Schools and Eating Disorders: Addressing Differences*

Schools can play a significant role in addressing eating disorders. In doing so effectively, school personnel must account for various types of eating problems and the many factors that make students different.

Beyond Anorexia Nervosa and Bulimia Nervosa

As widely delineated, the range of eating disorders include:

- Anorexia Nervosa
- Bulimia Nervosa
- Binge eating disorder
- Orthorexia
- Pica
- Avoidant Restrictive Food Intake Disorder
- Rumination Disorder
- Unspecified Feeding or Eating Disorder
- Other Specified Feeding and Eating Disorder or Eating Disorder (a term that has been replaced since 2013, but may still be encountered in discussions and medical literature).

See Exhibit on the next page for examples of associated symptoms.

While the literature and media focus on eating disorders has centered on White, middle/upper-class young women living in Western culture, clearly ***anyone may struggle with an eating disorder.*** Therefore, as always, schools are concerned about the well-being of *all* students and addressing individual differences in enhancing well-being.

> Students differ in age, gender, race, ethnicity, cultural and personal values, standards, priorities, household rules and dynamics, and more. All this not only can affect the type of eating problems experienced, but also how a student manifests them. For example, those with the same diagnosed eating disorder may display somewhat different symptoms; those with different diagnoses may share some of the same symptoms. And students differ in their acknowledgment or denial of eating problems, the degrees to which their symptoms are recognized, and in their motivation and support for seeking available help.

Personalizing Intervention

As with all specific student problems, addressing eating disorders at schools must be embedded in the schools' student/learning supports intervention domains for addressing barriers to learning and teaching. Such interventions take place across a continuum that includes promoting healthy development, preventing problems, responding quickly after problem onset, and playing a role in responding to severe and chronic problems. The degree of focus on any one type of problem depends on a school's current priorities.

Students, of course, differ in how they respond to efforts to provide them information and influence changes in their lives. Accounting for the wide range of individual differences among students requires personalized approaches (addressing developmental and motivational differences).

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The center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA.Website: http://smhp.psych.ucla.edu

Exhibit

Examples of Symptoms Associated with Eating Disorders

Anorexia Nervosa*
- Menstrual periods cease
- Dizziness or fainting from dehydration
- Brittle hair/nails
- Cold intolerance
- muscle weakness and wasting
- Heartburn and reflux (in those who vomit)
- Severe constipation, bloating & fullness after meals
- Stress fractures from compulsive exercise as well as bone loss resulting in osteopenia or osteoporosis
- Depression, irritability, anxiety, poor concentration and fatigue

Bulimia Nervosa*
- Frequent trips to the bathroom right after meals
- Large amounts of food disappearing or unexplained empty wrappers and food containers
- Chronic sore throat
- Swelling of the salivary glands in the cheeks
- Dental decay resulting from erosion of tooth enamel
- Heartburn and gastroesophageal reflux
- Laxative or diet pill misuse
- Recurrent unexplained diarrhea
- Misuse of diuretics (water pills)
- Feeling dizzy or fainting from excessive purging behaviors resulting in dehydration

Binge Eating Disorder*
- Eating more rapidly than normal
- Eating until uncomfortably full
- Eating large amounts of food when not feeling hungry
- Eating alone because of feeling embarrassed by how much one is eating
- Feeling disgusted with oneself, depressed or very guilty after a binge

Other Specified Feeding and Eating Disorder*

This diagnostic category includes eating disorders or disturbances of eating behavior that cause distress and impair family, social or work function but do not fit the other categories listed here. In some cases, this is because the frequency of the behavior does not meet the diagnostic threshold (e.g., the frequency of binges in bulimia or binge eating disorder) or the weight criteria for the diagnosis of anorexia nervosa are not met.

Avoidant Restrictive Food Intake Disorder*

Food avoidance or a limited food repertoire can be due to one or more of the following:
- Low appetite and lack of interest in eating or food
- Extreme food avoidance based on sensory characteristics of foods e.g. texture, appearance, color, smell
- Anxiety or concern about consequences of eating, such as fear of choking, nausea, vomiting, constipation, an allergic reaction, etc.

The disorder may develop in response to a significant negative event such as an episode of choking or food poisoning followed by the avoidance of an increasing variety of foods.

The diagnosis of ARFID requires that difficulties with eating are associated with one or more of the following:
- Significant weight loss (or failure to achieve expected weight gain in children)
- Significant nutritional deficiency
- The need to rely on a feeding tube or oral nutritional supplements to maintain sufficient nutrition intake
- Interference with social functioning (such as inability to eat with others).

