

Educator

TOOLKIT



NEDA TOOLKIT for Educators
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The NEDA Educational Toolkits Story

The background

In September 2007 the Board of Directors of NEDA officially approved the organization's new strategic priorities, listing educational toolkits as a new NEDA priority fitting the new mission

"To support those affected by eating disorders and be a catalyst for prevention, cures, and access to quality care." Educational Toolkits were created to strengthen existing materials and provide vital information to targeted audiences. A list of audiences was prioritized by the board and acts as a reference for ongoing materials and toolkit development.

The toolkit concept

The initial concept of the toolkits was to tie together existing information along with the development of new materials to create complete packages that would help targeted audiences during critical moments in their search for help, hope and healing. They are intended for guidance, not for standards of care and would be based on information available at the time of development.

Creation of the toolkits took thoughtful consideration. We identified several key questions as we began working on this project. First: "What is a NEDA Educational Toolkit?" led us to ask ourselves these questions:

- Who is the audience we are trying to reach?
- How many different toolkits will we develop?
- What should a toolkit contain?
- How do we include our stakeholders in the development of the toolkits?
- How does our audience want to receive the toolkit once it's developed?
- How do we market the toolkits?
- What is the plan to revise and enhance the toolkits over time?

Parents and Educators...the starting point

Using the core questions we decided the Parent and Educators Toolkits would be created first. Additional target audiences will include Coaches and Trainers, Health Care Providers, and Individual Patients. We then hired ECRI Institute, a recognized expert in providing publications, information and consulting services internationally for healthcare assessments. Their ability to translate work on behalf of the eating disorders community into useful, real world tools established an excellent partnership for creating the content of the toolkits.

Parents and Educators...the process

ECRI initially created two separate toolsets with a consistent tone. We brought together two focus groups to guide us in the types of information to be included for each of the audiences – parents and educators. ECRI conducted additional interviews with interested elementary and high school teachers and families. Next, ECRI researched and revised existing NEDA educational materials and handouts (as needed) and created new materials as appropriate for each kit. The result was a draft set of "tools" for each toolkit. Some basic information is common to each; other tools are unique to each toolkit. As with all our materials, we want to increase the outreach and support to our constituents while providing reliable information to the general public about the unique and complex nature of eating disorders.

All focus groups agreed that an electronic toolkit, accessible via the NEDA website, would be the easiest, most up-to-date way to make the toolkits available. NEDA researched and reviewed several online toolkits, looking for the best elements of each that could be used to inform the design concept. The final design plan for the organization of each kit was created by designer, David Owens Hastings. ECRI then produced the final documents that are the body of each of the first toolkits. The focus groups reviewed materials one more time and made suggestions for revisions. Their excellent edits and useful comments were integrated into the drafts. Joel Yager, MD, and former clinical advisors were final reviewers on all documents. ECRI then submitted the Toolkit documents to NEDA.

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Beyond parent and educators toolkits

We fully recognize that not all the information within each toolkit will be able to address the diversity and the nuances of each person's and/or families unique circumstances. Our intent is to provide a one-stop place for a comprehensive overview relating to eating disorders for each audience. We have included resources for further information and will be going deeper as funding permits with each audience. We are imagining at this point in the project Parent and Educator toolkits version 1.0, then version 2.0 and so on. The lifecycle of the toolkits is an important aspect in managing this strategic priority for the organization. Our goal is to maintain the usefulness of the toolkits by reviewing and revising each at two-year intervals and including the most up-to-date research and information. NEDA's clinical advisors will be primary reviewers, along with others invited by NEDA, including members of professional organizations that will be disseminating the toolkits.

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

Eating Disorder Information for a School Setting

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Common myths about eating disorders

This information is intended to help dispel all-too-common misunderstandings about eating disorders and those affected by them. If your family member has an eating disorder, you may wish to share this information with others (i.e., other family members, friends, teachers, coaches, family physician)

Eating disorders are not an illness

Eating disorders are a complex medical/psychiatric illness. Eating disorders are classified as a mental illness in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV)*, are considered to often have a biologic basis, and co-occur with other mental illness such as major depression, anxiety, or obsessive-compulsive disorder

Eating disorders are uncommon

They are common. Anorexia nervosa, bulimia nervosa, and binge-eating disorder are on the rise in the United States and worldwide. Among U.S. females in their teens and 20s, the prevalence of clinical and subclinical anorexia may be as high as 15%. Anorexia nervosa ranks as the 3rd most common chronic illness among adolescent U.S. females. Recent studies suggest that up to 7% of U.S. females have had bulimia at some time in their lives. At any given time an estimated 5% of the U.S. population has undiagnosed bulimia. Current findings suggest that binge-eating disorder affects 0.7% to 4% of the general population.

Eating disorders are a choice

People do not choose to have eating disorders. They develop over time and require appropriate treatment to address the complex medical/psychiatric symptoms and underlying issues.

Eating disorders occur only in females

Eating disorders occur in males. Few solid statistics are available on the prevalence of eating disorders in males, but the disorders are believed to be more common than currently reflected in statistics because of under-diagnosis. An estimated one-fourth of anorexia diagnoses in children are in males. The National Collegiate Athletic Association carried out studies on the incidence of eating-disordered behavior among athletes in the 1990s, and reported that of those athletes who reported having an eating disorder, 7% were male. For binge-eating disorder, preliminary research suggests equal prevalence among males and females. Incidence in males may be underreported

because females are more likely to seek help, and health practitioners are more likely to consider an eating disorder diagnosis in females. Differences in symptoms exist between males and females: females are more likely to focus on weight loss; males are more likely to focus on muscle mass. Although issues such as altering diet to increase muscle mass, over-exercise, or steroid misuse are not yet criteria for eating disorders, a growing body of research indicates that these factors are associated with many, but not all, males with eating disorders.

Men who suffer from eating disorders tend to be gay

Sexual preference has no correlation with developing an eating disorder.

Anorexia nervosa is the only serious eating disorder

All eating disorders can have damaging physical and psychological consequences. Although excess weight loss is a feature of anorexia nervosa, effects of other eating disorders can also be serious or life threatening, such as the electrolyte imbalance associated with purging.

