



National
Eating Disorders
Collaboration

Eating Disorders in Schools: Prevention, Early Identification and Response

Second Edition



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Eating Disorders in Schools: Prevention, Early Identification and Response



Second Edition



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INTRODUCTION

General information about Eating Disorders

Eating disorders are serious mental illnesses that are associated with significant physical complications. Eating disorders not only involve considerable psychological impairment and distress, but they are also associated with major wide-ranging and serious medical complications, which can affect every major organ in the body. Eating disorders are frequently associated with other psychological disorders such as depression, anxiety, substance abuse and personality disorders. A person with an eating disorder may experience long term impairment to social and functional roles and the impact may include psychiatric and behavioural effects, medical complications, social isolation, disability and an increased risk of death. The mortality rate for people with eating disorders is the highest of all psychiatric illnesses, and over 12 times higher than that for people without eating disorders. While estimates of the incidence of eating disorders vary between countries and studies, there is agreement that eating disorders, disordered eating and body image issues have increased worldwide over the last 30 years.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) lists all the Feeding and Eating disorders that are diagnosed by psychologists. Of these there are four specified eating disorders; Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder and Other Specified Feeding and Eating Disorder (OSFED). Fact sheets about disordered eating, body image and each of the eating disorders are available at: www.nedc.com.au/fact-sheets.

Eating disorders in Australia

Eating disorders have a significant and underestimated impact on Australian society.

- Eating disorders are estimated to affect approximately 9% of the population
- Anorexia Nervosa and Bulimia Nervosa affect between 2% and 4% of the population
- Approximately 15% of Australian women experience an eating disorders during their lifetime
- About one in 20 Australians has an eating disorder and this rate is increasing

Research conducted with young people in 2010 on behalf of the NEDC indicated that:

- Most young people know at least one other young person who they think might have a eating disorder

- 84.3% of respondents said they know one person who may have an eating disorder
- 62.8% said they know up to five people who may have an eating disorder

These figures do not take into account the frequent under-reporting and under-treatment of eating disorders.

Eating disorders and mortality rates

All eating disorders come with severe medical complications and increased mortality rates.

- The risk of premature death for women with Anorexia Nervosa is 6-12 times higher than the general population
- The risk of premature death for women with Anorexia Nervosa is 'much higher' than other psychiatric disorders
- For females with Anorexia Nervosa and diabetes, there is a 15.7-fold increase in mortality rates when compared with females with diabetes alone

Eating disorders and suicide

The risk of premature death in people with eating disorders relates in part to medical complications associated with the disorder; however suicide has also been identified as a major cause of death in people with eating disorders. In fact, 1 in 5 individuals with Anorexia Nervosa who die prematurely have committed suicide. Research on suicide in people with Bulimia Nervosa and OSFED is less available; however rates of suicide in Bulimia Nervosa and OSFED are higher than in the general population.

Eating disorders and adolescents

Eating disorders can occur in people of all ages; however adolescents and young people are increasingly at risk.

- Eating disorders represent the third most common chronic illness for young females
- Eating disorders represent the second leading cause of mental disorder disability for young females
- Adolescents with diabetes may have a 2.4-fold higher risk of developing an eating disorder
- Adolescent girls who diet at a severe level are 18 times more likely to develop an eating disorder within 6 months - this risk increases to a 1 in 5 chance over 12 months

Studies of body dissatisfaction in adolescence have found varying but consistently high levels:

- 70% of adolescent girls have body dissatisfaction
- Body dissatisfaction is identified in the Mission Australia Youth Survey (2013) as one of the top ranked issues of concern for young people

Eating disorders and obesity

Obesity and eating disorders may be viewed as occurring at the same end of a spectrum with healthy beliefs, attitudes, and behaviours at one end, and problematic beliefs, attitudes, and behaviours at the other end. Among the variety of weight- and eating-related problems, there are some separate and some overlapping protective, risk and maintaining factors.

- Obesity in adolescents has increased by 75% in the past three decades
- The development of co-morbid obesity with eating disorder behaviours has increased at a faster rate than that of either obesity or eating disorders alone
- Adolescent girls with obesity have high rates of disordered eating
- One in five people with obesity also present with disordered eating, mainly in the form of binge eating, but also evident in episodes of strict dieting and purging

The long term health consequences of eating disorders

The consequences of an eating disorder are not limited to acute episodes of illness but may also be long term. Only 46% of patients fully recover from Anorexia Nervosa while 20% remain chronically ill for the long term. Binge Eating Disorder is more common than Anorexia Nervosa or Bulimia Nervosa and is at least as chronic and stable as these disorders.

The financial consequences of eating disorders

The cost of care for a person with an eating disorder is substantial. Eating disorders are the 12th leading cause of mental health hospitalisation costs within Australia. The expense of treatment of an episode of Anorexia Nervosa has been reported to come second only to the cost of cardiac artery bypass surgery in the private hospital sector in Australia. Bulimia Nervosa and Anorexia Nervosa are the 8th and 10th leading causes, respectively, of burden of disease and injury in females aged 15 to 24 in Australia. This is measured by disability-adjusted life years.

Eating disorders are serious mental illnesses.

Eating disorders are estimated to affect approximately 9% of the population.



Eating disorders are frequently associated with other psychological and physical disorders such as depression, anxiety disorders, substance abuse and personality disorders.

If you suspect you or someone else you know has an eating disorder it is important to seek help immediately. Visit our website to find help in your area.

Eating disorders can occur in people of any age; however evidence shows that young people are more at risk.

The risk of premature death for women with Anorexia Nervosa is 6-12 times higher than the general population.

Risk factors for eating disorders can include dieting, negative body image, genetic vulnerability and psychological traits.

