerly described as Eating Disorders Not Otherwise Specified (EDNOS) in the DSM-IV, Other Specified Feeding or Eating Disorder (OSFED) is a feeding or eating disorder that causes significant distress or impairment, but does not meet the criteria for another feeding or eating disorder.

Out-of-network Benefits Healthcare obtained by a beneficiary from providers (hospitals, clinicians, etc.) that are outside the network that the insurance company has assigned to that beneficiary. Benefits obtained outside the designated network are usually reimbursed at a lower rate. In other words, beneficiaries share more of the cost of care when obtaining that care “out of network” unless the insurance company has given the beneficiary special written authorization to go out of network.

Partial Hospitalization (Intensive Outpatient) For a patient with an eating disorder, partial hospitalization is a time-limited, structured program of psychotherapy and other therapeutic services provided through an outpatient hospital or community mental health center. The goal is to resolve or stabilize an acute episode of mental/behavioral illness.

Peptic Esophagitis Inflammation of the esophagus caused by reflux of stomach contents and acid.

Pharmacotherapy Treatment of a disease or condition using clinician-prescribed drugs.

Phenethylamine Monoamine Reuptake Inhibitors A class of drugs used to treat depression.

Pica A disorder characterized by the eating of one or more nonnutritive, nonfood substances on a persistent basis over a period of at least one month.

Pre-existing Condition A health problem that existed or was treated before the effective date of one’s health insurance policy.

Provider A healthcare facility (e.g., hospital, residential treatment center), doctor, nurse, therapist, social worker, or other professional who provides care to a patient.

Psychoanalysis An intensive, nondirective form of psychodynamic therapy in which the focus of treatment is exploration of a person’s mind and habitual thought patterns. It is insight-oriented, meaning that the goal of treatment is for the patient to increase understanding of the sources of his/her inner conflicts and emotional problems.

Psychodrama A method of psychotherapy in which patients enact the relevant events in their lives instead of simply talking about them.

Psychodynamic Therapy Psychodynamic theory views the human personality as developing from interactions between conscious and unconscious mental processes. The purpose of all forms of psychodynamic treatment is to bring unconscious mental material and processes into full consciousness so that the patient can gain more control over his/her life.

Psychodynamic Group Therapy Psychodynamic groups are based on the same principles as individual psychodynamic therapy and aim to help people with past difficulties, relationships, and trauma, as well as current problems. The groups are typically composed of eight members plus one or two therapists.

Psychoeducational Therapy A treatment intended to teach people about their problem, how to treat it, and how to recognize signs of relapse so that they can get necessary treatment before their difficulty worsens or recurs. Family psychoeducation includes teaching coping strategies and problem-solving skills to families, friends, and/or caregivers to help them deal more effectively with the individual.

Psychopathological Rating Scale Self-Rating Scale for Affective Syndromes (CPRS-SA) A test used to estimate the severity of depression, anxiety, and obsession in an individual.

Psychopharmacotherapy Use of drugs for treatment of a mental or emotional disorder.

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Psychotherapy The treatment of mental and emotional disorders through the use of psychological techniques (some of which are described below) designed to encourage communication of conflicts and insight into problems, with the goal being relief of symptoms, changes in behavior leading to improved social and vocational functioning, and personality growth.

Purging To evacuate the contents of the stomach or bowels by any of several means. In bulimia, purging is used to compensate for excessive food intake. Methods of purging include vomiting, enemas, and excessive exercise.

Relaxation Training A technique involving tightly contracting and releasing muscles with the intent to release or reduce stress.

Remission A period in which the symptoms of a disease are absent. Remission differs from the concept of “cure” in that the disease can return. The term “cure” signifies that the treated condition or disorder is permanently gone and will never reoccur in the individual who received treatment.

Residential Services Services delivered in a structured residence other than the hospital or a client’s home.

Residential Treatment Center A 24-hour residential environment outside the home that includes 24-hour provision or access to support personnel capable of meeting the client’s needs.