A person cannot die from bulimia

While the rate of death from bulimia nervosa is much lower than that seen with anorexia nervosa, a person with bulimia can be at high risk for death and sudden death because of purging and its impact on the heart and electrolyte imbalances. Laxative use and excessive exercise can increase risk of death in individuals who are actively bulimic.

Subclinical eating disorders are not serious

Although a person may not fulfill the diagnostic criteria for an eating disorder, the consequences associated with disordered eating (e.g., frequent vomiting, excessive exercise, anxiety) can have long-term consequences and requires intervention. Early intervention may also prevent progression to a full-blown clinical eating disorder.

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Dieting is normal adolescent behavior

While fad dieting or body image concerns have become “normal” features of adolescent life in Western cultures, dieting or frequent and/or extreme dieting can be a risk factor for developing an eating disorder. It is especially a risk factor for young people with family histories of eating disorders and depression, anxiety, or obsessive-compulsive disorder. A focus on health, wellbeing, and healthy body image and acceptance is preferable. Any dieting should be monitored.

Anorexia is “dieting gone bad”

Anorexia has nothing to do with dieting. It is a life-threatening medical/psychiatric disorder.

A person with anorexia never eats at all

Most anorexics do eat; however, they tend to eat smaller portions, low-calorie foods, or strange food combinations. Some may eat candy bars in the morning and nothing else all day. Others may eat lettuce and mustard every 2 hours or only condiments. The disordered eating behaviors are very individualized. Total cessation of all food intakes is rare and would result in death from malnutrition in a matter of weeks.

Only people of high socioeconomic status get eating disorders

People in all socioeconomic levels have eating disorders. The disorders have been identified across all socioeconomic groups, age groups,

You can tell if a person has an eating disorder simply by appearance

You can't. Anorexia may be easier to detect visually, although individuals may wear loose clothing to conceal their body. Bulimia is harder to “see” because individuals often have normal weight or may even be overweight. Some people may have obvious signs, such as sudden weight loss or gain; others may not. People with an eating disorder can become very effective at hiding the signs and symptoms. Thus, eating disorders can be undetected for months, years, or a lifetime.

Eating disorders are about appearance and beauty

Eating disorders are a mental illness and have little to do with food, eating, appearance, or beauty. This is indicated by the continuation of the illness long after a person has reached his or her initial ‘target’ weight. Eating disorders are usually related to emotional issues such as control and low self-esteem and often exist as part of a “dual” diagnosis of major depression, anxiety, or obsessive-compulsive disorder.

Eating disorders are caused by unhealthy and unrealistic images in the media

While sociocultural factors (such as the ‘thin ideal’) can contribute or trigger development of eating disorders, research has shown that the causes are multifactorial and include biologic, social, and environmental contributors. Not everyone who is exposed to media images of thin “ideal” body images develops an eating disorder. Eating disorders such as anorexia nervosa have been documented in the medical literature since the 1800s, when social concepts of an ideal body shape for women and men differed significantly from today—long before mass media promoted thin body images for women or lean muscular body images for men.

Recovery from eating disorders is rare

Recovery can take months or years, but many people eventually recover after treatment. Recovery rates vary widely among individuals and the different eating disorders. Early intervention with appropriate care can improve the outcome regardless of the eating disorder. Although anorexia nervosa is associated with the highest death rate of all psychiatric disorders, research suggests that about half of people with anorexia nervosa recover, about 20% continue to experience issues with food, and about 20% die in the longer term due to medical or psychological complications.

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Eating disorders are an attempt to seek attention

The causes of eating disorders are complex and typically include socio economic, environmental, cultural, and biologic factors. People who experience eating disorders often go to great lengths to conceal it due to feelings of shame or a desire to persist in behavior perceived to afford the sufferer control in life. Eating disorders are often symptomatic of deeper psychological issues such as low self-esteem and the desire to feel in control. The behaviors associated with eating disorders may sometimes be interpreted as ‘attention seeking’; however, they indicate that the affected person has very serious struggles and needs help.

Purging is only throwing up

The definition of purging is 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 laxative abuse, insulin abuse, fasting, and excessive exercise. Any of these behaviors can be dangerous and lead to a serious medical emergency or death. Purging by throwing up also can affect the teeth and esophagus because of the acidity of purged contents.

Purging will help lose weight

Purging does not result in ridding the body of ingested food. Half of what is consumed during a binge typically remains in the body after self-induced vomiting. Laxatives result in weight loss through fluids/water and the effect is temporary. For these reasons, many people with bulimia are average or above-average weight.

You’re not sick until you’re emaciated

Only a small percentage of people with eating disorders reach the state of emaciation often portrayed in the media. The common belief that a person is only truly ill if he or she becomes abnormally thin compounds the affected individuals’ perceptions of body image and not being “good” at being “sick enough.” This can interfere with seeking treatment and can trigger intensification of self-destructive eating disorder behaviors.

Kids under age 15 are too young to have an eating disorder

Eating disorders have been diagnosed in children as young as seven or eight years of age. Often the precursor behaviors are not recognized until middle to late teens. The average age at onset for anorexia nervosa is 17 years; the disorder rarely begins before puberty. Bulimia nervosa is usually diagnosed in mid-to-late teens or early 20s, although some people do not seek treatment until even later in life (30s or 40s).

You can’t suffer from more than one eating disorder

Individuals often suffer from more than one eating disorder at a time. Bulimarexia is a term that was coined to describe individuals who go back and forth between bulimia and anorexia. Bulimia and anorexia can occur independently of each other, although about half of all anorexics become bulimic.

Achieving normal weight means the anorexia is cured

Weight recovery is essential to enabling a person with anorexia to participate meaningfully in further treatment, such as psychological therapy. Recovering to normal weight does not in and of itself signify a cure, because eating disorders are complex medical/psychiatric illnesses.

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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 in trouble. 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, including anxiety, depression, and obsessive-compulsive disorder.

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

- Can have detrimental effects on cognitive development in children
- Has a negative impact on student behavior and school performance
- Makes students feel irritable, decreases ability to concentrate and focus, decreases ability to listen and process information, may cause nausea, headache, and makes students feel fatigued and have lack of energy
- Makes students with disordered eating behaviors less able to perform tasks as well as their adequately nourished peers
- Leads to deficiencies in specific nutrients, such as iron, which has an immediate effect on students' memory and ability to concentrate
- Can make students become less active and more apathetic, withdrawn, and engage 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, which is even more difficult given their compromised physical and mental status.

