EATING DISORDERS

EATING DISORDER FACT SHEET FOR EDUCATORS

Coexisting Mental Disorders or Symptoms

- **Depression or depressive symptoms.** Commonly seen in individuals with AN who are severely underweight, and in individuals with BN soon after the onset of BN.
- **Substance abuse and/or dependence.** Typically including the use of alcohol and stimulants for weight control.
- **Obsessive-compulsive features.** Frequent thoughts of food, as well as obsessions and compulsions related to food which may be caused by or exacerbated by under-nutrition.

The Purpose of this Fact Sheet

Eating Disorders (EDs) and eating related problems often result in under-nutrition, and in some cases, significant medical complications. EDs have also been associated with mental health disorders or symptoms which can affect a child's cognitive functioning, and consequently his/her ability to learn.

Under-nutrition is known to cause increased irritability, decreased ability to concentrate, focus, listen and process information. It may cause nausea, headache, fatigue and lethargy, and lead to iron-deficiency which has an immediate effect on a student's memory and ability to concentrate. In addition to making pupils less active, more apathetic, and withdrawn, under-nutrition can impair the immune system, making pupils more vulnerable to illness and more likely to be absent and miss instruction.

The purpose of this fact sheet is to increase educators' knowledge and awareness of these medical and psychological concerns that affect school-age children. This fact sheet is therefore a primary prevention tool that seeks to assist in early identification, prevention and restoration of welfare, in addition to reduce the anxiety around the issue and increase awareness of the potentially damaging effects of comments about body shape, size, ability or weight on students' welfare.

About Eating Disorders

The most widely recognized eating disorders (EDs) of adolescence and young childhood are anorexia nervosa (AN) and bulimia nervosa (BN). AN and BN share many features such as issues with body image and anxious feelings after eating. However, those with AN are 15% or more below normal weight, whereas those with BN are often within 10% of normal weight. The maladaptive attitudes and behaviors around eating, weight and body image also tend to coexist with disturbances of self-image, mood, impulse control and interpersonal functioning.

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Terminology

- **Binge behavior/binge-eating:** The consumption of large amounts of food that is considered much larger than the amount most individuals would eat under similar situations within a given period of time. The hallmark of binge-eating is the feeling of loss of control.

- **Purge behavior/purging:** To empty the contents of the stomach or bowels. Methods of purging include vomiting, enemas, laxatives and excessive exercise.

- **Restrictive type:** A type of AN in which the individual restricts food consumption to prevent weight gain.

- **Inappropriate compensatory behaviors/methods:** Self-induced vomiting, fasting and misuse of diuretics, laxatives, enemas or diet pills to prevent weight gain. Excessive exercise is also an inappropriate compensatory behavior/method that is often overlooked by parents and educators.

Prevalence

The lifetime prevalence of AN is less than 1% and the lifetime prevalence of BN is 1-3%, however, the prevalence of partial syndrome is at least twice that of full syndrome ED.

AN and BN occur more frequently in industrialized nations and the rate of occurrence in males is one-tenth of that in females.

In general, eating disturbances are equally common among Hispanic and Caucasian females, more frequent among Native American females, and less frequent among African and Asian American females.

Risk factors for EDs are greater among minority females who are younger, heavier, better educated.

Anorexia Nervosa

AN is a form of self-starvation and it is characterized by low body weight (less than 85 percent of normal weight for height and age). These symptoms are often associated with a fear of the consequences of eating such as weight gain or obesity, and they appear to be driven by disturbances in the way body weight and shape are perceived by the individual. There are two types of AN: binge-eating/purging type and restrictive type. Binge-eating/purging type describes those who regularly engage in binge eating or purging behavior. Restrictive type describes individuals who don't engage in binge-eating or purging, but restrict their food intake.

Bulimia Nervosa

BN is characterized by binge-eating and inappropriate compensatory methods. There are two types of BN: purging type and non-purging type. Purging type describes those who regularly engage in purging behaviors such as self-induced vomiting, use of laxatives, enemas and/or diuretics. Non-purging type describes those who use other inappropriate compensatory behaviors such as fasting and/or excessive exercise. Excessive exercise as a means of purging is often overlooked by parents and teachers.

The Spectrum of Eating Disorders

The diagnosis of Eating Disorders Not Otherwise Specified (ED NOS) is made when significant eating problems exist but specific criteria for AN or BN are not met. The prevalence of partial syndrome EDs is at least twice that of full syndrome EDs, placing AN and BN at the extreme end of a continuum that begins with body dissatisfaction, over concerns around weight and shape, calorie restriction and dieting.

