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Eating Disorder Curriculum: In-Service for Elementary Teachers

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Eating Disorder Curriculum:
In-Service for Elementary Teachers

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By

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Abstract

The purpose of this project is to highlight the significant need for an eating disorder curriculum and/or in-service for educators in the school system. This project includes an in-service that is tailored for elementary school teachers in the areas of eating disorder identification, warning signs, resources, lesson planning cautions, where to turn for help, and what to do when dealing with a student who is struggling. The research behind this project highlighted an extreme deficit in teacher preparedness for students with eating disorders and a self-identified lack of confidence in their ability to handle such situations. I hope this training module will be helpful to educators facing the issues of eating disorders in their classrooms.

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Eating Disorder Curriculums For Public School Educators

Introduction

A preliminary literature review was done to explore the necessity, planning and purpose of an eating disorder curriculum for educators within the public school system, enacted by the school counselor in combination with combating mental illness, its prevention, and early detection of student symptoms.

The literature review offers an excellent overview of current and previous study in the area of eating disorders in the public school system, current educational programs and curriculums that are available, definitions of the most prominent eating disorder diagnoses, and what the school counselor's role may be in implementing the curriculum with teachers and staff. The majority of this research will highlight the significant need for educator and staff training in eating disorder curriculum, signs and symptoms, current prevention programs and their roles with students. However, I hope the largest takeaway from this topic is an awareness regarding the significant lack of actual eating disorder curriculums for school staff and teachers.

The average age of an eating disorder diagnoses is 17 years old and, particularly in females, ages 15 to 24, eating disorders in the United States have been continually rising for the past 50 years (National Eating Disorders Association, 2018).

To this end, I have chosen this area of study because, as an individual who has had a diagnoses of "anorexia nervosa", and as a current educator in the university system, I have seen the extreme difficulties not only students experience while dealing with an eating disorder and diagnoses, but also the lack of information, steps, and answers that a school curriculum for school faculty and staff may provide.

Review of Literature

Eating Disorder Definitions

Because of the vast number of diagnoses and the breadth and depth in the field of eating disorders, I will focus my efforts in this review on the most common diagnoses in adolescents, according to the National Eating Disorders Association (NEDA), 2017, and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th edition, 2013: Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Other Specified Feeding or Eating Disorders (OSFED).

Anorexia Nervosa (AN) is defined as the refusal to maintain body weight at or above a minimally normal weight (American Psychiatric Association, 2017). Those who struggle with Anorexia Nervosa often have an intense fear of gaining weight, with a body weight is 15% below what their expected healthy weight is.

Anorexia Nervosa has been categorized into two subtypes: Restricting Type and Binge Eating/Purging Type.

Bulimia Nervosa (BN) is characterized by a cycle of bingeing and compensatory behaviors (self-inducing vomiting, laxative use, fasting, or excessive exercise) to prevent weight gain following food intake (American Psychiatric Association, 2017). The disorder has been categorized into two subtypes: Purging Type and Non-purging Type.

Other Specified Feeding and Eating Disorders (OSFED) includes many attributes of multiple eating disorders; however, some and not all behaviors are not evident for a full diagnoses. The following two examples are given to highlight characteristics of eating behaviors that do not meet the criteria for a full diagnoses and would, therefore, meet the criteria for an OSDFED diagnoses:

1. All of the criteria for Anorexia Nervosa (AN) are met except that, despite significant weight loss, the patient's current weight is in the normal range.
2. All of the criteria for Bulimia Nervosa (BN) are met except that the binge eating and inappropriate compensatory mechanisms occur less than twice a week or for less than three months.

Eating Disorders in Schools

When approaching the subject of eating disorders in schools with teachers and staff, the school counselor should approach specific areas for educating, preventing, identifying, and intervening with colleagues and school personnel. The following topics were highlighted in a school-wide prevention program in Australia, and the areas of attention are paraphrased and cited from the "Educating Professionals: Early Identification and Response" plan document provided by the "National Eating Disorders Collaboration (NEDC)" of Australia. The school counselor will approach school administration and staff readying the school district by adapting:

School Policy

• Include a statement in the school mission about providing a body image friendly environment
• Ensure no weighing, measuring or anthropometric assessment of students in any context, specifically in physical education
• Display public material/posters including a wide diversity of body shapes, sizes and ethnicity

Staff Development

• Train staff in the early identification and referral of students with body image concerns and eating disorders
• Provide teachers with training and information about eating disorders and their impact on cognitive function and emotional well-being

• Train teachers to use body-friendly language in their interactions with students

School-wide Curriculum

• Have the school counselor and health educator, physical educator, and appropriate staff provide age-appropriate body image lessons

- Elementary: positive body image and self-esteem and healthy eating patterns
- Middle School: peer interventions and media literacy
- High School: identification of body image/eating problems, mental health literacy

Engaging Parents

• Make available up-to-date printed information about how parents can support their child to develop a positive body image and a healthy relationship with food

• Provide parents with links to information about body image and eating disorders on the school website

• Present talks and information nights for parents about eating disorder issues (NEDC, 2016).