The total social and economic cost of eating disorders in Australia in 2012 was estimated at \$69.7 billion.

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Snapshot

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Eating disorders in Australia

Common misconceptions about eating disorders

To read more about the following misconceptions, where they come from and why they are not true visit: www.nedc.com.au/myths-about-eating-disorders.

Myth: Eating disorders are a lifestyle choice, not a serious illness

There is a generally low level of mental health literacy in the community which affects community responses to eating disorders and leads to underestimation of the seriousness of these illnesses. The truth is that eating disorders are serious mental illnesses; they are not a lifestyle choice or a diet gone 'too far' and people can't 'just stop' their eating disorder. People with eating disorders require treatment for both mental and physical health addressing the underlying psychological issues and the impact on physical health.

Myth: Eating disorders are a cry for attention or a person 'going through a phase'

Research conducted with young people in 2010 on behalf of the NEDC indicated that 51.3% of 12-17 year olds agreed that a person with an eating disorder should 'snap out of it, there are more important things in life to worry about'. However, an eating disorder is not a phase and it will not be resolved without treatment and support. People with eating disorders are not seeking attention. In fact, due to the nature of these illnesses a person with an eating disorder may go to great lengths to hide, disguise or deny their behaviour, or may not recognise that there is anything wrong.

Myth: Eating disorders are about vanity

The association between body dissatisfaction and eating disorders can lead people to mistakenly believe that eating disorders are about vanity. In truth, no one can be blamed for developing an eating disorder. There are genetic and personality vulnerabilities as well as social and environmental triggers. Eating disorders are not just about food or weight, vanity, will power or control. They are fuelled by distress, anxiety, stress and cultural pressures. Eating disorders are serious and potentially life threatening mental illnesses, in which a person experiences severe disturbances in eating and exercise behaviours because of distortions in thoughts and emotions, especially those relating to body image or feelings of self-worth.

Myth: Families, particularly parents, are to blame for eating disorders

A common misconception is that family members can cause eating disorders through their interactions with a person at risk. While there are environmental triggers which may impact on the development and maintenance of an eating disorder, there is no evidence that a particular parenting style causes eating disorders. Clinical guidelines for best practice in managing eating disorders encourage the inclusion of families at each stage of treatment for adolescents, from the initial assessment to providing recovery support. The impact of an eating disorder is not only felt by the individual, but often by that person's entire family or circle of support.

Myth: Dieting is a normal part of life

According to research conducted with young people in 2010 on behalf of the NEDC, young people recognise that eating disorders are potentially harmful; however they also accept body 'obsession' and dieting as normal parts of growing up. While moderate changes in diet and exercise have been shown to be safe, significant mental and physical consequences may occur with extreme or unhealthy dieting practices. Eating disorders almost invariably occur in people who have engaged in dieting or disordered eating. Dieting is also associated with other health concerns including depression, anxiety, nutritional and metabolic problems, and contrary to expectation, with an increase in weight.

Myth: Eating disorders only affect white, middle class females, particularly adolescent girls

Adolescent females are one group with a high risk of eating disorders. However, eating disorders are not limited to any one group of people and the prevalence of eating disorders in specific high risk groups should not distract the community from the importance of recognising eating disorders in other populations. People from all age groups and cultural or socioeconomic backgrounds experience eating disorders. Eating disorders affect both men and women.

Eating disorders myths

Truth

Eating disorders are serious and potentially life threatening mental illnesses. A person with an eating disorder experiences severe disturbances in their behaviour around eating, exercising and related self-harm because of distortions in their thoughts and emotions.

Myth

Eating disorders are not serious; they are a lifestyle choice or about vanity.

Busted

Myth

Families, particularly parents, are to blame for eating disorders

Truth

There is no evidence that a particular parenting style causes eating disorders. Although a person's genetics may predispose them to developing an eating disorder this is certainly not the fault of their family.

Myth

Eating disorders are a cry for attention or a person 'going through a phase'

Truth

Due to the nature of an eating disorder a person may go to great lengths to hide behaviour, or may not recognise that there is anything wrong. Eating disorders are not a phase and will not be resolved without treatment and support.

Myth

Dieting is a normal part of life

Truth

Eating disorders almost invariably occur in people who have engaged in dieting or disordered eating. Dieting is also associated with other health concerns including depression, anxiety, nutritional and metabolic problems, and, contrary to expectation, with an increase in weight.

Myth

Eating disorders only affect white, middle class females, particularly adolescent girls

Truth

Eating disorders can affect anyone. They occur across all cultural and socio-economic backgrounds, amongst people of all ages, from children to the elderly and in both men and women.

Snapshot



To find out more visit

nedc.com.au/myths



HOW TO PROMOTE HEALTH AND WELLBEING WITHIN YOUR SCHOOL

The Melbourne Declaration on Educational Goals for Young Australians sets out nationwide objectives for Australian schools that all Australian Education Ministers have agreed to. According to this declaration 'schools play a vital role in promoting the intellectual, physical, social, emotional, moral, spiritual and aesthetic development and wellbeing of young Australians'. One of the Educational Goals outlined in the declaration is that 'all young Australians ... have a sense of self-worth, self-awareness and personal identity that enables them to manage their emotional, mental, spiritual and physical wellbeing'. Hence, mental and physical health education is critical within all Australian schools and teachers play an important role in promoting health and wellbeing within the school environment. Education about body image, disordered eating, the risks of dieting and eating disorders is an important aspect of all school health and wellbeing programs. Having the correct information and education about eating disorders can help prevent an eating disorder from developing, ease the suffering of a person in the early stages of an eating disorder, and reduce the stigma and misconceptions that surround eating disorders. Efforts to promote positive body image and healthy lifestyle choices should be integrated into every school's teaching program as a general practice with the aim of proactively helping to prevent eating disorders from arising rather than simply responding reactively to existing issues.

