Dying to be thin: what school-based behavioral health professionals need to know about eating disorders

Wendy L. Price, Psy.D., NCSP

February 28, 2024

SAMHSA
Substance Abuse and Mental Health Services Administration

Mountain Plains (HHS Region 8)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Disclaimer and Funding Statement

This presentation was prepared for the Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) under a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA). All material appearing in this presentation, except that taken directly from copyrighted sources, is in the public domain and may be reproduced or copied without permission from SAMHSA or the authors. Citation of the source is appreciated. Do not reproduce or distribute this presentation for a fee without specific, written authorization from the Mountain Plains MHTTC. For more information on obtaining copies of this presentation please email casey.morton@und.edu.

At the time of this presentation, Miriam Delphin-Rittmon served as SAMHSA Assistant Secretary. The opinions expressed herein are the views of Wendy Price and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

The work of the Mountain Plains MHTTC is supported by grant H79SM081792 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).

Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.

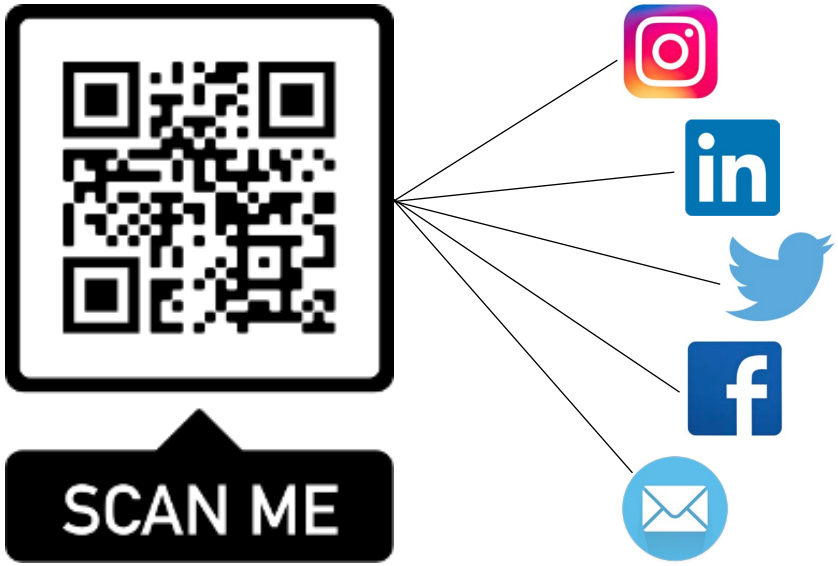
The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Healing-centered and trauma-responsive
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Stay Connected

Scan this QR code to follow us on Instagram, LinkedIn, Twitter, and Facebook. You can also join our e-mail newsletter!



DYING TO BE THIN: WHAT SCHOOL-BASED BEHAVIORAL HEALTH PROFESSIONALS NEED TO KNOW ABOUT EATING DISORDERS

Presented to MP-MHTTC on February 28th, 2024
by **Wendy L. Price, Psy.D., NCSP**
Whitman-Hanson Regional High School
NASP Past President 2020-2021
Adjunct Faculty UMASS Boston

THIS TOPIC IS TOUGH…

- **Please take care of yourself during this presentation**
- This is a troubling topic
- It can also be a TRIGGERING topic
- Please feel free to excuse yourself at any time to take a break

LEARNING OBJECTIVES

Learning Objectives

At the end of this session, participants will be able to explain:

1. the difference between Anorexia, Bulimia, and Binge Eating Disorder, including warning signs
2. each element of the Biopsychosocial model that is used to understand EDs
3. how to communicate with students and their families about a suspected ED
4. a variety of school accommodations to consider when a student returns from ED treatment

THINGS TO CONSIDER

- What did you learn about food as you grew up?
- How is your relationship with food?
- How has your view of your body changed over time?
- Is the image you have of your body POSITIVE OR NEGATIVE?

BODY IMAGE CONTINUUM

BODY IMAGE

- Visual Component: How you "see" yourself when you look in the mirror

  With poor body image, you might have a distorted, unrealistic perception of your shape. You might perceive parts of your body as larger or smaller than they actually are

- Mental Component: What you believe and think about your appearance.

  With poor body image, you might believe yourself to be ugly or unattractive because you are convinced that only certain types of features are attractive. Or you believe that what you like is irrelevant, and all that matters are the characteristics of which others approve.