In addition to the effects described above, preoccupation with food often dominates the life of a student with an eating disorder. A study on people with eating disorders indicated a 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.

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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 diagnose. However, be concerned about the student who appears to be the “perfect” student or who strives for perfection. Be concerned if a student consistently shows one or more of the signs or symptoms listed below.

Emotional

- Change 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
- Talks about dieting; avoids nutritious foods because they are “fattening”
- Is overweight but appears to eat small portions in presence of others
- Appears sad/depressed/anxious/expresses feelings of worthlessness
- Is target of body or weight bullying
- Spends increasing amounts of time alone
- Is obsessed with maintaining low weight to enhance performance in sports, dance, acting, or modeling
- Overvalues self-sufficiency; reluctant to ask for help

Physical

- Sudden weight loss, gain, or fluctuation in short time
- Abdominal pain
- Feeling full or “bloated”
- Feeling faint, cold, or tired
- Dry hair or skin, dehydration, blue hands/feet
- Lanugo hair (fine body hair)

Behavioral

- Diets or chaotic food intake; pretends to eat, then throws away food; skips meals
- Exercises for long periods; exercises excessively every day (can’t miss a day)
- Constantly talks about food
- Makes frequent trips to the bathroom
- Wears very baggy clothes to hide a very thin body (anorexia) or weight gain (binge eating disorder) or hide “normal” body because of disease about body shape/size
- Is fatigued; gets dizzy
- Avoids cafeteria
- Carries own food in backpack or purse
- Shows some type of compulsive behavior
- Denies difficulty

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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 student 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 “get smart” about eating disorders and share their knowledge and expertise with other school personnel and plan an in-service, if possible.
 - If a full in-service is not possible, plan some time at a faculty meeting to discuss eating disorders or hand out basic information to staff on healthy body image, nutrition, signs and symptoms of eating disorders, 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 that specialize in eating disorder treatment.
 - Update school policy on 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. Be sure the consequences for bullying behavior are clear.
 - Decide which staff will take responsibility for monitoring and communicating changes in a student’s wellbeing 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 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.
- Make it a policy not to weigh students publicly or in close proximity to fellow students. Consider eliminating weigh-in policies for sports programs if they are not absolutely necessary.
 - Consider offering a community outreach program on eating disorders with invited experts.
 - Review posters/books/materials in the school to ensure they include all body shapes, sizes, and racial groups.
 - 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.

Assist the student

- If a student discloses a personal problem, consider the setting in which the disclosure has occurred. If it is during a class or other setting where others are present for example, practice protective interrupting. For example: 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.

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Assist fellow students 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 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 disorder can 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.

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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, 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

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

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

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E. Illicit Activities

- Carrying weapons, beeper, cell phone
- 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

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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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.

When you start the conversation with family or guardians focus on empathy and concern

- Show empathy and support. Listen to what the family member says without interrupting, judging, or making pronouncements or promises.
- Aim to establish and maintain a positive, open, and supportive relationship with parents/families. Be mindful that parents may feel guilty, blamed, or responsible for the eating issue or disorder in some way.
- 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 a diagnosis.
- Encourage the family to access support, information, or treatment from external agencies and have resources available to refer them to.
- 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
- Affirm that the choice to not talk about it is OK
- 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; and
- 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 action 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.
- The school's ongoing communication with and support to the family and student
- 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.
- 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 and decide collaboratively on the next steps the school will take with the student and family.

Why parent-school communications may be difficult: Regulatory constraints and confidentiality issues

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 "my hands are tied by laws and regulations about what and how we are allowed to communicate concerns to parents. 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. Kids are good at hiding things when they want to. "

While rules vary from state to state, the Position Statement on Confidentiality from The American School Counselor Association may help both sides better understand why communications between family members and school personnel may be difficult at times. The rationale behind this position is that an atmosphere of trust is important to the counseling relationship. In addition, schools may be bound by strict protocols generated by state regulations about how teachers and staff are required to channel observations and concerns. For example, school districts in a state may be required to have a "student assistance program" team to handle student nonacademic issues. Teacher concerns are submitted on a standard form to the team that then meets to develop a "student action plan." Privacy laws can prohibit a teacher from discussing their concerns with a student without parent permission. Teachers explain that sometimes the student considers the problem to

be the parent, so contacting the parent about a concern can make a student's problem worse in the students' eyes. Conversely, a student can also prohibit a teacher from talking with parents about the teachers' concerns without evidence from direct observations of behavior.

The following link presents the position statement from the professional association of school counselors:<http://www.schoolcounselor.org/content.aspx?pl=325&sl=133&contentid=133>. It 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's summary is as follows:

"A counseling relationship requires an atmosphere of trust and confidence between student and counselor. A student has the right to privacy and confidentiality. The responsibility to protect confidentiality extends to the student's parent or guardian and staff in confidential relationships. Professional school counselors must adhere to P.L. 93-380."

NEDA TOOLKIT for Educators

Finding eating disorder treatment

Online databases and telephone referral lines are available to help families find a suitable treatment setting. Excellent resources are listed below

Treatment Center Databases to Search

NEDA

www.nationaleatingdisorders.org

Treatment center listings can be accessed from the NEDA homepage. This database contains listings from professionals who treat eating disorders. Simply open the treatment referral tab and agree to the disclaimer. Find an eating disorders treatment provider who will serve your state, a nationwide list of inpatient/residential treatment facilities, search for free support groups in your area or locate a national Eating Disorders Research Study.

Bulimia Guide

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

This database focuses on U.S. centers that treat all types of eating disorders (not just bulimia) and offer various levels of care and many types of treatment from standard to alternative. On this website, you can browse center listings by state, type of treatment offered, whether or not they accept insurance or other characteristics by selecting from the drop-down lists. Some states have no eating disorder treatment centers, and that's why no listings come up for some states. This information was compiled from detailed questionnaires sent to every center to gather information about its treatment philosophies, approaches, staffing, and the clinical and support services it offers. The amount of information centers provided varies widely among centers. This database does not contain listings for individual outpatient therapists who claim to treat eating disorders.