People who are identified and treated early in the course of an eating disorder have a significantly better chance of recovery when compared with those who have been living with an eating disorder longer; this is particularly relevant for young people. However, the median duration of treatment delay is extraordinarily long (10 years for those meeting criteria for bulimia nervosa and 15 years for those meeting criteria for anorexia nervosa). This suggests that people with eating disorders experience significant barriers to seeking help. One principal barrier has been identified as the stigma that exists around eating disorders. To reduce the stigma associated with eating disorders, there needs to be a shift in the attitudes and knowledge of the general community about eating disorders. In Australia there has been a growth in mental health awareness and active efforts by government, media and the wider community to reduce stigma and improve mental health literacy. Teachers are in a powerful position to help with these efforts. For early intervention to occur, young people and those in their circle of support, need to be able to recognise and respond to signs of distress, reduced functioning, and other indicators that present early in the development of an eating disorder. A person who has, or is at risk of developing an eating disorder can often feel high levels of shame, ambivalence and denial. As a result of this, that person may need guidance and support from those around them to take the first steps towards preventing or treating an eating disorder. It is therefore very important that schools work to deepen their level of understanding about eating disorders.

Make time for eating disorder prevention programs

Evaluation of the national mental health initiative ‘MindMatters’ has found that mental health education is competing for time within a crowded curriculum. Time for planning, lesson development and the provision of appropriate support after learning are all required to ensure that eating disorders prevention messages are safe and effective. The Australian Curriculum for Health and Physical Education (HPE) developed by the Australian Curriculum, Assessment and Reporting Authority (ACARA) is available at <http://www.australiancurriculum.edu.au/health-and-physical-education/rationale>. This document will help schools to approach the teaching of topics relating to health and wellbeing in a nationally consistent way. However, education about body image, disordered eating, the risks of dieting and eating disorders should not be limited to HPE programs. These topics can also be integrated into welfare programs conducted during roll call/form class/home room, peer support, pastoral care sessions or school camps. There are also opportunities for teachers to incorporate relevant information into other subject areas. For example, discussions about diet and exercise can be included in studies of Biology, body image awareness and media literacy education can be integrated into studies of English and The Arts, and opportunities to explore the influence of different societies and cultures on body image and healthy lifestyles may arise during History and Geography lessons.

Use a whole school approach

Each school should set out a clear policy with regards to what strategies they will employ for the prevention, early intervention and management of eating disorders. This policy should include initial response procedures such as the appropriate channels for teachers to report mental health disclosures through, who is responsible for informing the parents if this is appropriate, how to maintain adequate levels of confidentiality, how to deal with rumours, how to encourage the student and their family to seek help and a professional diagnosis (it is not the schools place to diagnose or treat eating disorders) and how to support a student recovering from an eating disorder (see ‘Developing a care plan for supporting a student’s recovery’ under HOW TO SUPPORT A STUDENT RECOVERING FROM AN EATING DISORDER). For case study examples and detailed guidelines of the types of policies a school might consider implementing visit www.nedc.com.au/for-schools (to access CEED & EDV, 2004).

Checklist for a whole of school approach (adapted from The National Advisory Group, 2009)

Policy

- Include a statement in the school mission about providing a body image friendly environment and celebrating diversity
- Prohibit appearance-related teasing, including cyber-bullying in school policy
- Ensure no weighing, measuring or anthropometric assessment of students in any context
- Provide an opportunity for all students to engage in regular physical activity in a noncompetitive, nonweight-loss focused, safe and secure environment
- Provide a balance of food options from all food groups in the canteen
- Display public material/posters including a wide diversity of body shapes, sizes and ethnicity

Workforce Development

- Train all relevant teaching staff in the early identification and referral of students with serious body image concerns and eating disorders

- Provide all teachers with training and information about eating disorders, their impact on the wellbeing of young people and ways that risk factors are reinforced by social environments
- Train teachers to use body friendly language in their interactions with students

Curricula

- Provide body image teachings at every year level and ensure all materials presented as part of your prevention program are age appropriate
 - Primary—positive body image and self-esteem and healthy eating patterns
 - Early high school—peer interventions and media literacy
 - Mid-high school—cognitive dissonance and peer programs
 - Late high school—early identification of body image and 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

Understand the different prevention strategies for eating disorders

In the case of people with eating disorders, ‘prevention’ refers to specific programs or interventions designed to reduce risk factors, enhance protective factors and ultimately stop the increasing rate of eating disorders in our society. Early diagnosis, prevention programs, and appropriate cost effective treatments have been proven to greatly reduce the impact of an eating disorder.

Primary prevention

Primary prevention interventions aim to prevent the onset or development of an eating disorder, and may be universal, selective or indicated.

Universal prevention for children and young people

Universal prevention efforts target whole communities and aim to promote general health and well-being, foster resilience and reduce the risk of eating disorders amongst non-symptomatic populations. This can be achieved in schools by targeting whole year groups. Universal prevention approaches aim to prevent the onset of eating disorders in those who are at high risk while also promoting the general health and well-being of those at low risk of eating disorders. Students aged between 12 and 15 are an appropriate group for these approaches as many personal and environmental risk factors that can trigger an eating disorder are known to develop during this stage of early adolescence (e.g. natural increases in body fat and weight associated with puberty, an increased desire for peer acceptance, onset of romantic interest, changes in academic expectations).