BODY IMAGE

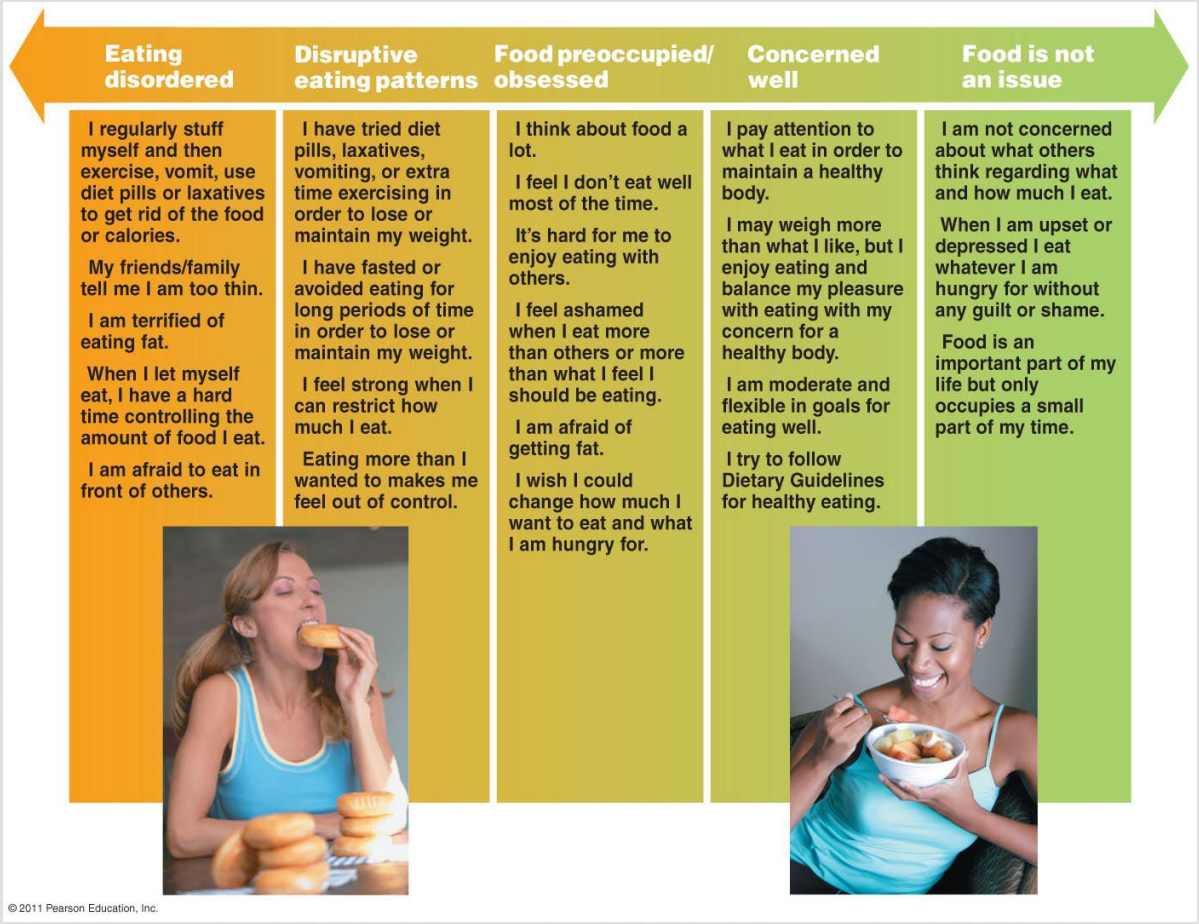
- Emotional Component: How you feel about your body, including your height, weight, and shape.

  With poor body image, the combination of your distorted perceptions and your self-rejecting ideals leads you to feel ashamed, self-conscious, and anxious about your body.

- Kinesthetic Component: How you feel in your body, not just about your body.

  With poor body image, you might not feel comfortable in your body. You do not express yourself with and through your body, for example in sports or dance.

FOOD AND EATING CONTINUUM



EATING DISORDER DEFINITIONS

The three Eating Disorders most people are familiar with:

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder

ANOREXIA NERVOSA (AN)

Anorexia Nervosa (AN) is a serious, potentially life-threatening eating disorder characterized by self-starvation and excessive weight loss.

Individuals with anorexia nervosa are unable or unwilling to maintain a body weight that is normal or expected for their age & height.