The good news is that interventions introduced at any place along the continuum may result in decreased incidence or prevalence of EDs. This seems to be especially true for interventions applied to prevent or decrease the earliest symptoms in the ED continuum such as body dissatisfaction, weight concerns and dieting. An example of a great prevention program that can be implemented by teachers is Full Of Ourselves (FOO). FOO is a health and wellness education program that addresses critical issues of body preoccupation and reduces risk for disordered eating.

Obesity and the Continuum of Eating Disorders

The field of EDs and eating problems is filled with controversies around causes, treatment and prevention, as well as around the relationship between obesity and eating disorders. Of relevance is that though some obese individuals may meet diagnostic criteria for BN, most do not report the presence of inappropriate compensatory behaviors. In essence, though binge eating may be common among some obese individuals, the etiology of binge eating and dieting behavior among this population is largely unknown. Despite this, it is important to consider that obesity is caused by many factors including genetic, environmental and biological factors. Obesity also places the individual at risk for being teased or rejected which can lead to body dissatisfaction and trigger pressure to be thin and/or dieting.

Selective and Picky Eating

Choosiness is a feature of the typical "picky eating", and it is common during the toddler years; however, growth, development and overall caloric intake tend to be adequate for these children. Selective eating is a severe pattern of "picky eating" and it occurs when individuals narrow their food selection to the extent that they are consuming insufficient amounts of key vitamins and minerals. At this time, more studies are needed to investigate the effects of childhood picky eating behaviors on the development of EDs later in life.

Risk factors

Biological Risk Factors

- **Dieting** - one of the most serious behaviors underlying the development of ED symptoms. Food restriction has been linked to starvation behaviors, and both dieting and weight loss provide young individuals a sense of control at an age when control and autonomy are important. Also, dieting has been associated with binge eating, and deprivation of food has been thought to contribute to eating at a psychological and physiological level.

- **Obesity** - body mass plays a role in promoting risk factors for eating pathology. In addition to be a risk factor for perceived pressure to be thin, body dissatisfaction and dieting, it places the individual at risk for being teased. In today's society weight loss is often celebrated and thereby reinforced. In addition to experience a sense of achievement following desired weight loss, compliments associated with weight loss may positively reinforce an individual's desire to lose further weight, regardless of the appropriateness of such a decision.

- **Puberty** - puberty brings about many body changes such as breast development and weight gain which can be difficult for those who mature earlier than their peers. These changes can increase an individual's body awareness, create insecurities, body dissatisfaction and increase dieting and unhealthy eating behaviors. Also, highly sensitive girls may experience puberty as a loss of control over their bodies.

- **Genetics** - first degree relatives share both genes and environments, making genetic and environmental causes for EDs difficult to differentiate. In spite of this, genetic vulnerability for EDs may be transmitted in families.

Socio-cultural Risk Factors

- **Thin-ideal** - the thin-ideal relates to the socio-cultural tendency for thinness and the model skeletal look seen in magazines and television. Individuals, especially adolescents, may define what their bodies should look like based on what is seen in the media. Some idealize the thin bodies seen in the media, and view them as something to be achieved. These individuals then compare their own bodies to the "idealized" body, and conclude that they are coming up short in comparison. This, in the very least, can result in body dissatisfaction, lower self-esteem and self-concept and trigger an individual to strive to reach the "ideal" by whatever means necessary. The more these individuals compare their own body, the more they strive to be thin, dislike their bodies and engage in unhealthy behaviors.

- **Peer pressure** - Peer pressure is of particular importance when considering that in adolescence, friendships become more influential in the development of attitudes and beliefs about the self and the world. Specific peer pressures related to eating problems include the importance peers play on weight and eating, along with an individual's desire to be popular.

- **Desire to be popular** - The desire to be popular is largely due to the media portrayal of the thin-ideal body which has been linked to general body dissatisfaction, image misconceptions and increased prevalence of EDs.

Familial Risk Factors

Overt and/or subtle parental attitudes can strongly influence a child's perception of weight and food, in addition to influence eating attitudes and behaviors throughout various stages of development.

- Children of overweight mothers develop a concern about becoming overweight which may manifest as inhibiting eating behaviors.

- Parental modeling in the form of maternal or parental complaints about their own weight is associated with weight loss attempts and body esteem, especially in girls.