Something Fishy

<http://www.something-fishy.org/treatmentfinder/>

The database contains listings from individual therapists, dieticians, treatment centers, and other professionals worldwide who treat eating disorders. Open the "treatment finder" tab on the left, and search by category (type of treatment), country, state, area code, name, services, description, or zip code.

What to Consider When Searching for a Treatment Center

Several considerations enter into finding a suitable treatment setting. Options may be limited by factors such as insurance coverage, location, or ability to pay for treatment in the absence of insurance. When contacting treatment centers, be sure to talk with them to find out their complete admission criteria and whether your loved one meets their criteria for treatment. That way, you can better ensure that your loved one will meet their criteria before traveling. Arriving at a center only to find out, after they take sufficiently detailed patient intake information, that they won't admit your loved one is a situation you'll want to prevent. Primary care physicians (i.e., family doctor, gynecologist, pediatrician, internal medicine doctor) may be able to assist in referring patients to appropriate treatment facilities, because they may have experience with various centers or outpatient therapists.

Telephone Referral and Information Helplines

Something Fishy 866.690.7239

Hope Line Network 800.273.TALK

National Suicide Hotline 988

National Call Center for At-Risk Youth 800.USA.KIDS

NEDA TOOLKIT for Educators

Guidance for schools on education plan for a student in treatment

Recovering from an eating disorder is a long-term process. Students miss significant amounts of time from school. 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
- Be aware of the effects of eating disorders on cognitive abilities, so your expectations are realistic
- Develop a realistic educational plan for the student
- Be flexible while balancing realistic workloads, deadlines, and the school's responsibility to ensure the student fulfills 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
- Recognize that the student's reconnecting with friends may be difficult and stressful
- Offer the student a buddy or buddy group for at-school support (lunch, recess) after an extended absence
- Create small group project opportunities in class for the student to participate in
- Provide tutoring support
- The National Association of School Psychologists published an article (see Key Sources) about the school psychologist's role in reintegrating a student after inpatient or outpatient eating disorder treatment. Key points include the following:
 - 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)
- 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 negotiate scheduling conflicts between school and doctor appointments; educate teachers about side effects of the student's medications)
- Provide in-school counseling (relaxation techniques, supportive and reflective listening, short-term solution-focused problem solving for in-school issues)
- Work with administrators to create a healthy school environment (zero-tolerance of appearance-based teasing and bullying, encourage that healthy lunch options be adopted in cafeteria, schedule in-services on eating disorders)
- Assist teachers in including healthy body and eating disorder prevention subjects into their curricula
- Discipline students who bully others based on their appearance
- Model healthy attitudes (balanced eating and exercise for health rather than appearance)
- Refer at-risk students for screening and evaluation as permitted by the student assistance program
- Promote alternatives to class activities that may trigger eating disorder behaviors (e.g., weigh-ins, co-education swim class, calorie counting in nutrition class)
- Consult with school nurse who may need to conduct periodic assessments and follow-up: pulse and blood pressure checks, medication dispensing, manage medical releases and restriction forms for activities and meals, monitor student during meals

NEDA TOOLKIT for Educators

Tips for school psychologists

- Appropriate resources and information needed to follow through on these tips are contained in the National Eating Disorders Association Educator and Parent Toolkits. According to the National Association of School Psychologists, school psychologists should:
 - Model healthy attitudes (balanced eating and exercise for health rather than appearance)
 - Assist teachers in including healthy body and eating disorder prevention into their curricula
 - Know how to approach individuals at risk for an eating disorder
 - Refer at-risk students for screening and evaluation as permitted by the student assistance program
 - Know how to communicate this information to parents
 - Be knowledgeable about making referrals to appropriate community treatment 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, short-term solutions focused or 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 (zero-tolerance of appearance-based teasing and bullying, encourage appropriate school personnel to evaluate school lunches to ensure inclusion of healthy options, schedule in-services on eating disorders)
- 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)

NEDA TOOLKIT for Educators

Tips for school nurses

“School nurses are required, by the scope of nursing practice, to provide education and counseling to students about health issues, including mental health issues.” -National Association of School Nurses

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 mental health issues and begin to deal with them
- Act as liaison between students and with 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

- Good nutrition
- Healthy exercise regimens and risks of over-exercise
- Adequate hydration during sports activities
- Body changes associated with puberty and adolescence (including weight gain)
- Talk with students about health and legal risks associated with anabolic steroids and suggest natural ways to increase muscle and strength

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 healthy nutrition and exercise.

NEDA TOOLKIT for Educators

Tips and information for coaches: What coaches, parents, and teammates need to know

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 sports are well-recognized: building self-esteem, staying in good physical condition, and setting a foundation for lifelong physical activity. Athletic competition, however, can 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.

Specific sports that can create risk for developing an eating disorder

- Gymnastics, swimming, diving, rowing, bodybuilding, and wrestling, because athletes must "make weight" or maintain a certain body size to stay competitive.
- Aesthetic or endurance sports such as gymnastics, figure skating, dance, diving or track and field because they focus on appearance and on the individual rather than on the entire team.

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.
- Low self-esteem or self-appraisal, dysfunctional interpersonal relationships, a genetic history of eating disorders/addiction, chronic dieting, history of physical or sexual abuse or other traumatic life experiences, peer and cultural pressures to be thin.
- 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 turn to altering their body composition 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.
- Factors that protect athletes from developing eating disorders
- Positive, person-oriented coaching style rather than negative, performance-oriented coaching style.
- Social influence and support from teammates with healthy attitudes towards size and shape.
- Coaches who emphasize factors that contribute to personal success such as motivation and enthusiasm rather than body weight or shape.

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Factors that protect athletes from developing eating disorders

- Positive, person-oriented coaching style rather than negative, performance-oriented coaching style
- Social influence and support from teammates with healthy attitudes towards size and shape
- Coaches who emphasize factors that contribute to personal success such as motivation and enthusiasm rather than body weight or shape

Concerns specific to female athletes

Female athletes may be at risk of a triad of harmful consequences, including:

- Disordered eating
- Loss of menstrual periods
- Osteoporosis (loss of calcium resulting in weak bones).