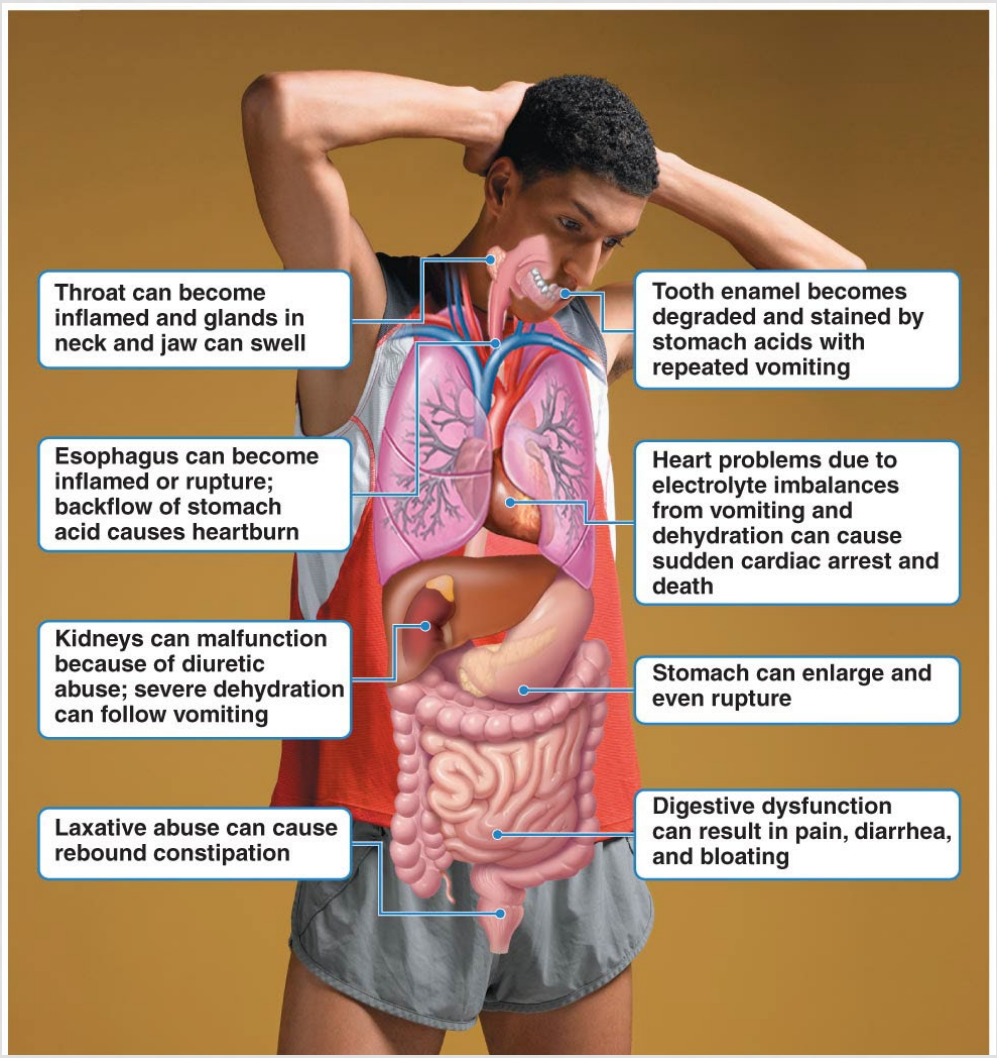
ANOREXIA AND THE BODY

BULIMIA NERVOSA (BUL)

Bulimia Nervosa (BUL) is a serious, life-threatening eating disorder characterized by a cycle of bingeing and compensatory behaviors such as self-induced vomiting

It is designed to undo or compensate for the effects of binge eating.

BULIMIA NERVOSA AND THE BODY



BINGE EATING DISORDER (BED)

Binge Eating Disorder (BED) is characterized by recurrent binge eating without the use of inappropriate compensatory weight control behaviors.

MEDICAL COMPLICATIONS ASSOCIATED WITH BINGE EATING DISORDER (BED)

Binge Eating Disorder often results in many of the same health risks associated with clinical obesity

HOWEVER **Binge Eating and Obesity/Overeating are NOT the same**

MEDICAL COMPLICATIONS ASSOCIATED WITH BINGE EATING DISORDER (BED)

Some of the potential health consequences of binge eating disorder include:

- Weight gain
- High blood pressure
- High cholesterol levels
- Heart disease as a result of elevated triglyceride levels
- Type II diabetes mellitus
- Gallbladder disease

EATING DISORDER DEFINITIONS: DISORDERED EATING

- The majority of those with eating disorders that do not fall within the criteria for Anorexia Nervosa, Bulimia Nervosa or Binge Eating Disorder are classified as EDNOS. There are numerous variants of **disordered eating** that nevertheless are eating disorders and require treatment.

DISORDERED EATING CONTINUED

Behaviors that don't meet DSM V criteria for an eating disorder and may still cause medical symptoms/complications/emotional distress:

Orthorexia

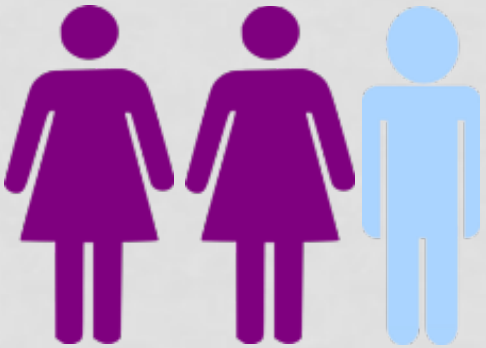
- Intense focus on eating "pure" or "healthy" foods only
- Usually driven by quality of foods vs. quantity of foods
- Organic, natural, farm fresh etc
- Less focus on weight/shape but it still can be a factor
- Individuals may chose to go without food instead of eating foods viewed as "unhealthy" or "processed"

DISORDERED EATING CONTINUED

Diabulimia

- Most often occurs in young women with Type 1 diabetes.
- Diabetes management requires attention to meal plan and dietary intake, often in the form of counting carbohydrates and sugar at every meal/snack.
- Manipulation of insulin to maintain and/or lose weight.
- Most common medical complications include:
  - Diabetic Ketoacidosis (build up of ketones in the urine)
  - Loss of eyesight
  - Decrease or loss of circulation in extremities

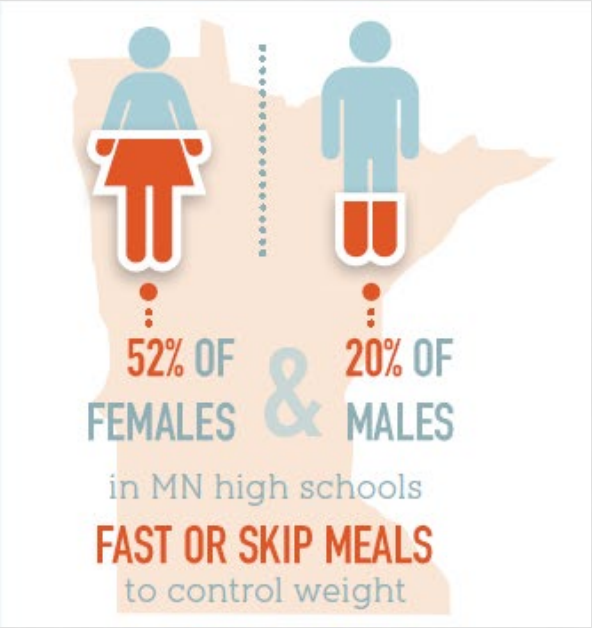
PREVALENCE OF EATING DISORDERS



Twenty million women and ten million men suffer from a clinically significant eating disorder at some point in their lives. (NEDA)

4 out of 10 Americans either suffered from an eating disorder or have known someone who has suffered from an eating disorder (NEDA).