- Maternal bulimic behaviors present an opportunity for children to acquire these behaviors through modeling and encourage the perception that eating is something to be done covertly.

- Maternal body dissatisfaction and parental overweight status may encourage children to become concerned with their own body weight, in addition to foster secretive eating patterns that may serve to shield from peer ridicule about weight.

- Maternal dieting and pursuit for the thin-ideal promote children's internalization of these goals, and can lead to reduced eating in the children, and consequently increased risk of overeating, a likely contributor to obesity

Psychological Risk Factors

External pressures to look thin and maintain control of one's body weight and appearance may interact with certain psychological characteristics to increase the risk for eating disturbances. However, this complex, interactive process involving many levels of biological, familial, personality and environmental factors make specific causal connections difficult to identify.

The affect-regulation model suggests that individuals may binge eat in an effort to obtain comfort and distraction from negative emotions. In this case, individuals may use vomiting to reduce anxiety about possible weight gain or because they believe that purging serves as an emotional release.

Perfectionism is the most widely recognized personality trait associated with eating problems since it may encourage a relentless pursuit of the thin-ideal. In the educational setting, perfectionism may be manifested as "perfect" handwriting, grades and appearance.

Body distortion or inaccurate body perception is also an important factor in body image.

Warning Signs

In regards to warning signs, it is important to keep in mind that 1. *Some exhibit many early signs while others only a few;* **2.** *EDs are secretive in nature, therefore the first identification may not indicate the disorder is in its initial phase.* **3.** *Proof is not necessary - having a concern that something may be going on with a student is enough to discuss your concerns with the school counselor and/or to initiate a conversation with the student and/or a family member.*

Early detection may be improved by increasing awareness of the following indicators:

Social

- Decreased interest in hobbies and activities previously enjoyed, in addition to withdrawal from social situations, especially those involving food.

Behavioral

- Dieting or overeating
- Decreased interest in preparing food or increased interest in preparing but not eating
- Obsessive rituals such as only eating out of a certain plate or eating certain foods on certain days
- Underachievement or overachievement at work or at school
- Change in clothing style or tendency to wear baggy clothes.
- Over exercising, exercising at inappropriate times, fluctuating exercise patterns
- Frequent excuses not to eat
- Eat very slowly or too fast, rearrange food on the plate, hoard food
- Trips to the bathroom after meals
- Vegetarianism
- Over exercising, exercising at inappropriate times, fluctuating exercise patterns
- Increased interest in watching cooking shows
- Increased interest in collecting food coupons and/or recipes

Physical

- Weight loss, rapid fluctuations in weight
- Faintness, dizziness or fatigue
- Increased sensitivity to cold
- Decreased metabolic rate which leads to slow heart rate, low blood pressure, reduced body temperature and bluish colored extremities
- Changes in hair, skin and nails which may become dry and brittle
- Fluid retention (puffiness)
- "Chipmunk cheeks" occur when salivary glands expand due to frequent vomiting
- Hypoglycemia (low glucose levels) which can cause confusion, illogical thinking, shakiness, irritability and coma.
- Bowel problems such as constipation, diarrhea, cramps
- Indigestion, heartburn
- Sore throat due to frequent vomiting
- Easy Bruising
- Dehydration
- Sore on knuckles
- Loss of menstruation in females

Emotional/Psychological

- Preoccupation with body appearance and body weight
- Mental list of "good and bad foods"
- Anxiety around meal times and feelings of being out of control with food
- Feelings of anxiety, guilt, depression, moodiness, irritability
- Obsessive behaviors, history of suicidal thoughts and/or behaviors
- Decreased concentration, memory and thinking ability
- Relationship problems
- Self-critical, overly sensitive to criticism
- Lack of assertiveness
- Alcohol and drug use

Prevention

EDs and eating-related problems are significant medical and psychological concerns that typically manifest during adolescence. Prevention is aimed at reducing the incidence of EDs by targeting risk and protective factors (variables that diminish the negative effects of risk factors). Risk and protective factors exist within the individual, the school environment, peer relationships and the wider community, thus making a coordinated school approach an effective means to address multiple risk and protective factors.

To date, many prevention programs focus at reducing "malleable" risk factors such as thin-ideal internalization, body dissatisfaction and negative affect while also decreasing factors that amplify the effects of other risk factors such as pressure to be thin and perfectionism. By increasing protective factors, such as social support and self-esteem, prevention programs may also bring about overall improvement in mental health, in addition to successful prevention of EDs and eating-related problems.