Adjusting Existing Programs

Several programs that are aimed at adolescents in the public school system will be listed, below, but each of them could very much be modified and tailored to meet the needs of a staff curriculum and/or program, through the direction and assessment of the school counselor:

- Entering Adulthood: Looking at Body Image and Eating Disorders (NEDA, 2018)
- “Everybody’s Different” Program,
- “Body Image Resiliency” Model (Snapp, Hensley-Choate, & Ryu, 2012),

One issue with using two of the listed programs, “Everybody’s Different” and the “Body Image Resiliency” model have been tied to detrimental effects on students because of information-sharing practices. However, with the adaptations for school teachers and staff, the

curriculum or prevention program could be utilized to prevent language-specific triggers and aid educators in identifying eating disordered-behavior (Snapp, Hensley-Choate, & Ryu, 2012).

The School Counselor's Role

In the research performed by Bardick et al., professional school counselors should be the point-person for the formation of an eating disorder curriculum, its programs and staff training(s), in order to reduce or prohibit the symptoms of and behaviors of eating disorders amongst the student population. School counselors can provide significant direction in tailoring lesson plan production with classroom teachers and utilizing individual discussions, entire group trainings, and meetings with other school personnel.

Research has pointed-out that in developing a school-wide prevention program or curriculum, staff must be extremely careful in approaching the topic of eating disorders, primarily because society tends to glamorize disordered-eating behaviors and eating disorders, as a whole (Bardick et al., 2004). Many of the programs within the current research field have also shown the tendency to "teach" disordered eating habits to students who are younger and particularly vulnerable to peer pressure (Russell, S. & Ryder, S. 2001).

Participation and engagement are key in prevention and intervention programs and curriculum versus a more traditional approach, for example, a simple education session or lesson planning. Teachers and staff may be more likely to connect the material with personal experience when actively participating, which may help in the process of retaining specific information and, hopefully, will result in behavior and/or attitude change with and toward students (Stice and Shaw 2004).

According to Carney & Scott (2012), many school staff members, including school counselors, feel that there is a significant disconnect between relevant information on eating

disorders, identifying risk factors, or ways of aiding students who struggle. School counselors and school staff have an incredible opportunity to shed light on eating disorders and their triggering events within the school system. Research, too, suggests that school counselors and their educator counterparts who acknowledge and identify eating disorders and use early intervention methods may be better suited to those students who are more susceptible to developing an eating disorder; and that those methods and early detection are a vital resource in promoting early eating disorder recovery among their students (Carney & Scott, 2012).

Current research states that school counselors who are effective will utilize a variety of ways to reach school teachers and staff, and that they play a critical role in assessing the school's need for assessment of prevention programs, interventions with students who are diagnosed, referring students to the appropriate professionals, when necessary, and supporting school staff and parents through the recovery process (Carney and Scott, 2012).

Curriculum Development for Educators and Staff

To begin, school counselors are not trained to be a therapist for students in the depths of an eating disorder. However, counselors must take the initiative to incorporate a curriculum plan and be the point-person for trainings and programs for teachers and staff. Programs that contain body image recognition components and changing attitudes are essential for school-wide preventative measures. School counselors can help educators to become able to detect body dissatisfaction and disordered eating issues earlier in the illness, so that intervention components of a curriculum and/or program with staff can be put in motion (Carney & Scott, 2012).

As part of the school counselor's role in addressing body image concerns in school, it is necessary to make sure school staff are receiving the appropriate information regarding the ever-changing issues of a students eating behavior. Like many school counselors, teachers may not

realize the level of impact that they have on the students they are around on a daily basis. Because children spend so much of their time at school, school staff are critical in the implementation and continuation of any progress in program implementation following training. Teachers need to be aware of their attitudes and behaviors concerning shape, weight and food and must be cognizant of the messages they are sending while with or around their students ("Eating Disorders: Best Practices in Prevention and Intervention", 2006). Specific measures that “Manitoba Health” recommends for counselors to introduce to their fellow teachers include(s):

- Placing an emphasis on building self-esteem in and outside of the classroom, critical thinking, and solid communication skills with teachers
- Modeling positive behavior around weight, shape and food
- Recognizing that difficulty with specific school experiences (weight classes in sport) may pose challenges to vulnerable students
- Recommend that administration place a “no-tolerance” policy with regard to sexual harassment and bullying, especially on the basis of weight and shape.