EATING DISORDER STATISTICS



Emily Project, 2015

EATING DISORDER STATISTICS

Emily Project, 2015

MEN HAVE EDS TOO!

MEN AND ED

- The rate of eating disorders among college men ranges from 4-10%.
- The prevalence of binge eating is the same among men and women.
- Male body image concerns have dramatically increased over the past three decades from 15% to 43% of men being dissatisfied with their bodies.
- Men are often more concerned with a combination of issues related to weight, body shape and strength.
- Men are less likely to seek help.

(NEDA, 2012)

STATISTICS MALE

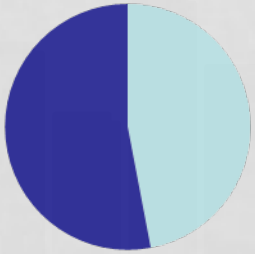
5-15% of individuals diagnosed with anorexia or bulimia are male (NIMH)

1/3 of teenage boys use unhealthy weight control behaviors such as skipping meals and fasting (Neumark-Sztainer)

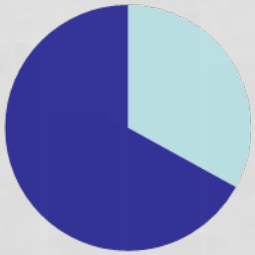
Up to 40% of binge eaters are male (Harvard University)

PROGNOSIS

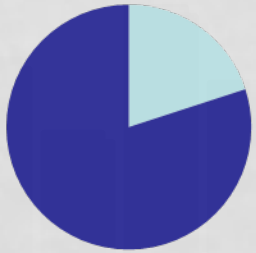
ANOREXIA



47%
Recovered

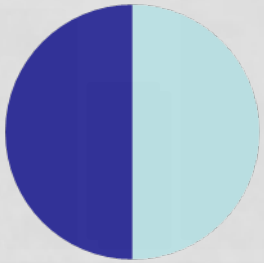


33%
Improve

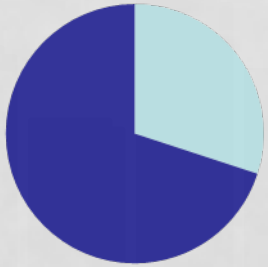


20%
Remain ill

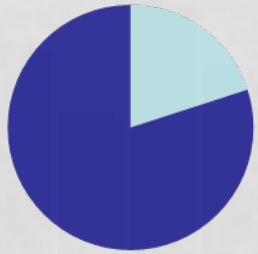
BULIMIA



50%
Recovered

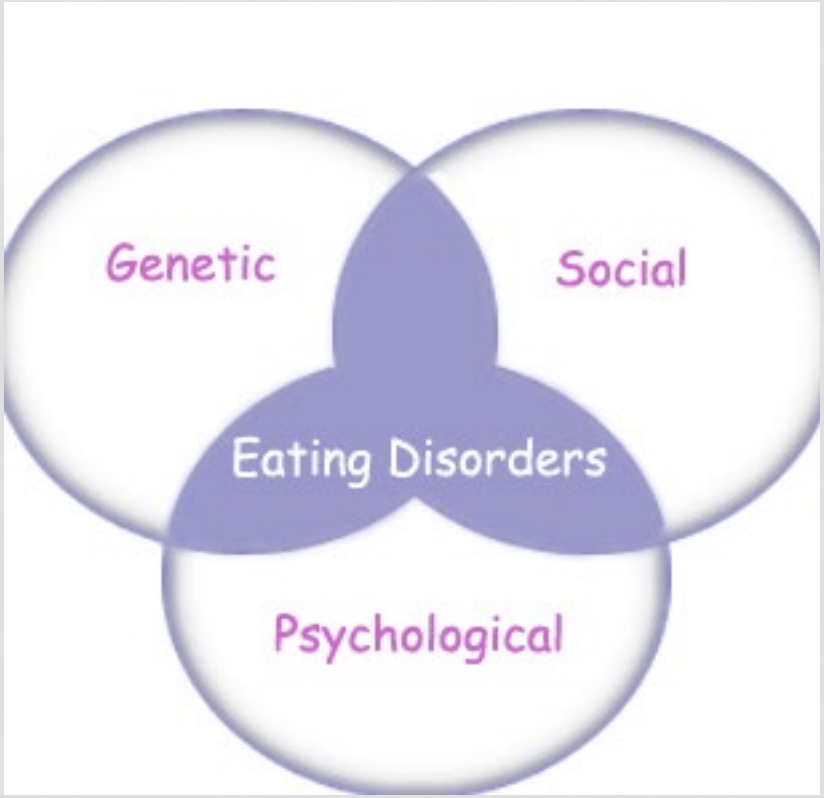


30%
Improve



20%
Remain ill

WHERE DO EATING DISORDERS COME FROM?