The lack of adequate nutrition resulting from disordered eating can cause the loss of several or more consecutive periods. This in turn leads to calcium and bone loss, placing the athlete at greatly increased risk for stress fractures of the bones. 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. Males may develop similar syndromes.

NEDA TOOLKIT for Educators

What coaches can and should do

By Karin Kratina, MA, RD

- Take warning signs and eating disordered behaviors seriously! Cardiac arrest and suicide are the leading causes of death for people with eating disorders.
- Pay attention to chronic dieting or slightly odd eating habits. Coaches should refer concerns to the school's student assistance program, responsible family member of the student, or a health professional with eating disorder expertise. Early detection increases the likelihood of successful treatment; left untreated a problem that begins as disordered eating may progress to an eating disorder.
- De-emphasize weight. Whenever possible, avoid weighing athletes. Eliminate comments about weight. Focus on areas that athletes can control to improve performance. For example, focus on strength and physical conditioning, and mental and emotional aspects of performance. Improving mental and emotional coping skills carries no risk.
- Don't assume that reducing body fat or weight will enhance performance. Weight loss or lower body fat may improve performance, but studies show this does not apply to all athletes. Performance should not come at the expense of the athlete's health.
- Coaches and trainers should obtain basic education on recognizing signs and symptoms of eating disorders and understand the role they can play in preventing them—or helping athletes who have them. People with eating problems are often secretive about their eating habits. They develop coping skills to mask symptoms and to make believable excuses when their behavior is noticed or questioned. They are often ashamed, though they may be aware that the behavior is abnormal.
- Athletes need accurate information about healthy weight, weight loss, body composition, good nutrition, sports performance, and the impact of bad nutrition. Information should include the common myths about eating disorders and challenge unhealthy practices. Make use of local health professionals with expertise in eating disorders and athletics who can help educate athletes.

- Emphasize the health risks of low weight, especially for female athletes with menstrual irregularities or total cessation of menses. Refer athletes for medical assessments in these cases.
- Understand why weight is such a sensitive and personal issue for both male and female athletes. Eliminate derogatory comments or behaviors about weight—no matter how subtle, slight, or “in good fun” they seem.
- If an athlete has an eating disorder, don't automatically curtail his/ her participation unless warranted by a medical condition that is documented by a physician. Consider the whole person: physical and emotional/mental health when making decisions about an athlete's level of participation in his/her sport.
- Coaches and trainers should explore their own values and attitudes regarding weight, dieting, and body image, and how their values and attitudes may inadvertently affect their athletes. They should understand their role in promoting a positive self-image and self-esteem in their athletes.

Guidelines and position statements related to sports and eating disorders from medical societies

The American Academy of Pediatrics Guidelines: Promotion of healthy weight-control practices in young athletes: These guidelines, published in 2005, provide 12 major recommendations, including advice for physicians about appropriate medical care for young athletes, nutrition, weigh-in procedures, healthy weight maintenance, weight loss, emotional support, body fat composition, and fluid intake.

Canadian Academy of Sport Medicine: Abandoning Routine Body Composition Assessment: A Strategy to Reduce Disordered Eating among Female Athletes and Dancers: The committee's position is that routine body composition assessment be abandoned for all female athletes and dancers. They assert that when supplemented by nutritional counseling and eating disorder prevention programs, this change would be a valuable strategy towards reducing the incidence of the “Female Athlete Triad”: eating disorders, amenorrhea, and osteoporosis. Their position is based on a review of the scientific literature from which they conclude that there is a lack of evidence that body composition assessments lead to improved athletic performance. <http://www.casm-acms.org/forms/statements/BodyCompDiscEng.pdf>

NEDA TOOLKIT for Educators

The physiological impact of eating disorders on athletic performance

The physiological impact of an eating disorder is related to its severity and duration, as well as the athlete's overall health, body stature and genetics.

An appropriately lean physique allows athletes to maximize speed. Yet often athletes are not taught that ideal body fat levels are not a one-size-fits all formula. The athlete's own body type, genetics, and fitness level should all be considered. It is important to convey to athletes that a thin athlete is not necessarily a strong athlete. In fact too much weight loss can result in the athlete's loss of power and strength.

An athlete suffering from an eating disorder may suffer from the following physiological conditions:

- Fatigue
- Malnutrition
- Dehydration
- Electrolyte imbalance
- Osteoporosis
- Loss of endurance
- Loss of coordination
- Loss of speed
- Muscle cramps
- Overheating

Athletes often strive for a low level of body fat, and in the case of women, even levels that are too low to support monthly periods. The result is what is known as The Female Athlete Triad. It is important that you help educate your athletes so that their goal body-fat composition and physiques are both realistic and healthy.

Even short-term weight loss can hurt performance

Some athletes may only engage in eating-disordered behaviors during their competitive season. Even a short period of weight loss, though, will often result in a decrease in water weight, and this can leave the athlete dehydrated. When athletes in weight-class sports restrict carbohydrate intake to make weight goals, they may suffer a decline in strength, speed, or stamina. Tell your athletes that restricting fluid or food intake to make weight does not optimize performance, and in fact can hurt it.

Medical problems that can arise from specific eating disorders

Although the following medical complaints may not all affect athletic performance they are further signs that an athlete may be suffering from an eating disorder and is in a compromised medical state.

Anorexia Nervosa

- Heart failure. This can be caused by slow heart rate and low blood pressure. Those who use drugs to stimulate vomiting, bowel movements, or urination are also at high risk for heart failure. Starvation can also lead to heart failure, as well as 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
- Osteoporosis

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)
- Damage to the stomach 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

Binge Eating Disorder

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

Additional Resources

NEDA TOOLKIT for Educators

Frequently Asked Questions

What is an eating disorder?

Eating disorders are serious, but treatable illnesses with medical and psychiatric aspects. The eating disorders most commonly known to the public are anorexia and bulimia. There are also other eating disorders, such as binge eating disorder. Some eating disorders combine elements of several diagnostic classifications and are known as “eating disorder not otherwise specified.” 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 from seven or eight years old on up may get eating disorders. While it’s true that eating disorders are more commonly diagnosed in females than males and more often during adolescence and early adulthood than older ages, many cases are also being recognized in men and in women in their 30s, 40s and older. Eating disorders affect people in 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 U.S. females. Recent studies suggest that up to 7% of U.S. females have had bulimia at some time in their lives. At any given time an estimated 5% of the U.S. population has undiagnosed bulimia. Current findings suggest that binge eating disorder affects 0.7% to 4% of the general population.