Rhyne & Winkler and Hubbard (1994) suggested conducting staff and teacher in-service trainings on topics relevant to body image and eating disorders to reinforce professional development amongst school personnel.

School counselors can also provide programming to educators and school staff in order to help develop strategies, which reduce the risk of eating disorder symptoms among adolescents (Stout & Frame, 2004).

Russell & Ryder (2001), in their research, have indicated that all inclusion of teachers and other school staff in prevention programs is crucial, and that various studies have shown that

educators (health, physical education) have shown eating disordered behavior, including over-exercising, and attitudes in the school setting.

It is important to create a curriculum or program for educators and staff regarding healthy body image, food attitudes, and recognizing the signs of negative attitudes students may have towards their bodies and food (Stout & Frame, 2004). Any program or curriculum established and implemented by the school counselor should give educators insight on how to create an affirming and supportive classroom – one that models health attitudes about food and body image – and stresses the importance of an educators reflection on their own attitudes and negative experiences with regard to body shape or weight. This emphasis may aid an educator to empathize with the students in their classroom. may help teachers empathize with their students (Piran, 2004).

Conclusion

In conclusion, the research that I have conducted has garnered very little in substance regarding curriculum(s) and/or programs specifically made for educators and school staff. This has made my research regarding current or existing programs and their effects on students important, in order to tailor their use for school staff. I have also learned more about the triggering effects of programs on students – strategies that should be avoided.

I fully believe that using a tailored program for educators, guided and/or implemented by the school counselor, will help students cope with and prevent eating disorders and eating disordered-behavior. Educators who, in my opinion, are equipped with the knowledge of the various eating disorder diagnoses, behaviors, triggers, tips, and different resources for students and their families would, potentially, save countless students from the horrors of an eating disorder.

School counselors and educators need to know and understand how to spot, prevent, and intervene in the school setting. Educators and counselors alike must make sure that the needs of all students are being met and taken care of. Much further study is needed in terms of developing curriculum and programs that are tailored for specific teachers, how they are going to be successful or not, and whether potential programs, like what I propose, would be accepted by schools nation-wide.

Project Overview

Eating Disorder Curriculum: Elementary Teachers

Prepared by: Troy Roness

Session: 1 **In-Service Length**: Three, two hour sessions (6 hours)

ASCA Standards Addressed:

Academic Development: A1.1-5, A:A2.1-4, A:A3.2-5, Standard B A:B1.3, 4, 5, 6, 7, A:B2.1, 2, 3, 5, 6,

Personal/Social Development: PS:A1.1, 3, 4, 5, 7, 9, 11, PS:A2.1, 2, 3, 4, 6, 7, PS:B1.3, 4, 5, 12, PS:C1.4-114

TIME	TOPIC	ACTIVITY/EXERCISE	ASSESSMENT/MATERIALS
9 AM	WELCOME & INTRODUCTIONS	• Group Introductions • Ice Breaker(s) (Introductions, Names, Professional Location & title, one good thing about week) • In-Service Overview (Agenda)	• Name Tags • Paper • Group Numbers
9:10 AM	"Instant Activity" Eating Disorder Facts and Myths	• Facts & Myths Card Association - Educators will work with their groups to correctly place information cards with either "myths" or "facts" columns on velcro fabric	• Initial Pre-Assessment (ED Knowledge using fact/myth activity cards) • Velcro Fabric Fact/Myth Poster to sort cards
9:30 AM	"What Are Eating Disorders?" Powerpoint, Word Cloud Polling, Discussion	• Group Polling of Pre Assessment Answers & Predictions • Facts & Myths Explanation & Ellaborate on the "Why" • Resources • What does an eating disorder look like in the classroom?	• Word Cloud Access • Review of Instant Activity • Power Point (ED resources, information, what it looks like)
10:20 AM	BREAK	BREAK	BREAK
10:30 AM	"Cautionary Tales"	• Eating Disorder Information • Lesson Sharing Do's & Don'ts:	• Appendix A has the in-service outline and myths and facts • Appendix B has do's and don'ts and links to vital eating disorder information for teachers
11:00 AM	Wrap-Up Module 1 & Lunch	• Provide resource page with websites used in lesson 1	• Resource Page