BIOPSYCHOSOCIAL MODEL

Biological Factors

- Genetics (family history)
- Instrumental delivery
- Twins
- Low birth weight
- Temperament
- Early or late puberty

Psychological Factors

- Cognitive distortions around body shape and size
- Emotional regulation problems
- Anxiety, OCD, Depression, Addictive D/O

Social Factors

- Values around thinness and beauty
- Dieting culture
- Family values around beauty, eating and exercise
- Peer related stressors
- History of abuse

SOCIAL FACTORS

- Social Factors (media and cultural pressures)
  - Cultural pressures that glorify "thinness" and place value on obtaining the "perfect body"
  - Narrow definitions of beauty that include only women and men of specific body weights and shapes
  - Cultural norms that value people on the basis of physical appearance and not inner qualities and strengths
  - People pursing professions or activities that emphasize thinness are more susceptible
    - ie. Modeling, dancing, gymnastics, wresting, long distance running

MEDIA AND ITS INFLUENCE

- Media messages help to create the context within which people learn to place value on the size and shape of their body.
  - Advertising and celebrity spot lights scream "thin is in," defining what is beautiful and good.
  - Media has high power over the development of self-esteem.
- According to a recent survey of adolescent girls, the media is their main source of information about women's health issues
- Researchers estimate that 60% of Caucasian middle school girls read at least one fashion magazine regularly

MEDIA AND ITS INFLUENCE

- Another study of mass media magazines discovered that women's magazines had 10.5 times more advertisements and articles promoting weight loss than men's magazines did

- A study of one teen adolescent magazine over the course of 20 years found that in articles about fitness or exercise plans, 74% cited "to become more attractive" as a reason to start exercising and 51% noted the need to lose weight or burn calories

MEDIA AND ITS INFLUENCE

- A study of 4,294 network television commercials revealed that 1 out of every 3.8 commercials send some sort of "attractiveness message," telling viewers what is or is not attractive.
- These researchers estimate that the average adolescent sees over 5,260 "attractiveness messages" per year.

AD FOR PRETZEL CRISPS

MODELING

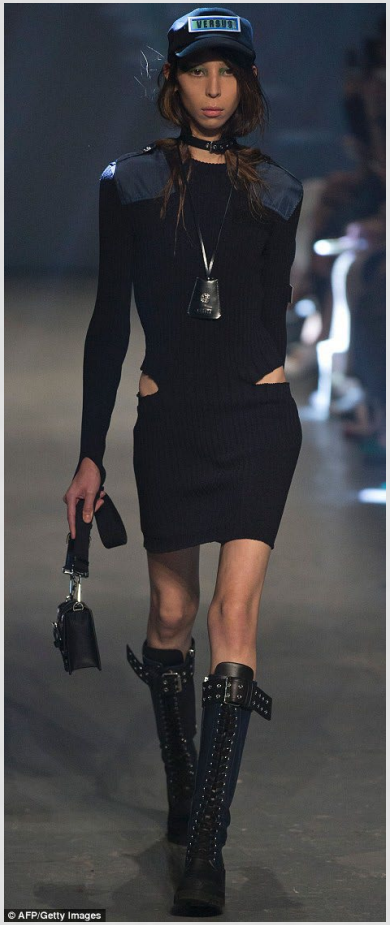
DIOR: NEIMAN MARCUS FALL/WINTER 2016

VERA WANG

ZAC POSEN

LONDON FASHION WEEK

LONDON FASHION WEEK: VERSACE



SOCIAL MEDIA INFLUENCER: EUGENIA COONEY

PHOTO SHOP

This version of Fillipa Hamilton presents a thin but more real-looking woman.

http://bit.ly/29JhHa

CELEBRITIES WHO HAVE STRUGGLED WITH EATING DISORDERS

1. Demi Lovato
2. Lady Gaga
3. Caleb Followill
4. Alanis Morissette
5. Princess Diana
6. Russel Brand
7. Ella Mai
8. Ireland Baldwin
9. Whitney Cummings
10. Zayn Malik
11. Lily Collins
12. Hilary Duff
13. Nicole Scherzinger
14. Elton John
15. Bianca Belair