Specific aims of universal interventions may include:

- Improving general health, nutrition, and psychological well-being (e.g. self-esteem, positive body image)
- Enhancing media literacy and promoting critical evaluation of media messages
- Helping children learn how to manage the socio-cultural influences linked to the development of body image dissatisfaction
- Reducing teasing, including weight-based teasing

Selective prevention for children and young people

Instead of targeting the whole population selective prevention programs target those at higher-risk. This commonly includes females, but may also include populations such as athletes and dancers. In general selective population interventions aim to promote general health and well-being, foster resilience and reduce the risk of eating disorders.

Specific aims of selective interventions may include:

- Improving general health, nutrition, and psychological well-being (e.g. self-esteem, positive body image)
- Enhancing media literacy and promoting critical evaluation of media messages
- Reducing teasing, including weight-based teasing
- Helping the person identify the costs of pursuing the Western cultural body ideal of 'thin' (for girls) or 'muscular/lean' (for boys)
- Promoting the adoption of healthy, balanced attitudes on body image, eating and weight
- Reducing the importance placed on body shape and weight for defining personal success, happiness, and self-worth
- Providing education on the unhelpful physical and psychological effects of dieting and extreme dietary restriction
- Providing psychoeducation on balanced nutrition and physical activity

Indicated prevention for children and young people

Indicated prevention programs are more targeted in their approach, and are designed to maximise early detection and treatment for people with symptoms of eating disorders, who do not meet threshold diagnostic criteria, but are at high-risk for developing an eating disorder. At this stage, interventions seek to reduce the symptoms related to eating disorders. In schools, indicated prevention is generally most relevant to members of the welfare team such as School Counsellors who will often encourage students to seek external help.

Specific aims of indicated interventions may include:

- Teaching the person healthy non-disordered eating ways of maintaining a healthy weight
- Enhancing media literacy which provides education on the media's promotion of unrealistic standards of 'beauty' so that people learn to critically analyse media messages and thus reduce the risk for the development of eating disorders
- Having the person identify the costs of pursuing the Western cultural body ideal of 'thin' (for girls) or 'muscular/lean' (for boys)
- Promoting the adoption of healthy, balanced attitudes on body image, eating and weight

- Reducing the importance the person places on body shape and weight for defining personal success, happiness and self-worth
- Providing education on the unhelpful physical and psychological effects of dieting and extreme dietary restriction
- Providing psychoeducation on balanced nutrition and physical activity

Secondary prevention

Secondary prevention interventions aim to lower the severity and duration of an illness through early intervention, including early detection and early treatment. These interventions occur early in the pathway to an eating disorder and aim to emphasise that eating disorders are highly treatable, very common and just a step further on the continuum of disordered eating. These attempts to normalise the person's behaviours are intended to encourage a person in the early stage of an eating disorder to seek help. There is considerable overlap between indicated prevention and secondary prevention with the difference relating to the degree of demonstrable risk. Similarly to indicated prevention, secondary prevention in schools is most relevant to members of the welfare team such as School Counsellors who will often encourage students to seek external help.

Tertiary prevention

Tertiary prevention aims to reduce the impact of an eating disorder on a person's life through approaches such as rehabilitation and relapse prevention. You can read more about how to support students through rehabilitation in the next section 'HOW TO RECOGNISE AND RESPOND TO EATING DISORDERS'.

Know how to make your prevention program effective

The most effective eating disorder prevention programs:

- Use a health promotion approach, focusing on building self-esteem, positive body image, and a balanced approach to nutrition and physical activity
- Utilise interactive approaches, as young people may learn more this way
- Develop social and relational practices that incorporate the person's support network
- Are based on a theoretical or clinical understanding of how a risk factor, such as poor body image, leads to eating disorders; and how protective factors, such as coping skills, reduce risk of eating disorders
- Use developmentally appropriate materials
- Are socio-culturally relevant to the target audience
- Focus on strengthening protective factors
- Follow a multisession structure, allowing for both direct experience and time between sessions for reflection (this is necessary to reinforce learning)
- Include a long-term follow-up – just as discussions about the dangers of tobacco, alcohol or drugs do not end after the initial program, discussions about healthy eating, cultural values, and prejudices toward obesity should be ongoing

Know what material to cover in your prevention program

Some topics for a successful prevention program for children and young adults include:

- Media literacy and advocacy
- Promoting a balanced approach to nutrition and physical activity
- Challenging the societal pressures to be thin, emphasising the negative outcomes of pursuing the thin or muscular ideal
- Personal identity and self-esteem
- Peer relationships
- Coping skills that promote resilience

Programs designed to increase positive body image and self esteem should focus on risk factors that can be changed (i.e. thin ideal internalisation, body dissatisfaction, peer pressure, bullying and fat talk, perfectionism) and on increasing protective factors (i.e. self esteem, social support, non competitive physical activity, healthy eating behaviours and attitudes, respect for diversity).

Provide developmentally appropriate teachings at every year level

7-10 Years Primary School

In general, children under the age of 12 years do not need information on eating disorders. Communication with children should focus on positive behaviours

In school prevention programs focus on:

- ▶ Good health
- ▶ Body image and self esteem
- ▶ General mental health literacy

10-14 Years Middle School

Transitional years of puberty are a critical period for intervention

In school prevention programs focus on:

- ▶ Self esteem
- ▶ Perfectionism
- ▶ Media literacy and 'ideal body shape' internalisation
- ▶ Healthy eating
- ▶ Risks of dieting
- ▶ Natural changes in variation in body shape
- ▶ Standing up to a peer pressure
- ▶ Building a peer environment that supports positive body image

15-18 Years High School & Tertiary

For young people aged 15 to 25 years, information on eating disorders may contribute to recognition of risk factors in themselves and others and the development of supportive community environments.