Eating Disorder Curriculum: Elementary Teachers

Prepared by: Troy Roness

Session: 2 **In-Service Length:** Three, two hour sessions (6 hours)

ASCA Standards Addressed:

Academic Development: A1.1-5, A:A2.1-4, A:A3.2-5, Standard B A:B1.3, 4, 5, 6, 7, A:B2.1, 2, 3, 5, 6,

Personal/Social Development: PS:A1.1, 3, 4, 5, 7, 9, 11, PS:A2.1, 2, 3, 4, 6, 7, PS:B1.3, 4, 5, 12, PS:C1.4-114

TIME	TOPIC	ACTIVITY/EXERCISE	ASSESSMENT/MATERIALS
12 PM	GROUP NORMS, DISCUSSION	• Safe Space Group Discussion: Discuss past experiences with students, fears about addressing eating disorders in the classroom, and other relevant information or history.	• Group norm creation about safe space expectations •
12:30 PM	EATING DISORDER DOCUMENTARY	• "Someday Melissa" Documentary	• Documentary DVD • SmartBoard projection
1:30 PM	DOCUMENTARY DE-BRIEF	• Thoughts/Questions Reactions	• Group Discussion • Appendix C will include resources to documentaries and personal stories
1:50 PM	PERSONAL STORY 2	• "Dr. Phil Show" Troy Roness, creator of this curriculum	• Book written by Troy Roness, "Unbroken: Journaled Reflections of Recovery"
2:00 PM	BREAK	BREAK	BREAK

Eating Disorder Curriculum: Elementary Teachers

Prepared by: Troy Roness

Session: 3 **In-Service Length**: Three, two hour sessions (6 hours)

ASCA Standards Addressed:

Academic Development: A1.1-5, A:A2.1-4, A:A3.2-5, Standard B A:B1.3, 4, 5, 6, 7, A:B2.1, 2, 3, 5, 6,

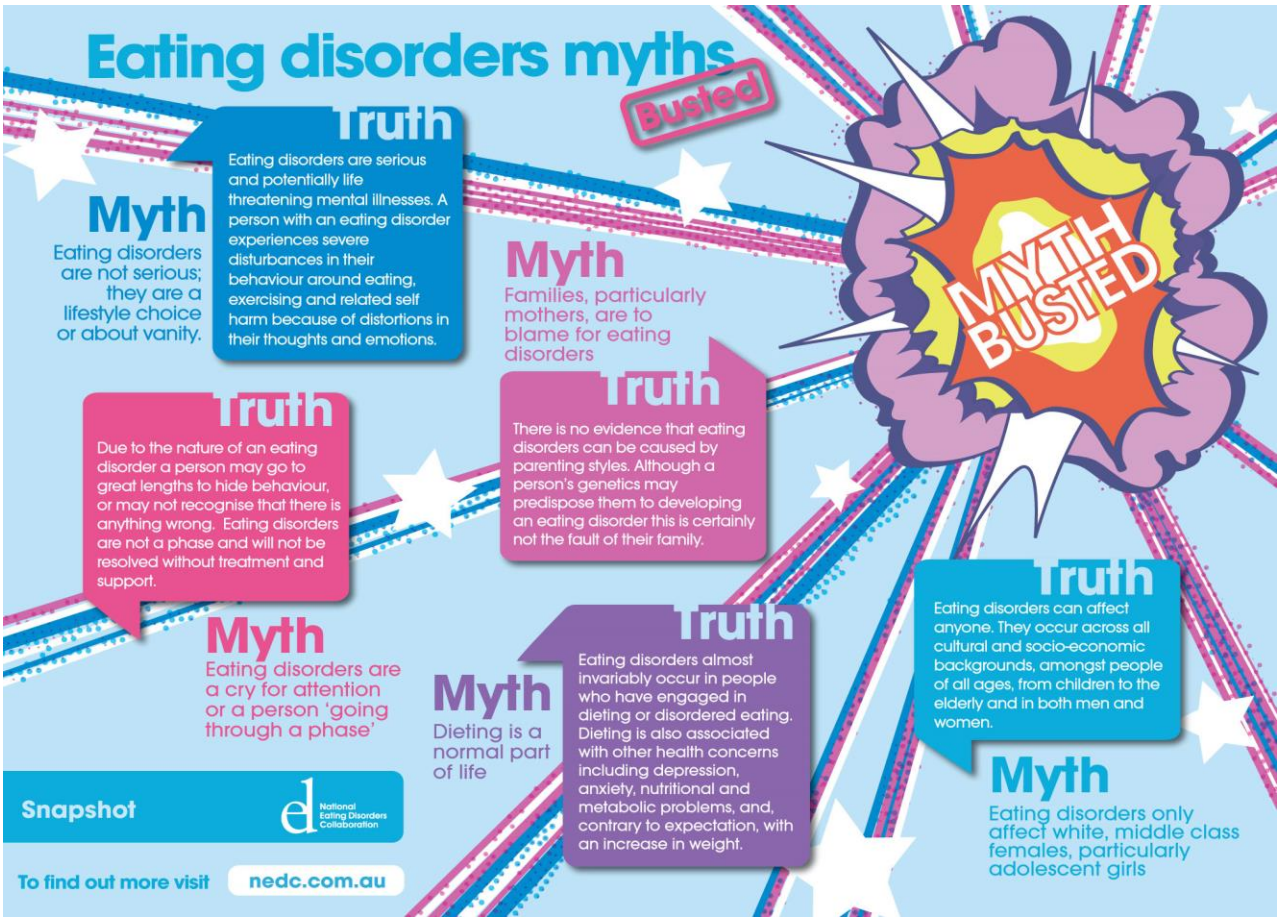
Personal/Social Development: PS:A1.1, 3, 4, 5, 7, 9, 11, PS:A2.1, 2, 3, 4, 6, 7, PS:B1.3, 4, 5, 12, PS:C1.4-114