Selective Serotonin Reuptake Inhibitors (SSRI) A class of antidepressants used to treat depression, anxiety disorders, and some personality disorders. These drugs are designed to elevate the level of the neurotransmitter serotonin. A low level of serotonin is currently seen as one of several neurochemical symptoms of depression. Low levels of serotonin in turn can be caused by an anxiety disorder, because serotonin is needed to metabolize stress hormones.

Self-directedness A personality trait that comprises self-confidence, reliability, responsibility, resourcefulness, and goal orientation.

Self-guided Cognitive Behavior Therapy A modified form of cognitive behavior therapy in which a treatment manual is provided for people to proceed with treatment on their own, or with support from a nonprofessional. Guided self-help usually implies

that the support person may or may not have some professional training, but is usually not a specialist in eating disorders. The important characteristics of the self-help approach are the use of a highly structured and detailed manual-based CBT, with guidance as to the appropriateness of self-help, and advice on where to seek additional help.

Self Psychology A type of psychoanalysis that views anorexia and bulimia as specific cases of pathology of the self. According to this viewpoint, for example, people with bulimia nervosa cannot rely on human beings to fulfill their self-object needs (e.g., regulation of self-esteem, calming, soothing, vitalizing). Instead, they rely on food (its consumption or avoidance) to fulfill these needs. Self psychological therapy involves helping people with bulimia give up their pathological preference for food as a self-object and begin to rely on human beings as self objects, beginning with their therapist.

Self-report Measures An itemized written test in which a person rates his/her feeling towards each question; the test is designed to categorize the personality or behavior of the person.

State Mandate A proclamation, order, or law from a state legislature that issues specific instructions or regulations. Many states have issued mandates pertaining to coverage of mental health benefits and specific disorders the state requires insurers to cover.

Substance Abuse Use of a mood or behavior-altering substance in a maladaptive pattern resulting in significant impairment or distress of the user.

Substance Use Disorders The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines a substance use disorder as a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.

Subthreshold Eating Disorder Condition in which a person exhibits disordered eating but not to the extent that it fulfills all the criteria for diagnosis of an eating disorder.

Supportive Therapy Psychotherapy that focuses on the management and resolution of current difficulties and life decisions using the patient’s strengths and available resources.

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Telephone Therapy A type of psychotherapy provided over the telephone by a trained professional.

Tetracyclics A class of drugs used to treat depression.

Therapeutic Foster Care A foster care program in which youths who cannot live at home are placed in homes with foster parents who have been trained to provide a structured environment that supports the child's learning, social, and emotional skills.

Thinspiration Slang. Photographs, poems, or any other stimuli that aim to influence a person to strive to lose weight.

Third-party Payer An organization that provides health insurance benefits and reimburses for care for beneficiaries.

Thyroid Medication Abuse Excessive use or misuse of drugs used to treat thyroid conditions; a side effect of these drugs is weight loss.

Treatment Plan A multidisciplinary care plan for each beneficiary in active case management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, all funding options, treatment goals, and assessment of the beneficiary environment. The plan is updated monthly and modified when appropriate.

Tricyclic Antidepressants A class of drugs used to treat depression.

Trigger A stimulus that causes an involuntary reflex behavior. A trigger may cause a recovering person with bulimia to engage in bulimic behavior again.

Usual and Customary Fee An insurance term that indicates the amount the insurance company will reimburse for a particular service or procedure. This amount is often less than the amount charged by the service provider.

Vocational Services Programs that teach skills needed for self-sufficiency.

Yoga A system of physical postures, breathing techniques, and meditation practices to promote bodily or mental control and well-being.

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Curriculum on healthy body image and eating disorders

Many educational resources are available for each school age group and can be incorporated into school health education classes about healthy body image and eating disorders.

Entering Adulthood: Looking at Body Image and Eating Disorders

<http://www.eric.ed.gov/PDFS/ED329840.pdf>

A Curriculum for Grades 9-12. Contemporary Health Series. 1991. Susan Giarratano.