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 patients whose symptoms improve—even if the symptoms are not totally gone (called a partial remission)—the burden of the illness can diminish a lot. This can open the way for healthier relationships with food, improved quality of life, and happier and more productive patients. 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 at some future point in life. Many patients in recovery agree that remission more accurately describes their recovery, because they continue to need to 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, and underlying psychological issues. This doesn’t necessarily mean the person has a diagnosable eating disorder, but expressing concern to a friend about the behavior is warranted. If he or she denies the problem or gets defensive, it might be helpful to have information about what eating disorders actually are.

I know someone who exercises every day 3 or 4 hours a 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 if the compulsion is driven by a desire to lose weight, despite being within a normal weight range, or if the compulsion is driven 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 this much. If you are concerned about weight or the rationale behind the excessive exercise regime, lead the person to information and resources that could help.

NEDA TOOLKIT for Educators

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, 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. See p. 13 of this toolkit for a sample conversation with an athlete you are concerned about.

A group of athletes is dieting together. What should we (coaches/trainers) 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 one 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 very uncomfortable coming to school, a strategy to deal with the gossip is in order. 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. 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 come up with ways of 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?"

NEDA TOOLKIT for Educators

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 observed directly 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?

Most people overeat now and then, but 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 feeling out of control over eating during the binge. 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.

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 compare their other body parts then, and believe they have “proof” of their perceived need to strive for further 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 with friends at or outside school. How can he/she 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.

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.

Ana Slang for 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 and bulimia nervosa.

Anorexia Nervosa 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. (See Mood Disorders.)

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.

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 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. Also referred to as "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 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.

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Body Dysmorphic Disorder or Dymorphophobia A mental condition defined in the DSM-IV in which the patient is preoccupied with a real or perceived defect in his/her appearance. (See DSM-IV.)

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 U.S. Centers for Disease Control and Prevention Web site offers BMI calculators and standardized BMI charts.

Bulimia Nervosa A disorder defined in the DSM-IV-R 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.

Bulimarexia A term used to describe individuals who engage alternately in bulimic behavior and anorexic behavior.

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 family members supporting that patient and 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 U.S. 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 4 to 5 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.

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.

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Comorbid Conditions Multiple physical and/or mental conditions existing in a person at the same time. (See Dual Diagnosis.)

Crisis Residential Treatment Services Short-term, round-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.” (See 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 (also called Major Depressive Disorder) A condition that is 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-IV-R. (See Mood Disorders.)

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 20 group sessions lasting 2 hours once a week. (See Behavioral Therapy.)

Disordered Eating Term used to describe any atypical eating behavior.

Drunkorexia Behaviors that include any or all of the following: replacing food consumption with excessive alcohol consumption; consuming food along with sufficient amounts of alcohol to induce vomiting as a method of purging and numbing feelings.

DSM-IV The fourth (and most current as of 2006) edition of the *Diagnostic and Statistical Manual for Mental Disorders IV* published by the American Psychiatric Association (APA). This manual lists mental diseases, conditions, and disorders, and also lists the criteria established by APA to diagnose them. Several different eating disorders are listed in the manual, including bulimia nervosa.

DSM-IV Diagnostic Criteria A list of symptoms in the *Diagnostic and Statistical Manual for Mental Disorders IV* published by 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-IV diagnosis be made by a qualified clinician before approving benefits for a patient seeking treatment for a mental disorder such as anorexia or bulimia.

DSM-IV-TR Diagnostic Criteria Criteria in the revised edition of the DSM-IV used to diagnose mental disorders.

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 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 (ED-NOS) Any disorder of eating that does not meet the criteria for anorexia nervosa or bulimic nervosa.

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.

Eating Disorder Inventory-2 (EDI-2) Second edition of the EDI.

Ed Slang Eating disorder.

ED Acronym for eating disorder.

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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 bowel. 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 horse 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. (See Behavioral Therapy.)

Expressive Therapy A nondrug, nonpsychotherapy 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 nonpsychotherapy 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. (See Alternative Therapy.)

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 and standards for electronic health information and protect 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: http://www.cms.hhs.gov/HealthInsReformforConsumers/01_Overview.asp#TopOfPage

- 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.

Hypno-behavioral 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) IPT (also called interpersonal psychotherapy) is 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 4 to 5 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 Depression See Major Depressive Disorder.

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Major Depressive Disorder A condition that is 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. (See Depression)

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.

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.

Mandates See State Mandates.

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. For bulimia or bulimic.

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

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

Mood Disorders Mental disorders characterized by periods of depression, sometimes alternating with periods of elevated mood. People with mood disorders suffer from severe or prolonged mood states that disrupt daily functioning. Among the general mood disorders classified in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* are major depressive disorder, bipolar disorder, and dysthymia. (See Anxiety and Major Depressive Disorder)

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 is 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.

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Nonpurging Any of a number of behaviors engaged in by a person with bulimia nervosa 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 refeed, 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 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 mood disorder diagnoses can be found in the DSM-IV.

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 eating 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-IV.

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.

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.

Parity Equality (see Mental Health Parity Laws).

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.

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.

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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.

Psychotherapy The treatment of mental and emotional disorders through the use of psychologic 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.

Recovery Retreat See Residential Treatment Center.

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, never to return 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.

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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 fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* defines a substance use disorder as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period: (1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home; (2) Recurrent substance use in situations in which it is physically hazardous; and (3) Recurrent substance-related legal, social, and/ or interpersonal 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 Residential Services See Residential Treatment Center.

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

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 stimulus that influences 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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Selected books

The following list of books is available through Gurze Books (www.gurze.com), which specializes in publishing and distributing books and materials on eating disorders.