TIME	TOPIC	ACTIVITY/EXERCISE	ASSESSMENT/MATERIALS
2:15 PM	GROUP NORMS FORMATION	• Group formation • Norm explanation / Safe space	• Power point
2:25 PM	Eating Disorder Scenarios	• Working in groups, two scenarios of a student with an eating disorder in the school system	• Scenario Cards • Group Discussion
3:10 PM	Scenario Debrief & Share	• What to do, • How to do it, • When to do it, • How to do it, • Whom to work with?	• Group Answer Explanation
3:40 PM	Post Test & Course Evaluation	• Post-test on myths, facts, eating disorder information • Resource sharing.	• Post-Test • Course Evaluation • Information/Resource sheet • Appendix D will include the case study cards and course evaluation
4:15 PM	Wrap-Up	• Conclusion	• Conclusion

Appendix A. Participant Resources Handout & Myth/Fact Cards

Participant Resources
Welcome!

	Session Outline	Website Resources	Notes
Session 1:	*Welcome, Instant Activity, Facts/Myths & The Many Faces of Eating Disorders*	www.nationaleatingdisorders.org https://www.eatingrecoverycenter.com/families/portal/resource-center/eating-disorder-glossary-of-terms https://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml	
Session 2:	*The Powerful Story of Two Faces: "Someday Melissa" & Troy Roness' Story*	http://www.somedaymelissa.org/ https://www.youtube.com/watch?v=bx2RJvOkBts https://www.amazon.com/Troy-Roness/e/B078MY9G2D?ref=dbs_p_pbk_r00_abau_000000	
Session 3:	*Scenarios: Putting Knowledge into Practice*	www.nationaleatingdisorders.org https://www.eatingrecoverycenter.com/families/portal/resource-center/eating-disorder-glossary-of-terms https://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml	



Myth: ***You can tell if someone has an eating disorder simply by looking at them***
Fact: Individuals with eating disorders come in all shapes and sizes. Many times, the media and other public discussions about eating disorders focus solely on individuals with a diagnosis of anorexia who are severely emaciated. In reality, many individuals with anorexia may not ever appear so drastically underweight. Furthermore, many individuals with severe disorders including bulimia, binge eating, and OSFED can be underweight, normal weight, overweight or obese and often fluctuate in weight. Even athletes who appear to be incredibly fit might be struggling with an eating disorder. The bottom line is that you cannot define someone's health by how much they weigh and you cannot determine whether they have an eating disorder just by looking at them.

Myth: *Eating Disorders are caused by Photoshopped images in the media*
Fact: Many people are exposed to the media and altered images on a daily basis but only a small percentage of them actually develop eating disorders. Eating Disorders are serious illnesses that have biological, genetic and psychological underpinnings. Sociocultural messages about weight and beauty (including photoshopped images) can certainly impact a person's body image and stimulate pressures to look a certain way, but they cannot cause an eating disorder.