Dying to be Thin: PBS Video and Teaching Resources

<http://www.pbs.org/>

This includes a video (first debuted on television on the NOVA program) that is free for viewing online. The video typically takes at least two class periods. The Web site also includes many other related resources, including discussion questions and a lesson plan that uses some math skills. Lessons are tied to National Science and Health education standards.

Discovery Education

<http://school.discoveryeducation.com>

This Discovery Channel resource provides many materials and resources on eating disorders and healthy body image and nutrition, many of which are free or have a nominal cost (such as those that include a video). Use the website search box and enter the term “eating disorders” to find many curricula. Lessons are tied to National Science and Health education standards.

Books

The Gurze-Salucore Eating Disorders Resource Catalogue (www.edcatalogue.com) specializes in publishing and distributing books and materials on eating disorders.

Visit www.edcatalogue.com/books for a categorized listing of eating disorders-related books.

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Useful online resources for eating disorders

Academy for Eating Disorders (AED)

www.aedweb.org

An organization for healthcare professionals in the eating disorders field. The academy promotes research, treatment, and prevention of eating disorders. Their website lists current clinical trials and general information about eating disorders.

Anorexia Nervosa and Related Eating Disorders, Inc. (ANRED)

www.anred.com

An organization providing information about anorexia nervosa, bulimia nervosa, binge-eating disorder, and other lesser-known food and weight disorders. ANRED resources include self-help tips and information about recovery and prevention.

American Psychiatric Association (APA)

www.psychiatry.org

A website that provides mental health information, including warning signs, symptoms, treatment options, and preventative measures.

Binge Eating Disorder Association (BEDA)

www.bedaonline.com

An organization focused on providing leadership, recognition, prevention, and treatment of BED and associated weight stigma.

Eating Disorders Coalition for Research, Policy & Action

www.eatingdisorderscoalition.org

A coalition with representatives from various eating disorder groups. This organization focuses on lobbying the federal government to recognize eating disorders as a public health priority.

Eating Disorder Referral and Information Center

www.edreferral.com

This is a sponsored site with a large archive of information on eating disorders and treatment centers referral information.

ECRI Institute

www.bulimiaguide.org

A resource for supporting a family member or friend with bulimia nervosa.

The Emily Program Foundation

emilyprogramfoundation.org/

This nonprofit organization provides eating disorders-related support and raises awareness.

International Association of Eating Disorders Professionals (IAEDP)

www.iaedp.com/

IAEDP offers nationwide education, training, certification, and a symposium for practitioners who treat people with eating disorders.

National Alliance on Mental Illness (NAMI)

www.nami.org/

A national grassroots mental health organization dedicated to improving the lives of people living with serious mental illness and their families.

National Association of Anorexia Nervosa and Associated Disorders (ANAD)

www.anad.org

This organization seeks to alleviate the problems of eating disorders by educating the public and healthcare professionals, encouraging research, and sharing resources on all aspects of these disorders. ANAD's website includes information on finding support groups, referrals and treatment centers, advocacy, and background on eating disorders.

The National Association for Males with Eating Disorders, Inc. (N.A.M.E.D.)

www.namedinc.org

N.A.M.E.D. is dedicated to providing support for males affected by eating disorders, providing access to collective expertise, and promoting the development of effective clinical intervention and research in this population.

National Eating Disorders Association (NEDA)

www.nationaleatingdisorders.org

NEDA is the largest not-for-profit organization in the United States working to support individuals and families affected by eating disorders and serve as a catalyst for prevention, cures, and access to quality care.

National Institute of Mental Health (NIMH)

www.nimh.nih.gov/index.shtml

NIMH is a government agency that supports research on mental health through grants and internal research efforts. NIMH's mission is to transform the understanding and treatment of mental illness.

Office on Women's Health (OWH)

www.womenshealth.gov/

The National Women's Health Information Center is a government agency with free health information for women.

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Perfect Illusions

www.pbs.org/perfectillusions/index.html

These Public Broadcasting System (PBS) webpages are based on a NOVA television program documentary. The site provides information on eating disorders with personal stories and links to treatment resources.