PICA*

Pica is an eating disorder in which a person repeatedly eats things that are not food with no nutritional value. The behavior persists over at least one month and is severe enough to warrant clinical attention. Typical substances ingested vary with age and availability and might include paper, paint chips, soap, cloth, hair, string, chalk, metal, pebbles, charcoal or coal, or clay. Individuals with pica do not typically have an aversion to food in general.

ORTHOREXIA**
- Compulsive checking of ingredient lists and nutritional labels
- An increase in concern about the health of ingredients
- Cutting out an increasing number of food groups (all sugar, all carbs, all dairy, all meat, all animal products)
- An inability to eat anything but a narrow group of foods that are deemed "healthy" or "pure"
- Unusual interest in the health of what others are eating
- Spending hours per day thinking about what food might be served at upcoming events
- Showing high levels of distress when "safe" or "healthy" foods aren't available
- Obsessive following of food and "healthy lifestyle" blogs on Twitter and Instagram
- Body image concerns may or may not be present"

Rumination Disorder**
- Repeated regurgitation of food for a period of at least one month. Regurgitated food may be re-chewed, re-swallowed, or spit out.
- The repeated regurgitation is not due to a medication condition (e.g., gastrointestinal condition).
- The behavior does not occur exclusively in the course of anorexia nervosa, bulimia nervosa, BED, or avoidant/restrictive food intake disorder.
- If occurring in the presence of another mental disorder (e.g., intellectual developmental disorder), it is severe enough to warrant independent clinical attention.

*American Psychiatric Association

**National Eating Disorders Association

Examples of What Eating Disorders Associations' Recommend

From: ***Eating Disorders in Schools: a Guide for Educators***

... teachers can help identify those at risk and promote an environment that discourages negative body image and disordered eating behaviors. The following list of ideas can help:

- Advocate for a safe and respectful school environment that prohibits gender, culture, and racial stereotyping as well as sexual harassment, teasing and bullying.
- Help to promote the self-esteem and positive self-image of the individual student, with regards to their culture, gender and individual needs.
- Provide students with diverse role models, of all shapes and sizes, who are praised for their accomplishments, not their appearance.
- Conduct media literacy activities that allow students to critically examine how magazines, television and other media—including those targeting specific cultural groups present the concept of beauty.
- Guard against size discrimination and bullying in your classroom.

Are you promoting size discrimination?

A teacher who models good health habits provides more valuable health lessons than any textbook. But, teachers need to assess their own attitudes and behaviors about weight to ensure that they do not inadvertently model body dissatisfaction or promote size discrimination. Consider the following:

- Do you inadvertently promote “fear of fat” in students by your words and actions?
- Are you dissatisfied with your body size and shape?
- Are you always on a diet or going on a diet?
- Do you make negative comments about other people’s sizes and shapes?
- Are you prejudiced against overweight children and adults?
- Do you purposefully incorporate role-models of all shapes of sizes in your classroom?
- Do you allow students to bully one another over appearance, size, or shape?
- Do you bully others based on their appearance, size, or shape?

From: ***Educator Toolkit***.

About peer support

- 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 the eating disorder.
- Remind friends that they are not responsible for their friend’s eating disorder or recovery.
- Encourage 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.
- 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 (taking time-out)
  >Their responsibility as a friend (to provide friendship rather than to ‘fix’’ their friend)
  >The ineffectiveness of focusing on food, weight, or appearance with their friend
- The friends of the student with an eating disordercan be supportive by learning basic information about eating disorders. Such information could be integrated into health education or lifestyle classes, if those classes are available for students.

Concluding Comments

Schools have a major role to play in preventing and addressing problems such as eating disorders. A challenge for school staff is how to watch for problems and encourage students (and families) to access help. This involves more than outreaching and ensuring students receive and understand information about what assistance is available and how to access it. School personnel also must build student and family confidence and trust and guarantee privacy and confidentiality.

On an institutional level, school staff must be certain that there is a student/learning support system in place that fully embeds mental health concerns. For a detailed discussion of this, see ***Embedding Mental Health as Schools Change.***

Every day is another opportunity for schools to promote personal and social growth and counter problems. Staff and students need to feel positive about themselves and what they are doing if they are to cope with challenges proactively and effectively. The stakeholders at every school need to commit to fostering staff and student strengths and creating an atmosphere that encourages mutual support, caring, and sense of community.

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For more on Eating Disorders, see the many resources on the Center's Quick Find:

>***Eating Disorders***