Myth: *Men don't get eating disorders*
Fact: At least 1 out of every 10 people with an eating disorder is male. In fact, within certain diagnostic categories like Binge Eating Disorder, men represent as many as 40% of those

affected. In a recently released report from the American Academy of Pediatrics, boys and men were cited as one of the groups seeing the fastest rise in eating disorders over the past 10 years along with 8-12 year olds and ethnic minorities. It's equally important to screen for eating disorders among females and males.

Myth: *Only people of high socioeconomic status get eating disorders*
Fact: People in all socioeconomic levels have eating disorders. The disorders have been identified across all socioeconomic groups, age groups, both sexes, and in many countries in Europe, Asia, Africa, and North and South America. (source: NEDA)

Myth: *Eating Disorders are a lifestyle choice; someone can choose to stop having an eating disorder.*
Fact: Eating disorders are serious illnesses with mental and physical consequences that often involve a great deal of suffering. Someone can make the choice to pursue recovery, but the act of recovery itself is a lot of hard work and involves more than simply deciding to not act on symptoms. In most cases, the eating disorder has become a person's primary way of coping with intense emotions and difficult life events. In order to heal from the eating disorder, a person needs appropriate treatment and support regarding medical monitoring, nutritional rehabilitation as well as learning and practicing healthier ways to manage stress.

Myth: *Purging is an effective way to lose weight*
Fact: Purging does not result in ridding the body of ingested food. At least half of what is consumed during a binge typically remains in the body even after self-induced vomiting. It's important to know that laxatives do not prevent the body from absorbing calories either because they impact the large intestine and most calories are absorbed in the small intestine. Laxatives may provide an illusion of weight loss because they stimulate a temporary loss of fluids from the body which can lead to dehydration. Purging does not cause weight loss, nor does it prevent weight gain. In fact, over time, the binge/purge cycle can actually contribute to increased or accelerated weight gain as it affects the body's metabolic rate. For these reasons, many people with bulimia are average or above-average weight.

Myth: *Eating Disorders are a result of over controlling parents and dysfunctional families*
Fact: In the past, parents were often blamed for an individual's eating disorder but new research and conventional wisdom have helped to dispel this myth. Families affected by eating disorders are very diverse. We now know that between 50-80% of a person's risk for developing an eating disorder is due to genetic factors. We also know that parents and families can play an integral role in helping a loved one recover. For this reason family therapy is a primary therapeutic modality used for adolescents and is also strongly encouraged for adults.

Myth: *Anorexia is the only life threatening eating disorder*
Fact: Eating Disorders in general have the highest mortality rate of any mental illness. Recent research has expanded our knowledge about the risks associated with each of the specific diagnoses.
The research (Crow, S., et al. 2009) showed mortality rates for bulimia and EDNOS that were similar to, and higher, than those for anorexia. Bulimia had a 3.9% mortality rate and EDNOS had a 5.2% mortality rate while anorexia had a 4.0% rate. These numbers were based on a study

of individuals seeking outpatient services. Without treatment, it's suspected that as many as 20% individuals will die as a result of their illness. Even for patients whose eating disorders don't prove fatal, there are often severe medical complications associated with starvation and purging, including bone disease, cardiac complications, gastrointestinal distress, and infertility.

Myth: *Recovery from eating disorders is rare*
Fact: Recovery, though challenging, is absolutely possible. Recovery can take months or years, but with treatment, many people do eventually recover and go on to live a life free from their eating disorder.

Appendix B. Eating Disorder Information & Do's and Don'ts of Sharing

ANOREXIA NERVOSA

Characterized primarily by self-starvation and excessive weight loss.

Symptoms include:
- Inadequate food intake leading to significant weight loss.
- Intense fear of weight gain, obsession with size, and persistent behavior to prevent weight gain.
- Disturbance in self-image.
- Denial of the seriousness of low body weight.

Health consequences include:
- Heart failure, osteoporosis, muscle loss, and growth of lanugo (hair all over the body).

BULIMIA NERVOSA

Characterized primarily by a cycle of binge eating followed by compensatory behaviors, such as self-induced vomiting, in an attempt to counteract the effects of binge eating.

Symptoms include:
- Regular intake of large amounts of food accompanied by a sense of loss of control over eating behavior.
- Use of inappropriate compensatory behaviors such as vomiting, laxative or diuretic abuse, fasting, and/or obsessive or compulsive exercise.
- Extreme concern with body weight and shape.