This age group may be at higher risk, having already engaged in disorder eating behaviours. Messages should be tailored to meet the needs of high risk audiences.

Messages should include ways to challenge the thin ideal

18-25 Years Tertiary & Employment

As for 15-18 year olds, this group may be at higher risk and require specifically targeted messages to address risk behaviours.

Awareness of eating disorders is required to enable peer and partner support.

Messages may target specific occupations and interest groups at higher risk including athletes, entertainment industry and employers of young people.

Make sure your program is evidence based

Prevention programs are not all equally successful. Stice et al. (2007) found that 51% of eating disorder prevention programs actually reduced eating disorder risk factors and 29% reduced current or future eating pathology. Some programs which are supported by research evidence include MediaSmart, Happy Being Me, Everybody's different, The Body Project, Student Bodies (a good resource for teacher education), Y's Girls, Planet Health, Healthy Buddies and 5-2-1-Go. You can read about the structure and target audience of each program and find where to access it at www.nedc.com.au/for-schools.

Create a positive classroom environment

It is important that students feel safe and comfortable when discussing issues relating to health and wellbeing and that they understand any contributions they make to class discussions will be treated with respect by their teachers and peers. Developing a classroom agreement before communicating about issues relating to eating disorders can help to establish an appropriate teaching environment.

Communicate appropriately about eating disorders

Educational institutions play a large and ongoing role in the influence of young people and are therefore instrumental in delivering positive messaging about body image and healthy eating and exercise behaviours. Eating disorders are often misunderstood and underestimated in our society. Mistaken beliefs that eating disorders are about vanity, a dieting attempt gone wrong, an illness of choice, a cry for attention, or a person 'going through a phase' are common. Appropriate messages can be combined with effective engagement strategies to help educate the community about eating disorders. No single communication approach to eating disorders is likely to reach all targeted audiences or achieve all desired outcomes in terms of reduced risk and stigma, and earlier identification and intervention. Hence, eating disorders communication strategies require a multi-strand approach.

Communication about eating disorders should:

- Be developmentally appropriate for the intended audience
- Support understanding of eating disorders as serious, complex illnesses, not a lifestyle choice
- Provide accurate, evidence-based information
- Respect the experience of people who have eating disorders
- Assist people in making appropriate decisions about help seeking
- Balance representation of males and females and diverse cultures and age groups (unless specifically addressing a single target audience)
- Be reviewed for ambiguity and possible risk of harm
- Be monitored and evaluated on an ongoing basis to ensure the continuing safety and appropriateness of content

Communication about eating disorders should not:

- Describe details of how to engage in eating disorder behaviours
- Use or provide information on personal measurements in relation to people who have experienced an eating disorder (e.g. weight, amount of exercise, number of hospital admissions)
- Normalise, glamorise or stigmatise eating disorder behaviours
- Use judgemental or value-laden language
- Motivate people to act based on fear or stigma

How to get through to young people

Puberty is a time of great change biologically, physically and psychologically. Teenagers are often vulnerable to societal pressures and can feel insecure and self-conscious, factors that increase the risk of developing an eating disorder. Research conducted in 2010 on behalf of the NEDC showed young people recognise that eating disorders are potentially harmful; however they also accept body 'obsession' and dieting as normal parts of growing up. Consequently, adolescents and their peers are a key audience for eating disorder communication. To communicate effectively with young people, the avenues taken must be appropriate to what is known about the way they receive, absorb and accept information.

Messages for young people should:

- Emphasise positive behaviours for good health
- Seek to build self-esteem and self-determination
- Address perfectionism and the thin-ideal internalisation
- Include media literacy

For information on how to promote positive body image visit www.nedc.com.au/body-image.

eatingdisordersinfo.org.au

The NEDC have developed an online resource to communicate about eating disorders with young people. This resource has been designed to be relevant and engaging to young people who are either at risk of, or experiencing an eating disorder or who want to access online resources to help a friend or family member. This resource can be incorporated into PDHPE classes, media literacy programs and other school curriculum by teachers, school counsellors and other education professionals.

You can explore this resource by visiting: <http://eatingdisordersinfo.org.au>.

Communicating with families

Parents and extended family members are instrumental in providing early education on health, achievement and well-being. Families serve as role models and can, often inadvertently, place pressure on children and young people to achieve unrealistic standards. However, with appropriate education and training, families can support children by reinforcing appropriate messages they are hearing from school programs. Similarly, families can contradict inappropriate messages their children are receiving from the media, through fashion magazines and through film and TV.

Parents and families require messages that:

- Assist to identify symptoms and encourage help-seeking
- Give guidance on teaching their children healthy eating patterns
- Promote positive body image - parents and carers can often have negative body image themselves and require support both for their own needs and as role models
- Explain the facts about eating disorders, and provide information on access to treatment and support
- Enhance recognition of risk