100 Questions and Answers about Eating Disorders (2007) Carolyn Costin, MA, MEd, MFT

All Made Up: A Girl's Guide to Seeing Through Celebrity Hype to Celebrate Real Beauty (2007) Audrey D. Brashich

Andrea's Voice: Silenced by Bulimia: Her Story and Her Mother's Journey through Grief toward Understanding (2006) Doris Smeltzer

Beyond Measure: A Memoir About Short Stature and Inner Growth (2006) Ellen Frankel

Binge-Eating Disorder: Clinical Foundations and Treatment (2007) Michael J Devlin, MD, FAED; Martina de Zwaan, MD, FAED; Scott J. Crow, MD

Bulimia: A Guide to Recovery (1998) Lindsey Hall; Leigh Cohn

Clinical Manual of Eating Disorders (2007) Joel Yager, MD; Pauline S. Powers, MD

Drawing From Within: Using Art To Treat Eating Disorders (2006) Lisa D. Hinz, PhD

Eating and Weight Disorders(2006) Carlos Grilo, PhD

Eating Disorders Sourcebook (1999) Carolyn Costin, MA

Feeling Good About the Way You Look: A Program for Overcoming Body Image Problems (2006) Sabine Wilhelm, PhD

Full of Ourselves: A Wellness Program to Advance Girl Power, Health, and Leadership (2006) Catherine Steiner-Adair, MD; Lisa Sjostrom

Gaining: The Truth About Life After Eating Disorders (2008) Aimee Liu

Girls Rock! Just the Way We Are: Wise Teens Offer Tweens & Moms Advice on Healthy Body Image, Self Esteem & Personal Empowerment (2006) Lisa Miller

How I Look Journal (2007) Nan Dellheim; Molly Dellheim

I'm Beautiful? Why Can't I See it? Daily Encouragement to Promote Healthy Eating & Positive Self-Esteem (2006) Kimberly Davidson
I'm Still Caroline: My Story of Hope, Health, and Long-term Recovery from Bulimia (2008) Caroline Miller, MAPP, ACC

Inside Anorexia: The Experiences of Girls and their Families (2007) Christine Halse; Anne Honeoy; Desiree Boughtwood

Inside Out: Portrait of an Eating Disorder (2007) Nadia Shivack

Integrated Treatment of Eating Disorders: Beyond the Body Betrayed (2008) Kathryn J. Zerbe, MD

It's Not About the Weight: Attacking Eating Disorders from the Inside Out (2007) Susan J. Mendelsohn, PsyD

Life Doesn't Begin 5 Pounds from Now (2007) Jessica Weiner

Locker Room Diaries: The Naked Truth about Women, Body Image and Re-imagining the "Perfect" Body (2006) Leslie Goldman, MPH

Love Your Body: Change the Way You Feel About the Body You Have (2007) Tami Brannon-Quan, PhD, CAS, MFT; Lisa Licavoli, RD, CCN

Lying in Weight: The Hidden Epidemic of Eating Disorders in Adult Women (2008) Trisha Gura, PhD

Mindful Eating 101: A Guide to Healthy Eating in College and Beyond (2006) Susan Albers, PsyD

Mindless Eating: Why We Eat More Than We Think (2006) Brian Wansick, PhD

Next to Nothing: A Firsthand Account of One Teenager's Experience with an Eating Disorder (2007) B. Timothy Walsh, MD; Carrie Arnold

Perfect Girls, Starving Daughters: The Frightening New Normalcy of Hating Your Body (2007) Courtney E. Martin

Personality Disorders and Eating Disorders: Exploring the Frontier (2006) Randy A. Sansone, MD; John L. Levitt, PhD

Pieces of a Puzzle: The Link Between Eating Disorders and ADD (2006) Carolyn Piver Dukarm, MD

Preventing Eating Disorders : A Handbook of Interventions and Special Challenges (1999) Michael P. Levine, Ph.D., FAED; Niva Piran, MD; Catherine Steiner-Adair, MD

Radical Recovery: A Manifesto of Eating Disorder Pride (2006) Chris Kraatz, PhD

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Real World Recovery: Intuitive Food Program Curriculum for the Treatment of Eating Disorders (2007) Rebekah Hennes, RD; Erin Naimi, RD; et al.

Regaining Your Self: Breaking Free from the Eating Disorder Identity: A Bold New Approach (2007) Ira Sacker, MD; Sheila Buff

Re-Versing the Numbers: A Poetry Notebook for Eating Disorders (In-Versing Your Life) (2006) Cynthia Blomquist Gustavson, MSW, LCSW, ACSW

Skills-based Learning for Caring for a Loved One with an Eating Disorder: The New Maudsley method (2007) Janet Treasure; Grainne Smith; Anna Crane

Soul Hunger (2006) Sandy Richardson, MS; Susan Wilsie Govier

Spiritual Approaches in the Treatment of Women with Eating Disorders (2006) P.Scott Richards, PhD; Randy K. Hardman; PhD; Michael E. Berrett, PhD

Surviving an Eating Disorder: Strategies for Family & Friends (1997) Michelle Siegel, PhD; Judith Brisman, PhD; Margot Weinschel, PhD

The Appetite Awareness Workbook: How to Listen to Your Body & Overcome Bingeing, Overeating & Obsession With Food (2006) Linda Craighead, PhD

The Body Betrayed: A Deeper Understanding of Women, Eating Disorders, and Treatment (1995) Katheryn J. Zerbe, MD

The Body Project, Workbook: Ten-copy Set (Treatments That Work) (2007) Eric Stice, PhD; Katherine Presnell, PhD

The Diet Survivor's Handbook: 60 Lessons in Eating, Acceptance and Self-Care (2006) Judith Matz, LCSW; Ellen Frankel, LCSW

The Exercise Balance: What's Too Much, What's Too Little, and What's Just Right for You! (2008) Pauline S. Powers, MD; Ron Thompson

The Food and Feelings Workbook: A Full Course Meal on Emotional Health (2007) Karen R. Koenig, LCSW, MEd

The Journey Toward Freedom: Rediscovering the Pleasures of Normal Eating (2006) Kate Butitta; Marna M

The Parent's Guide to Eating Disorders: Supporting Self Esteem, Healthy Eating & Positive Body Image at Home (2007) Marcia Herrin, EdD, MPH, RD; Nancy Matsumoto

The Starving Family: Caregiving Mothers and Fathers Share Their Eating Disorder Wisdom (2005) Cheryl Dellasega, PhD

Thin (2006) Lauren Greenfield; Joan Jacobs Brumberg, PhD

Treating Bulimia in Adolescents: A Family-Based Approach (2007) Daniel Le Grange, PhD; James Lock, MD, PhD

Unlocking the Mysteries of Eating Disorders (2007) David B. Herzog, MD; Debra Franko, PhD; Pattie Cable, RN

We Are More Than Beautiful: 46 Real Teen Girls Speak Out about Beauty, Happiness, Love and Life (2007) Woody Winfree

What's Eating You: A Workbook for Teens with Anorexia, Bulimia, and Other Eating Disorders (2008) Tammy Nelson, MS, ATR, LADC, LPC

When Dieting Becomes Dangerous: A Guide to Understanding and Treating Anorexia and Bulimia (2003) Deborah M. Michel, PhD; Susan G. Willard, LCSW, et al.