Health consequences include:
- Heart failure, gastric rupture, tooth decay, rupture of the esophagus, and pancreatitis.

BINGE EATING DISORDER

Characterized primarily by recurrent binge eating without the regular use of compensatory measures.

Symptoms include:
- Frequent episodes of eating large quantities of food in short periods of time.
- Feeling out of control during the binge.
- Experiencing shame, guilt, and distress after the binge.

Health consequences include:
- Heart disease, type II diabetes mellitus, gastric rupture, and gallbladder disease.

OTHER SPECIFIED FEEDING OR EATING DISORDER (OSFED)

A feeding or eating disorder that causes significant distress or impairment but does not meet the criteria for another feeding or eating disorder.

Examples of OSFED include:
- Atypical anorexia nervosa (weight is not below normal)
- Bulimia nervosa (with less frequent behaviors)
- Binge eating disorder (with less frequent occurrences)
- Purging disorder (purging without binge eating)
- Night eating syndrome (excessive nighttime food consumption)

Eating disorders come in many different forms and OSFED is equally as severe as the other eating disorder diagnoses.

WHAT DOES TREATMENT INVOLVE?

Eating disorders require the care of a trained professional with expertise in the treatment of eating disorders.
- The most effective treatment involves some form of psychotherapy or counseling coupled with careful attention to medical and nutritional needs.
- Treatment should be tailored to the patient's individual issues.
- Treatment must address the eating disorder symptoms as well as psychological, biological, nutritional, interpersonal, and cultural forces that contribute to or maintain the disorder.
- Early diagnosis and intervention significantly enhance recovery.

WHO'S AT RISK?

- Anyone can develop an eating disorder regardless of gender, age, race, ethnicity, culture, size, socioeconomic status, or sexual orientation.
- Eating disorders also impact the family, friends, and loved ones of someone struggling.

HELP ENCOURAGE HEALTHY BEHAVIORS

- Learn all you can about eating disorders and the dangers of dieting.
  - Awareness encourages healthy attitudes about food and body shape.
- Model good behaviors in your attitudes about food, body image, and weight-related issues.
  - Avoid negative comments about your or anyone else's body.
  - Eat balanced meals, get plenty of rest, and exercise for enjoyment.
  - Demonstrate openness in talking to a counselor and your loved ones about mental health.
- Talk to others about natural differences in body types and the body's powerful attempts to maintain these naturally varied shapes and sizes.
- Connect with organizations like the National Eating Disorders Association by volunteering your time or giving a tax-deductible donation.

Some Helpful Eating Disorder Resources

Academy for Eating Disorders - AED (www.aedweb.org)

Binge Eating Disorder Association - BEDA (www.bedaonline.com)

Families Empowered and Supporting Treatment of Eating Disorders - F.E.A.S.T. (www.familiesempowered.org)

Maudsley Parents (www.maudsleyparents.org)

National Association of Anorexia Nervosa & Associated Disorders - ANAD (www.anad.org)

Association for Size Diversity and health - ASDAH (www.sizediversityandhealth.org)

Eating Disorder Hope (www.eatingdisorderhope.com)

Gurze Books (www.gurzebooks.com)

Tips for communicating with parents/guardians

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

Before you approach the family

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

When you start the conversation with the family or guardians

- Show empathy and support. Listen to what the family member says without interrupting, judging, or making pronouncements or promises.
- Balance supportive and empathetic concern with a serious tone.
- Aim to establish and maintain a positive, open, and supportive relationship with parents/families. Be mindful that the parents may feel guilty, blamed, or in some way responsible for the eating issue or disorder.
- Begin by telling the parents/families that you are concerned about the student AND offer specific, factual observations about the student's behavior to illustrate your concerns. Don't interpret what the behavior could mean — just state the facts of the observed behaviors.
- Don't make or suggest a diagnosis.
- Stay calm and stay focused on the goal of the conversation: to help the family help your student with his/her problems and improve academic performance and quality of life.
- Encourage the family to access support, information, or treatment from external agencies, and have resources available to which to refer them.
- Don't persist with a conversation that isn't going well. This may damage future communication.