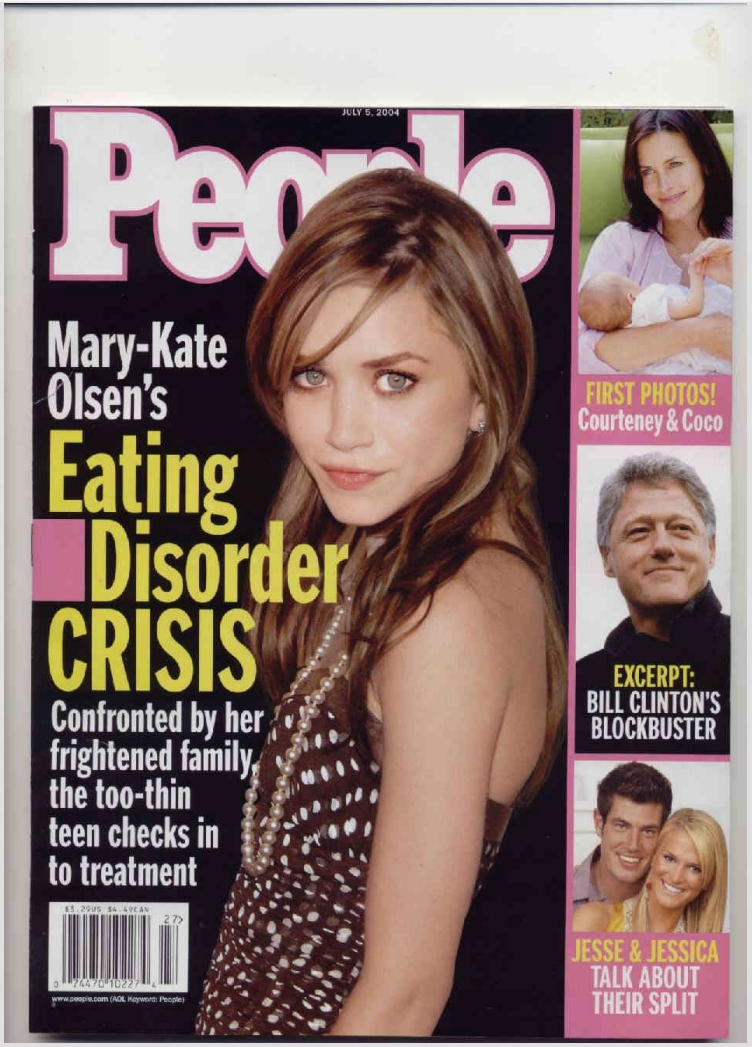
CELEBRITIES: NICOLE RITCHIE

CELEBRITIES: KAREN CARPENTER

CELEBRITIES: TRACEY GOLD

CELEBRITIES IN THE NEWS

CELEBRITIES IN THE NEWS



WHAT TO LOOK FOR: RED FLAGS

Emotional

-Change in Mental Status

-Irritability

-Difficulty Concentrating and/or Processing Information

-Apathy

-Withdrawal

-Express heightened body image concerns

Physical

-Sudden weight loss, gain, or fluctuation in short time

-Feeling faint, cold, tired, or fatigued

Behavioral

-Diets or has increasingly chaotic food intake

-Excessive exercise (long periods of time, can't miss a day)

-Frequent trips to bathroom

-Wears baggy clothing

-Avoids cafeteria / social setting involving food

ATHLETES AND EATING DISORDERS

Prevalence of eating disorders in elite athletes is higher than in the general population, particularly in these categories:

- **Endurance** (e.g. long-distance running, swimming)
- **Weight** (e.g. wrestling, diving, boxing)
- **Aesthetic** (e.g. gymnastics, figure skatin cheerleading)
- **Anti-gravity** (e.g. ski-jumping, horse racing)

(Sundgot-Borgen J, Torstveit MK. *Clin J Sport Med.* 2004 Jan; 14(1):25-32.)

PART FOUR

How are EDs treated?

- Overview of treatment
  - Strategies
  - Tx for Anorexia
  - Tx for Bulimia
  - What works?

HOW ARE EATING DISORDERS TREATED?

- Ideally, treatment addresses physical and psychological aspects of an eating disorder.
- People with eating disorders often do not recognize or admit that they are ill
  - May strongly resist treatment
  - Treatment may be long term

TREATMENT STRATEGIES:

- EDs are very complex and because of this several health practitioners may be involved:
  - General practitioners, Physicians, Dieticians, Psychologists, Psychiatrists, Counselors, etc.

TREATMENT STRATEGIES:

- Depending on the severity, an eating disorder is usually treated in an:
  - **Outpatient setting:** individual, family, and group therapy
  - **Inpatient/Hospital setting:** for more extreme cases

ED TREATMENT

- Medical Treatment
  - **Medications** can be used for:
    - Treatment of depression/anxiety that co-exists with the eating disorder
    - Restoration of hormonal balance and bone density
    - Encourages weight gain by inducing hunger
    - Normalization of the thinking process
  - Drugs may be used with other forms of therapy
    - Antidepressants (SSRI's such as Zoloft)
      - May suppress the binge-purge cycle
      - May stabilize weight recovery

ED TREATMENT

Individual Therapy

- Allows a trusting relationship to be formed
- Difficult issues are addressed, such as:
  - Anxiety, depression, low self-esteem, low self-confidence, difficulties with interpersonal relationships, and body image problems

ED TREATMENT

- Several different approaches can be used, such as:
  - Cognitive Behavioral Therapy (CBT)
    - Focuses on personal thought processes
  - Interpersonal Therapy
    - Addresses relationship difficulties with others
  - Rational Emotive Therapy
    - Focuses on unhealthy or untrue beliefs

ED TREATMENT

- **Nutritional Counseling**
  - Dieticians or nutritionists are involved
  - Teaches what a well-balanced diet looks like
    - This is essential for recovery
    - Useful if they lost track of what "normal eating" is.
  - Helps to identify their fears about food and the physical consequences of not eating well.

ED TREATMENT

- **Group Therapy**
  - Provides a supportive network
    - Members have similar issues
  - Can address many issues, including:
    - Alternative coping strategies
    - Exploration of underlying issues
    - Ways to change behaviors
    - Long-term goals

ED TREATMENT

- **Family Therapy**
  - Involves parents, siblings, partner.
  - Family learns ways to cope with ED issues
  - Family learns healthy ways to deal with ED
  - Educates family members about eating disorders
  - Can be useful for recovery to address conflict, tension, communication problems, or difficulty expressing feelings within the family

TREATING ANOREXIA

- Three main phases:
  - **Restoring** weight lost
  - **Treating** psychological issues, such as:
    - Distortion of body image, low self-esteem, and interpersonal conflicts.
  - Achieving long-term **remission and rehabilitation.**
- Early diagnosis and treatment increases the treatment success rate.