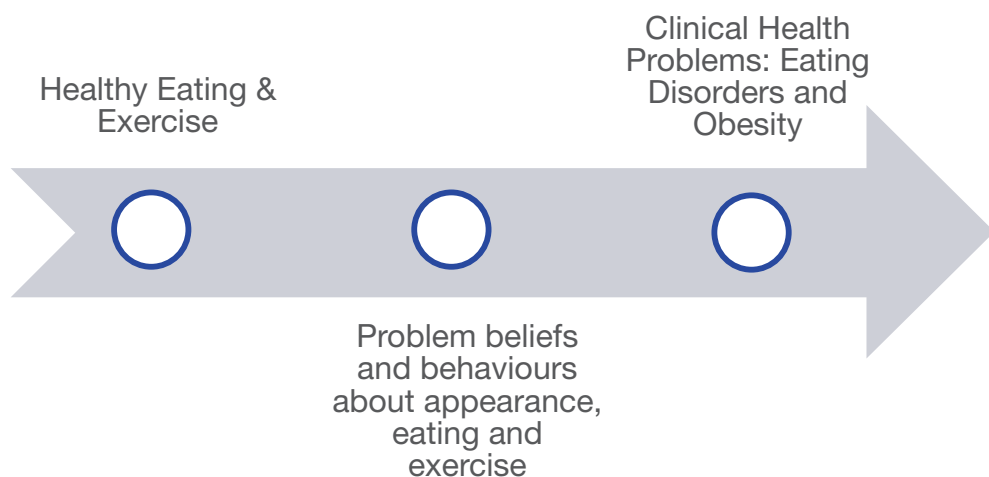
Rather than waiting for a problem to develop before communicating with families about eating disorders it is better to communicate with all families within the school community regularly about prevention and early identification of eating disorders (e.g. through newsletters, emails, information evenings, parent/teacher interviews and more active support for families facing crises). For detailed information on how to involve families visit www.nedc.com.au/for-schools (to access CEED & EDV, 2004).

Do no harm

Care must be taken in promoting information about eating disorders in order to ensure positive outcomes rather than accidental harm. The challenge is similar to that faced by health promotion and prevention campaigns for other health issues such as illicit drug use and binge drinking. There is a potential for harm in talking about eating disorders in a detailed way to people at risk. Without due caution, highlighting the symptoms or effects of eating disorders may increase the prevalence of the disorder. It is recommended that key messages are tailored and tested for audiences, especially in the case of messages for those at risk of developing an eating disorder. All communication about eating disorders should contribute to one or more of these goals:

- **Recognition** – broad community awareness and understanding of eating disorders as a priority mainstream health issue to increase support and reduce stigma
- **Resilience** – ability to resist pressures towards high risk behaviours for eating disorders
- **Help seeking** – eating disorders and risk factors are identified at an early stage leading to early intervention and reduction in the impact of the illness

Understand the relationship between eating disorders and obesity



Contrary to what many people think, obesity and eating disorders share many common factors. People who are overweight and obese have a higher risk of developing disordered eating and eating disorders than the general population. In addition, young people and adults who diet and use unhealthy weight-control practices gain more weight over time and are at higher risk of becoming overweight or developing obesity.

In the last three decades, worldwide rates of obesity have doubled and instances of obesity and eating disorders occurring at the same time have quadrupled. This extreme rise illustrates the urgent need to address the relationship between eating disorders and obesity, and the research-based recommendations of health promoting activities. At present, the health promotion strategies for obesity and eating disorders tend to be separate; however, there is growing evidence to suggest that a shared approach could be of benefit. Obesity and eating disorders may be viewed as occurring at the same end of a spectrum from healthy beliefs, attitudes, and behaviours at one end to problematic beliefs, attitudes, and behaviours at the other end.

Obesity and eating disorders: a shared approach

Coordinated and consistent messaging promoting health outcomes for overweight and eating disorder problems is possible, especially in the area of prevention. Focusing on the risk and protective factors that are common to eating disorders and obesity presents an opportunity to collaborate and redirect people in a positive direction. Weight and eating-related conditions often occur in an environment where ambiguous and opposing demands and messages are present, for example, ‘taking diet pills will help you lose weight and are therefore good for your health’ is often presented in the same space as warnings to the effect of ‘diet pills are unhealthy and dangerous.’ A first step to reducing the risks and increasing the protective factors for both eating disorders and obesity is to recognise that we all aspire to a healthy, disease-free population who eat well, are physically active, and are satisfied with their bodies.

Shared risk factors:

- Being overweight in childhood
- Weight bias and stigmatisation
- Childhood weight-related teasing
- Amount of time spent watching television/using the internet/playing video games
- Media and marketing exposure
- Dieting and disordered eating
- Poor body image
- Depressive symptoms and anxiety
- Family talk about weight, parent weight-concern & weight-related behaviours (e.g. dieting)

Shared protective factors:

- Enjoying physical activity
- Positive body image
- High self-esteem
- Eating breakfast, lunch and dinner every day
- Family modelling of healthy behaviours (e.g. avoiding unhealthy dieting, engaging in physical activity, having regular and enjoyable family meals)

The boomerang effect

Despite having the best intentions, occasionally health promotion efforts cause unintended harm. When attitude and behaviour change occurs in the direction opposite to that which was intended, it is known as the ‘boomerang effect.’ Very little research has been done in the eating & weight fields to ascertain whether obesity prevention programs may be harmful in relation to eating disorders, and vice versa.

Public health messages should avoid:

- The measurement of weight/BMIs especially in school settings and overemphasising these measures as indicators of health
- Moralisation of eating (e.g. labelling foods as ‘good’, ‘bad’, ‘right’ or ‘wrong’)
- The possibility for weight bias and stigmatisation

- Nutritional advice that may encourage food fears and unhealthy dieting
- Inappropriate messages that may increase body dissatisfaction, dieting, and use of unhealthy weight control practices

Public health messages designed to reduce eating disorder prevalence should follow these guidelines:

- Interventions should focus on health, not weight, and be delivered from a holistic perspective with equal consideration given to social, emotional and physical health
- Weight is not a behaviour and therefore not an appropriate target for behaviour modification; interventions should focus only on modifiable behaviours (e.g. physical activity, eating habits, time spent watching television)
- People of all sizes deserve a nurturing environment and will benefit from a healthy lifestyle and positive self-image
- The ideal intervention is an integrated approach that addresses risk factors for the spectrum of weight-related problems, and promotes protective behaviours
- Interventions should honour the role of parents and carers and support them to model healthy behaviours at home without overemphasising weight
- Representatives of the community should be included in the planning process to ensure that interventions are sensitive to diverse norms, cultural traditions and practices
- It is important that interventions are evaluated by qualified health care providers and/or researchers, who are familiar with the research on risk factors for eating disorders



HOW TO RECOGNISE AND RESPOND TO EATING DISORDERS

How to recognise when a student may have, or be developing, an eating disorder

Anyone can experience an eating disorder. Being as informed as possible about how to recognise eating disorders will help you identify the warning signs in someone you are concerned about. It is also important to talk to a professional with specialised knowledge about eating disorders who can give advice, information and support. It is not easy to detect who may have an eating disorder as eating disorders cannot be identified by someone's size or shape. A person with an eating disorder may have disturbed eating behaviours coupled with extreme concerns about weight, shape, eating and body image. However, people with eating disorders may go to great lengths to hide, disguise or deny their behaviour, or may not recognise that there is anything wrong. This may make the characteristic behaviours of the illness difficult to identify and it is often very difficult for people with eating disorders to ask for help. The following information can help you to recognise existing issues.

Understand who is most at risk

While research into the causes of eating disorders continues, this remains an area that is not well understood. No single cause has been identified; however, there are many risk factors that increase the likelihood that a person will experience an eating disorder at some point in their life. Knowing who is most at risk of developing an eating disorder can help teachers know who will benefit most from preventative interventions.

The risk factors for eating disorders include:

Biological

- Gender
- Genetic susceptibility
- Timing of the onset of puberty

Psychological

- Low self-esteem
- Anxiety
- Depression
- Feeling 'out of control'
- Personality traits such as perfectionism, obsessive-compulsiveness, neuroticism
- Stress
- Overvaluing body image in defining self-worth
- Trauma

Socio-cultural

- Internalising the western beauty ideal of thinness, and muscularity and leanness
- Societal pressure to achieve and succeed
- Involvement in a sport or industry with an emphasis on a thin body shape and size (e.g. ballet dancer, gymnast, model, athlete)
- Peer pressure
- Teasing or bullying (especially when based on weight or shape)
- Troubled family or personal relationships

Some protective factors which make some people more resilient to eating disorders than others include:

Individual

- High self-esteem
- Positive body image
- Critical processing of media images (i.e. media literacy)
- Emotional well-being
- Being self-directed and assertive
- Possession of good social skills and social functioning
- Problem solving and coping skills

Family

- Family connectedness
- Belonging to a family that does not overemphasise weight and physical attractiveness
- Rating regular meals with the family
- Socio-cultural
- Belonging to a less westernised culture that accepts a range of body shapes and sizes
- Involvement with sport or industry where there is no emphasis on physical attractiveness or thinness
- Peer or social support structures and relationships where weight and physical appearance are not of high concern

High risk groups that you may be in contact with as a teacher

Eating disorders occur in both males and females; in children, adolescents, adults and older adults; across all socio-economic groups and cultural backgrounds. Within this broad demographic however some groups have a particularly high level of risk. High risk groups that teachers might encounter include:

Adolescents - The peak period for the onset of eating disorders is between the ages of 12 and 25 years, with a median age of around 18 years.

Women, particularly during key transition periods (e.g. from school to adult life) - Women with high weight and shape concerns, a history of critical comments about eating, weight and shape, and a history of depression are at a higher than average risk for eating disorders.

Young people with Diabetes or Polycystic Ovary Syndrome - Adolescents with diabetes may have a 2.4-fold higher risk of developing an eating disorder, particularly Bulimia Nervosa and Binge Eating Disorder, than their peers without diabetes. Polycystic Ovary Syndrome is associated with body dissatisfaction and eating disorders.

Athletes - People engaged in competitive fitness, dance and other physical activities where body shape may be perceived as affecting performance have a high level of risk of eating disorders.

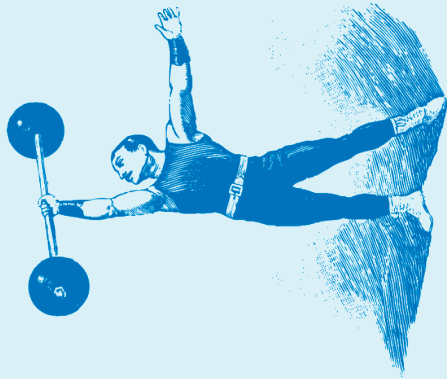
People with a family history of eating disorders - There is evidence that eating disorders have a genetic basis and people who have family members with an eating disorder may be at higher risk of developing an eating disorder themselves.

People who are interested in weight loss - Eating disorders almost invariably occur in people who have engaged in dieting or disordered eating.

Eating disorders in males

Population studies have suggested that males make up approximately 25% of people with Anorexia Nervosa or Bulimia Nervosa and 40% of people with Binge Eating Disorder. In a recent study lifetime prevalence for Anorexia Nervosa in adolescents aged 13 – 18 years found no difference between males and females. One unique difference between males and females with eating disorders is that men often engage in compulsive exercise as a compensatory behaviour, typically with the aim of achieving a more muscular, and not just slender, body type. Compulsive exercise describes a rigid, driven urge to exercise and is a serious health concern. There is a fact sheet about eating disorders in males at: www.nedc.com.au/fact-sheets

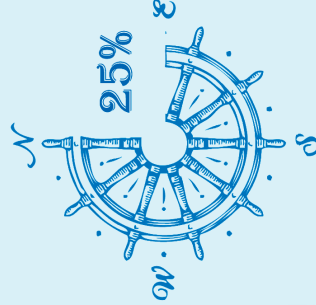
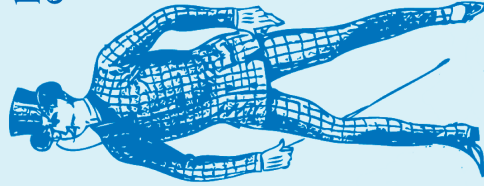
GUYS GET EATING DISORDERS TOO



“Over-exercising and extreme pursuit of muscle growth are often seen as healthy behaviours for males. Actually they can indicate a significant disorder and can lead to severe health issues.”