Here are some examples:

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

To end a conversation that isn't going well

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

The school and student of concern

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

Appendix C. Documentary Resources & Personal Story Links

"Someday Melissa"
http://www.somedaymelissa.org/

The "Dr. Phil Show" – Body Obsessed Boys
https://www.youtube.com/watch?v=bx2RJv0kBts

Troy Roness, author of "Unbroken: Journaled Reflections of Recovery"
https://www.amazon.com/Troy-Roness/e/B078MY9G2D?ref=dbs_p_pbk_r00_abau_000000

Appendix D. Scenario Cards In-Service Evaluation

Scenario 1

A ballet performance is being held in a school gymnasium during the last hour in school. Numerous local reporters are present and guests include parents, teachers, local representatives and more. The main dancer, Amelia, has completed rehearsals and is anticipating her debut performance. She has been on a severely restricted diet and just before the performance, collapses and needs to be carried off stage by staff.

Amelia has a history of an eating disorder. During her early teens, Amelia spent some time in a residential program for eating disorders, followed up by sessions with a psychologist to monitor her progress and learn strategies to attain her healthy weight goal. She has many close friends in the dance program and is also a ballet teachers-aide, with many of her peers in the audience.

Some important facts are:

- The event was witnessed by the entire audience (students, parents, teachers, etc.)
- The performance was scheduled for multiple showings (games, plays, etc.) throughout the year
- Many defamatory comments start to appear on Amelia's Facebook and twitter sites
- Many students are distraught and don't know what to do
- You and your teacher's have know about Amelia for some time, but have not intervened
- There is little to no information available about Amelia's mental health and well-being outside of what her parents have told her sixth grade classroom teacher

Scenario 2

Malik gets nicknamed "string bean" by the principal because he had a growth spurt and grew much taller and slimmer than his peers. Malik was already feeling self-conscious about his height and knows the principal was just kidding around but now he does everything he can to avoid seeing him in the hallways.

Dean came back to school a size smaller and friends are requesting her "weight loss secrets". They don't know she was in treatment for an eating disorder over the summer and has developed heart problems and other health complications as a result.

Some important facts are:

- The principal believes eating disorders are "just a phase"
- Social media has inflamed this situation both inside and outside of school
- Other students begin glamorizing or constantly talking about ways to begin eating less and getting away with it. Some are even saying it can "help them do better in sports"
- Again, teachers are only aware of information that has been given to them by her parents

Eating Disorder In-Service Evaluation Form

Topic Title: _____
Participant's Name (optional): _____

EVALUATION TOOL

We appreciate your help in evaluating this in-service. Please indicate your rating of the modules and presentation in the categories below by circling the appropriate number, using a scale of 1 (low) through 5 (high). Please fill out both sides of this form:

OBJECTIVES

This in-service met the stated objectives of:

1. Identifying eating disorder facts and myths, and related information pertinent — 1 2 3 4 5
2. Making personal connections to participants through shared experiences with ED's — 1 2 3 4 5
3. Identifying the need for awareness and education through teacher involvement in ED behaviors — 1 2 3 4 5

SPEAKER(S) (generally)

1. Knowledgeable in content areas — 1 2 3 4 5
2. Content consistent with objectives — 1 2 3 4 5
3. Clarified content in response to questions — 1 2 3 4 5

CONTENT

1. Appropriate for intended audience — 1 2 3 4 5
2. Consistent with stated objectives — 1 2 3 4 5

TEACHING METHODS

1. Visual aids, handouts, and oral presentations clarified content — 1 2 3 4 5
2. Teaching methods were appropriate for subject matter — 1 2 3 4 5

Presenter	Knowledgeable in Content area	Content consistent with objectives	Clarified content in response to questions
Mr./Ms.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

COMMENTS:

RELEVANCY

1. Information could be applied to practice	1 2 3 4 5
2. Information could contribute to achieving personal, professional goals	1 2 3 4 5

FACILITY

1. Was adequate and appropriate for session	1 2 3 4 5
2. Was comfortable and provided adequate space	1 2 3 4 5

This program enhanced my professional expertise.	____ Substantially	____ Somewhat	____ Not at all
I would recommend this program to others.	____ Yes	____ No	____ Not sure

COMMENTS/PROGRAM IMPROVEMENTS:

I would like (name of APA-approved sponsor) to provide seminars or workshops on the following topics:

IN GENERAL

Do you prefer: ____half-day in-service ____full-day in-service ___multi-day in-service

Do you prefer in-services in: ____hotels ____hospital ____no preference

How much time do you need to respond to an in-service announcement?
____less than 1 month ____4 to 6 weeks ____more than 6 weeks

How did you learn about this in-service?
____brochure ____supervisor ____colleague ____other

How far did you travel to attend this in-service?
____0-25 miles ____25-50 miles ____50-100 miles ____over 100 miles

If you would like to comment in person, please feel free to call the Office of _____ at [phone number].

THANK YOU

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