BULIMIA TREATMENT

- Primary Goal
  - Cut down or eliminate binging and purging
  - Patients establish patterns of regular eating
- Treatment Involves:
  - Psychological support
    - Focuses on improvement of attitudes related to E.D.
    - Encourages healthy but not excessive exercise
    - Deals with mood or anxiety disorders
  - Nutritional Counseling
    - Teaches the nutritional value of food
    - Dietician is used to help in meal planning strategies
  - Medication management
    - Antidepressants (SSRI's) are effective to treat patients who also have depression, anxiety, or who do not respond to therapy alone
    - May help prevent relapse

TREATMENT THAT WORKS: FBT

Family Based Treatment (FBT) Overview

- Began as a program looking to support and empower families with children in treatment for eating disorders.
- Developed during the late 1970s at the Institute of Psychiatry at the Maudsley Hospital in London, England.
- Introduced to United States in mid 1990s by Dr. Daniel le Grange and Dr. James Lock.
- Commonly referred to as "Maudsley Method" or "Maudsley Therapy."

TREATMENT THAT WORKS: FBT

FBT Characteristics/Key Facts

- **Removes blame:** not about how you got here, focus on what will you do to move forward and treat ED.
- **Parents are in charge of treatment**: what providers you use, meal plan choices/changes, behavioral interventions, etc.
- **Increase level of supervision** around food and opportunities to use behaviors recommended: at home, at school, etc.
- Maudsley treatment can still be **effective even if** adolescent is expressing **ambivalence** towards recovery.
- **Viewed weights:** exposure therapy, decreases emotional response over time, used in family therapy sessions.

PART FIVE

The school psychologists role

Before formal diagnosis/treatment:

- Approaching a student with a suspected ED
- Tips for communicating with parents

After student returns to school from treatment:

- School's involvement in treatment
- Education plans for students returning from treatment

Prevention:

- Things to consider (e.g. health classes)
- Body Image Groups

Resources

APPROACHING A STUDENT WITH A SUSPECTED ED

When to approach:

- Significant weight loss in a short amount of time
- New or drastic change in dietary habits
- Intense focus on body, weight, shape or size
- Sudden change to wearing baggy clothing
- Avoidance of cafeteria or eating in a social setting
- Change in behavior ie. academic performance, social isolation, lethargy, not participating in things preciously enjoyed.
- Rigid eating habits (what, when and where)
- Family voicing concern

APPROACHING A STUDENT WITH A SUSPECTED ED

How to Present Concern:

- With confidence..don't walk on egg shells
- Non-Judgmentally
- Non-Reactively
- Without blame
- Discuss with genuine concern for health and well being
- Focus on describing own experience of what you observe
- Stick to the facts
- Educate regarding what you know regarding behaviors
- Avoid arguing…it's your experience

QUESTIONS YOU MIGHT ASK

- Are you constantly thinking about food?
- Is it difficult to concentrate on the daily tasks of studying or work because of food and weight thoughts?
- Do you worry about what your last meal is doing to your body?
- Do you experience guilt or shame around eating?
- Is it difficult for you to eat in public?
- Do you count calories every time you eat or drink?
- When others tell you that you are too thin, do you still feel fat?
- If you see yourself as thin, do you still obsess about your stomach, hips, thighs, or buttocks being too big?
- Do you weigh yourself several times daily?
- Does the number on your scale determine your mood and outlook, for the day?

QUESTIONS YOU MIGHT ASK

- When you are momentarily satisfied with your weight, do you resolve to be even more vigilant?
- Do you punish yourself with more exercise or restrictions if you don’t like the number on the scale?
- Do your exercise more than 45 minutes, 5 times each week with the goal of burning calories?
- Will you exercise to lose weight even if you are ill or injured?
- Do you label foods as “good” and “bad”?
- If you eat a “bad” or forbidden food do you berate yourself and compensate by skipping your next meal, purging, or adding extra exercise?
- Do you vomit after eating and/or use laxatives or diuretics to keep your weight down?
- Do you severely limit your food intake?

TIPS FOR COMMUNICATING WITH PARENTS

- Begin by telling parents/families that you are concerned about the student AND offer observations about behaviors that illustrate your concerns—just the facts!
- Don't make a diagnosis
- Do encourage the family to access support, information, or treatment from specialized facilities.

HOW TO SUPPORT RECOVERY IN THE SCHOOL CONTEXT

Areas to address:

- 1. Safety
- 2. Meals at school
- 3. Activity level at school
- 4. Supporting social interactions
- 5. How to interact with the youth
- 6. Academic expectations and support

(http://keltymentalhealth.ca/sites/default/files/eating_disorders_in_the_school_context.pdf)

RECOVERY AT SCHOOL: SAFETY

- Establish consistent and clear criteria for student's attendance in school
- Establish open lines of communication with parents/team re: changing treatment needs, emerging concerns
- Special considerations: suicidality and/or self-harm; bulimia risks
- Issues of privacy and confidentiality

(http://keltymentalhealth.ca/sites/default/files/eating_disorders_in_the_school_context.pdf)

RECOVERY AT SCHOOL: MEAL SUPPORT

- Clarify which family member or staff member will be providing meal support and when;
- Provide a quiet private space for this to occur versus parent meeting child outside school
- Supportive check-ins made available

- YOUR JOB IS NOT TO MAKE THE STUDENT EAT! IT IS TO VALIDATE AND SHOW SUPPORT!