Project HEAL

www.theprojectheal.org/

Project HEAL: Help to Eat, Accept and Live is a 501(c) not-for-profit organization that provides scholarship funding for people with eating disorders who cannot afford treatment.

Websites to Beware of

Some websites actually encourage people to become bulimic or to maintain their bulimic behavior by giving tips and emotional support on binge eating and purging or restricting behaviors. These sites are called “pro-mia” for “promoting or proactive bulimia nervosa” and there are also pro-ana (pro-anorexia) sites.

Web searches for support sites may turn up pro-mia or pro-ana sites as well. The sites show pictures of very thin supermodels or “thinspiration” intended to

invoke the desire to lose more weight. They encourage the behavior through chat rooms, poems, weight loss diaries, and personal stories. Although most of these sites give explicit warnings that they are pro-ana or pro-mia and may contain triggers for relapse, it is still very important to be aware of them because they may pose a threat to anyone who is in recovery. Many of these sites are transient and new ones emerge as older sites disappear online.

NEDA TOOLKIT for Educators

References

Frequently asked questions about eating disorders

American Psychiatric Association
www.healthyminds.org/DocumentLibrary/Brochure-Library/EatingDisorders.aspx?FT=.pdf

Victorian Centre of Excellence in Eating Disorders, The Royal Melbourne Hospital, Australia
<http://www.rch.org.au/ceed/>

Andrea Vazzana, Ph.D., Clinical Assistant Professor of Child and Adolescent Psychiatry NYU Child Study Center. www.aboutourkids.org/files/edscape_Interview_with_Andrea_Vazzana_3-6-09.pdf?CSRT=10375589042555625145

Common myths about eating disorders

ECRI Institute Feasibility Study on Eating Disorders Awareness and Education Needs. March 2004; 24 p.

An Eating Disorders Resource for Schools, The Victorian Centre of Excellence in Eating Disorders and the Eating Disorders Foundation of Victoria (2004); pgs 11-12

Eating Disorders: A Time for Change

Russell, Michael. 2006 Myths About Eating Disorders. EzineArticles (December 02), ezinearticles.com/?Myths-About-EatingDisorders&id=374760

U.S. Department of Health and Human Services; Office on Women's Health; Eating Disorders

www.mirror-mirror.org/myths.htm

American Psychiatric Association Diagnostic and Statistical Manual for Mental Disorders-5

Eating disorder signs and symptoms specific to a school setting

U.S. Dept. of Health and Human Services National Women's Health Information Center

BodyWise Handbook Eating Disorders Information for Middle School Personnel; Douglas Bunnell, PhD

NEDA Educators Workshop, Sept 2006;
www.womenshealthiowa.info/docs/bodywise.pdf

Impact of eating disorders on cognitive abilities and functioning in school

U.S. Dept. of Health and Human Services National Women's Health Information Center, BodyWise Handbook Eating Disorders

Information for Middle School Personnel 2005
www.womenshealthiowa.info/docs/bodywise.pdf

School strategies for assisting students with eating disorders

Full of Ourselves, The School Guide by Catherine Steiner-Adair, EdD. and Lisa Sjostrom, Ed.M.

ECRI Institute interviews with educators and parents;
www.bulimiaguide.org

Guidance for schools on an education plan for a student in treatment

The Prevention and Treatment of Eating Disorders: An Overview for School Psychologists by Catherine Cook-Cottone & Melinda Scime

Why parent-school communications may be difficult

American School Counselor Association
www.schoolcounselor.org/

ECRI Institute interviews with educators and parents of children with eating disorders

Tips for communicating with parents/guardians

ECRI Institute Bulimia Resource Guide
www.bulimiaguide.org

ECRI Institute interviews with educators

Tips for school psychologists

National Association of School Psychologists

Tips for school nurses

National Association of School Nurses
www.nasn.org/Default.aspx?tabid=276



National Eating Disorders Association

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Helpline hours are

9:00 AM to 9:00 PM Monday to Thursday (Eastern Time)

9:00 AM to 5:00 PM Friday (Eastern Time)

Website: www.NationalEatingDisorders.org