Treatment

There are many different treatments for EDs and eating-related problems. Given the variety of symptoms that individuals may experience, different health practitioners may need to be involved in the treatment. A multi-disciplinary approach is most often utilized, and the treatment team may include general physicians, pediatricians, psychiatrists, dietitians/nutritionists, psychologists/therapists, nurses, social workers and occupational therapists. In addition, some individuals may require nutritional counseling to help them identify their fears around food and promote both healthy eating habits and the understanding of the consequences of not eating well. Psychological treatment may include individual, group and family therapy with an experienced therapist.

Eating Disorders and the Schools

EDs typically manifest during adolescence and many children begin dieting in the elementary years. In addition to adopt a prevention-oriented atmosphere that prohibits in-school advertising, teasing, harassment and gender-biased discussions, schools must encourage healthy nutritional behaviors and provide opportunity for positive physical activity. Schools may also wish to adopt prevention programs that can be implemented by teachers such as the Full of Ourselves (FOO).

Educators

The understanding that EDs usually begin during school-age highlights the fact that educators are exposed to students who may be at-risk. Because teachers and other educators are in close contact with children and adolescents, they are prime candidates for the identification of changes in the welfare of students.

What else can educators do?

1. Create a school environment where all students feel safe from harassment. Establish zero tolerance on teasing, taunting and negative talk about students' bodies

2. Teach media literacy skills to ensure that students have the skills to be critical consumers and to understand that media images are often modified or enhanced. Teach students that images, commercials and television shows have messages, created by individuals or groups with specific agendas and/or points of view

3. Focus physical education on skills building and establishing healthy habits, rather than focusing on weight management

4. Ensure that school lunches have healthy options and that vending machines have healthy snacks

5. Include prevention information such as healthy eating and lifestyles tips in the curriculum. Teach students a non-dieting philosophy, whole nutrition and eating all colors of foods

6. Don't weigh students in front of each other. Group weight-ins may make students consider weight an important indicator of self-worth

7. Avoid placing scales in public places where students with body or weight concerns can be overly focused on weighing themselves

8. Don't measure students' body fat with calipers. Some students may obsess over the results of the fat caliper testing and view them as a measure of their self-worth

9. Ensure that participation in school or extracurricular activities is not limited by physical size or shape

10. Provide general information about EDs but do not show movies of individuals with EDs - movies may present "new ways to lose weight" and inadvertently teach an individual how to develop an ED

11. Don't show videos on animal cruelty. It traumatizes children to become vegetarian which may lead to food avoidance/phobia and possibly an ED

12. Watch your own dieting behaviors. Teacher dieting can influence the children to diet which is a risk factor and trigger for EDs

13. Confront students who talk negatively about their bodies or about restricting their food intake to lose weight. Respond immediately and stress that their bodies need fuel several times daily to be able to think, grow, and be healthy. Emphasize that internal - not external - beauty is important

14. Incorporate ED prevention groups that are based on wellness and limit detailed descriptions of eating-disordered behaviors and consequences. This may be done by collaborating with a local college or university or following an established curriculum such as Full of Ourselves (FOO).

15. Encourage the establishment of appropriate procedures and the identification of resources to assist students in need of help. Share your concerns about at-risk students with the school counselor and the school nurse for a possible referral to a qualified professional

16. Closely monitor elementary school students displaying obsessive-compulsive behaviors as they are likely to develop an ED as they go through puberty.

Educational Support

Once ED symptoms reach clinical levels, students will require comprehensive and multifaceted care that is beyond what is available in the educational setting.

Ideally, schools should establish a school support transition team including educators, mental health professionals, medical and nutritional practitioners, and/or identify specific liaisons to communicate with treatment teams and coordinate services and supports within the educational environment.

In some cases, Section 504 plans or special education services and supports may be required in order to provide or facilitate access to the curriculum. Accommodations and supports are based on individual needs, and they may range from accommodating for medical or therapeutic appointments during school hours to school-based counseling, medical monitoring, release from physical education, meal monitoring or support and ongoing communication with treatment team and family. Academic consultation or hospital educational services may be required when inpatient treatment for health or psychiatric reasons is required.

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ADDITIONAL RESOURCES

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The Victoria Centre of Excellence in Eating Disorders
http://www.ceed.org.au

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