(http://keltymentalhealth.ca/sites/default/files/eating_disorders_in_the_school_context.pdf)

RECOVERY AT SCHOOL: ACTIVITY LEVEL

- Youth will have a prescribed activity level
- Work with parent/team around how this will change with time
- Discussion around how to manage witnessed extra exercise (e.g. student does extra laps in the hallway going to class)

(http://keltymentalhealth.ca/sites/default/files/eating_disorders_in_the_school_context.pdf)

RECOVERY AT SCHOOL: SOCIAL CONNECTEDNESS

- Transitioning to school looking different after a possible lengthy absence and after having isolated from peers
- Peers do not know how to support
- Peers may not eat/may restrict
- May need support in connecting with a "point person"
- Adaptations around prior interests (i.e., friends connected to sports)
- Emphasis on normalizing

(http://keltymentalhealth.ca/sites/default/files/eating_disorders_in_the_school_context.pdf)

RECOVERY AT SCHOOL: INTERACTING WITH THE STUDENT

- No comments around appearance, weight, shape, or food
- No shaming/blaming either the student or family for the ED: **Behaviors represent attempts at coping; everyone is doing the best they can**
- Sensitivity – the student may yet be experiencing effects of starvation, depression, anxiety
- Try to anticipate triggers (societal, curriculum)
- Check-ins with a safe person

(http://keltymentalhealth.ca/sites/default/files/eating_disorders_in_the_school_context.pdf)

RECOVERY AT SCHOOL: ACADEMIC EXPECTATIONS AND SUPPORT

- Graduated return to school
- Limited and focused coursework
- Adaptations around exams and assignments
- Release/Excused Time for appointments and therapy;
- May need re-hospitalization

(http://keltymentalhealth.ca/sites/default/files/eating_disorders_in_the_school_context.pdf)

Areas to Discuss	Things to consider/discuss				
Safety	Establish consistent and clear criteria for student's attendance in school	Establish open lines of communication with parents/team re: changing treatment needs, emerging concerns	Special considerations: suicidality and/or self-harm; bulimia risks	Issues of privacy and confidentiality	Signed therapist release form
Meals/Snacks at school	Clarify which family member or staff member will be providing meal support and when	Provide a quiet private space for this to occur versus parent meeting child outside school	Supportive check-ins made available	Release time from class for scheduled snacks and meals	Communication about what the snack/meal is
Activity level at school	Youth will have a prescribed activity level	Work with parent/team around how this will change with time	Discussion around how to manage witnessed extra exercise (e.g. student does extra laps in the hallway going to class)	P.E. class-instead of activity, student is assigned a paper	Stairs, route to classes
Supporting social interactions	Transitioning to school looking different after a possible lengthy absence and after having isolated from peers	Peers do not know how to support Peers may not eat/may restrict	May need support in connecting with a "point person"	Adaptations around prior interests (i.e., friends connected to sports)	Emphasis on normalizing
How to interact with the youth	No comments around appearance, weight, shape, or food	No shaming/blaming either the student or family for the ED: Behaviors represent attempts at coping; everyone is doing the best they can	Sensitivity – the student may yet be experiencing effects of starvation, depression, anxiety	Try to anticipate triggers (societal, curriculum)	Check-ins with a safe person
Academic expectations and support	Graduated return to school	Limited and focused coursework	Adaptations around exams and assignments	Release/Excused Time for appointments and therapy;	May need re-hospitalization

http://keltymentalhealth.ca/sites/default/files/eating_disorders_in_the_school_context.pdf

RETURN TO SCHOOL PLAN: THINGS TO CONSIDER

Areas to Discuss	Things to consider/discuss
Safety	
Meals/Snacks at school	
Activity level at school	
Supporting social interactions	
How to interact with the youth	
Academic expectations and support	

Adapted from http://keltymentalhealth.ca/sites/default/files/eating_disorders_in_the_school_context.pdf

EXCELLENT RESOURCE: NEDA

- https://www.nationaleatingdisorders.org/sites/default/files/Toolkits/EducatorToolkit.pdf
- https://www.nationaleatingdisorders.org/sites/default/files/Toolkits/ParentToolkit.pdf
- https://www.nationaleatingdisorders.org/sites/default/files/Toolkits/CoachandTrainerToolkit.pdf

FAMILIES EMPOWERED AND SUPPORTING TREATMENT OF EATING DISORDERS (F.E.A.S.T.)

Connect with other parents, follow us on social media and learn how to better support your loved one

- Around the Dinner Table online forum: http://aroundthedinnertable.org
- Closed Facebook group: https://www.facebook.com/groups/ATDTCarerSupportGroup/
- F.E.A.S.T. Facebook page: https://www.facebook.com/FEASTeatingdisorders/
- Pinterest: https://www.pinterest.com/feast0356/
- Twitter: https://twitter.com/FEAST_ED

THANK YOU!

- Questions? Comments?