When Your Child Is Cutting: A Parent's Guide to Helping Children Overcome Self-injury (2006) Merry E. McVey-Noble, PhD; Sony Khemlani-Patel, PhD; Fugen Neziroglu, PhD, ABBP

Why She Feels Fat: Understanding Your Loved One's Eating Disorder and How You Can Help (2008) Johanna Marie McShane, PhD; Tony Paulson, PhD

Woman Redeemed (2007) Diana Kline

You Are Not Alone: The Book Of Companionship For Women Struggling With Eating Disorders (2006) Andrea Roe

NEDA TOOLKIT for Educators

Useful online resources for eating disorders

Academy for Eating Disorders

www.aedweb.org

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

A Chance to Heal Foundation

www.achancetoheal.org

This foundation, based in southeastern Pennsylvania, was established to provide financial assistance to individuals with eating disorders who might not otherwise receive treatment or reach full recovery due to their financial circumstances. The organization's mission also focuses on increasing public awareness and education about eating disorders and advocating for change to improve access to quality care for eating disorders.

Anna Westin Foundation

www.annawestinfoundation.org

This organization was founded in memory of a child who died from bulimia complications. It provides advocacy, education, speakers, and resources about eating disorders, treatment, and navigating the health insurance system. The Anna Westin Foundation and Methodist Hospital Eating Disorders Institute partnered to establish a long-term residential eating disorder treatment program for women in Minnesota.

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, including self-help tips and information about recovery and prevention.

American Psychiatric Association (APA)

www.healthyminds.org

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

Eating Disorders Coalition for Research, Policy & Action

www.eatingdisorderscoalition.org

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

Eating Disorder Recovery Center

www.edrecover.com

The Eating Disorder Recovery Center's mission is to financially assist individuals with eating disorders, and their family members, to attain treatment.

Eating Disorder Referral and Information Center

www.edreferral.com

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

ECRI Institute

www.bulimiaguide.org

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

The Harris Center

www.harriscentermgh.org

A national nonprofit organization dedicated to research and education, as well as seeking to expand knowledge about eating disorders and their detection, treatment, and prevention.

NEDA TOOLKIT for Educators

International Association of Eating Disorders Professionals (IAEDP)

www.iaedp.com

IAEDP offers nationwide education, training, certification, and a semiannual conference 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/site/anadweb

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 Web site 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 offering support to and public awareness about males with eating disorders.

National Eating Disorders Association

www.nationaleatingdisorders.org

NEDA is the largest not-for-profit organization in the United States working to prevent eating disorders and provide treatment referrals to those who feel extremely dissatisfied with body image and weight.

National Women's Health Information Center

<http://www.womenshealth.gov/>

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

Perfect Illusions

www.pbs.org/perfectillusions/index.html

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

Something Fishy

www.something-fishy.org

This Web site gives detailed information on most aspects of eating disorders: defining them, preventing them, finding treatments, and paying for recovery. Useful links to related articles and stories are provided.

Voices not Bodies

www.voicesnotbodies.org

An all-volunteer organization dedicated to eating disorders awareness and prevention.

NEDA TOOLKIT for Educators

Websites to beware of

Some Web sites 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.

A recent study estimated that pro-ana and pro-mia websites outnumber pro-recovery sites at a ratio of 5 to 1, so it is likely that any web search for support sites will turn up some pro-mia 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.

Links to useful articles that warn about pro-mia and pro-ana sites

- www.womensenews.org/article.cfm/dyn/aid/1529/context/archive
- <http://www.aboutkidshealth.ca/En/News/NewsAndFeatures/Pages/Starved-for-attention-pro-anorexia-websites-glorify-eating-disorders.aspx>
- www.sirc.org/articles/totally_in_control.shtml
- www.time.com/time/health/article/0,8599,169660,00.html
- www.webmd.com/content/article/109/109381.htm
- www.firstcoastnews.com/printfullstory.aspx?storyid=27567

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Frequently Asked Questions

American Psychiatric Association
<http://www.healthyminds.org/Document-Library/Brochure-Library/Eating-Disorders.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.
http://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),
<http://ezinearticles.com/?Myths-About-Eating-Disorders&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-IV

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
<http://www.womenshealthiowa.info/docs/bodywise.pdf>

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;
<http://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. at
<http://www.teacherscollegepress.com/pdfs/FOOschoolguide.pdf>

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

Tips for communicating with parents/guardians of a student with an eating disorder

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

ECRI Institute Bulimia Resource Guide
www.bulimiaguide.org

ECRI Institute interviews with educators

NEDA TOOLKIT for Educators

Why parent-school communications may be difficult: Regulatory constraints and confidentiality issues

American School Counselor Association
<http://www.schoolcounselor.org/content.asp?contentid=240>

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

Guidance for schools on education plan for a student in treatment

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

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

<http://www.nasponline.org/publications/cq/cq345eatingdisorders.aspx>

Tips for school psychologists from: National Association of School Psychologists

www.nasponline.org/publications/cq/cq345eatingdisorders.aspx

Tips for school nurses

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

Healthy and Wise: Middle School (grades 6-8)
Coordination Health School Nurse Participation Plan

[http://www.caprockpress.com/middleschool/Middle%20School%20Nurse%20Participation%20Plan\(07-08\).pdf](http://www.caprockpress.com/middleschool/Middle%20School%20Nurse%20Participation%20Plan(07-08).pdf)

Guidelines for Parents; Guidelines for Nurses
<http://medainc.org/uploads/File/docs/4.pdf>