While eating disorders are often portrayed as illnesses that only affect females up to a quarter of people with an eating disorder are

MALE



FALSE MESSAGES

Males are often exposed to cultural messages that can increase their vulnerability towards developing an eating disorder.

These messages do not reflect the reality of mental and physical health in males



You are what you look like
MALES SHOULD ONLY HAVE ONE BODY TYPE
Males need to be in control
Eating disorders aren't masculine

Getting Help



If you suspect you or someone you know has an Eating Disorder seek help immediately

Find help in your area by visiting:
www.nedc.com.au/helplines

Is it possible for a male to recover from an eating disorder?

Evidence shows the sooner anyone starts treatment for an eating disorder, the shorter the recovery process.

YES



Snapshot

National Eating Disorders Collaboration

nedc.com.au/eating-disorders-in-males

The National Eating Disorders Collaboration (NEDC) is an initiative of the Australian Government Department of Health

Recognise the warning signs

Warning signs that can signal the onset or the presence of an eating disorder include:

Physical warning signs

- Rapid weight loss or frequent changes in weight
- Loss of or disturbance of menstrual periods in girls and women
- Fainting or dizziness
- Always feeling tired and not sleeping well
- Swelling around the cheeks or jaw, calluses on knuckles, damage to teeth and bad breath which can be signs of vomiting
- Feeling cold most of the time, even in warm weather

Psychological warning signs

- Preoccupation with eating, food, body shape and weight
- Feeling anxious around meal times
- Feeling 'out of control' around food
- Having a distorted body image
- Feeling obsessed with body shape, weight and appearance
- 'Black and white' thinking (e.g. rigid thoughts about food being 'good' or 'bad')
- Changes in emotional and psychological state (e.g. depression, stress, anxiety, irritability, low self esteem)
- Using food for comfort (e.g. eating as a way to deal with boredom, stress or depression)
- Using food as self punishment (e.g. not eating for emotional reasons like depression/stress)

Behavioural warning signs

- Dieting behaviour (e.g. fasting, counting calories, avoiding food groups such as fats and carbohydrates)
- Eating in private and avoiding meals with other people
- Evidence of binge eating (e.g. disappearance or hoarding of food)
- Frequent trips to the bathroom during or shortly after meals
- Vomiting or using laxatives, enemas or diuretics
- Changes in clothing style (e.g. wearing baggy clothes)
- Compulsive or excessive exercising (e.g. exercising in bad weather, continuing to exercise when sick or injured, and experiencing distress if exercise is not possible)
- Making lists of good or bad foods
- Suddenly disliking food they have always enjoyed in the past
- Obsessive rituals around food preparation and eating (e.g. eating very slowly, cutting food into very small pieces, insisting that meals are served at exactly the same time everyday)
- Extreme sensitivity to comments about body shape, weight, eating and exercise habits
- Secretive behaviour around food (e.g. saying they have eaten when they haven't, hiding uneaten food in their rooms)

It is common for someone to display a combination of these symptoms. It is important to remember that due to the nature of an eating disorder some of these characteristic behaviours may be concealed.

Specific Questions to Ask- SCOFF

- S-** Do you make yourself **sick** because you feel uncomfortably full?
- C-** Do you worry you have lost **control** over how much you eat?
- O-** Have you recently lost more than **one** stone (6.35kg) in a three-month period?
- F-** Do you believe yourself to be **fat** when others say you are too thin?
- F-** Would you say **food** dominates your life?

An answer of 'yes' to two or more questions indicates the need for a more comprehensive assessment.

What to do if you suspect a student has an eating disorder

Be familiar with Mental Health First Aid

The Mental Health First Aid guidelines for eating disorders, which are available at www.mhfa.com.au/documents/guidelines/8244_MHFA_eatdis_guidelines_Sep09.pdf provide evidence based recommendations about how to help a person developing or experiencing an eating disorder.

Be prepared

There is no 'right' or 'wrong' way to talk to someone with an eating disorder. However, it is important to be prepared. The person may be experiencing high levels of anxiety, shame, embarrassment, guilt or denial, or may not recognise that anything is wrong. It is important to take this into consideration. Any approach needs to be made in a caring manner in an environment which can support an open and calm conversation. Avoid broaching the topic if you are around food, or in situations in which either of you are angry, tired or emotional. If you are approaching someone with an eating disorder you need to take into account their fear of disclosing their behaviours. Be prepared for the person to respond with anger or denial. This does not mean they do not have a problem. Let them know that you care about them and want to support them through every stage of their process.

If you are planning to talk to a student about a potential eating disorder, here are some questions to ask yourself first:

- Have you documented the place and time of the specific behaviours you have witnessed which lead you to suspect the student might be suffering from an eating disorder?
- Are you the best person to approach the student or is there a member of staff who might have a better rapport with the student or be experienced in dealing with eating disorders?
- If you are the best person to speak with the student, would they respond better to a one-on-one chat or is there another member of staff who could be present to provide support?
- Do you know the schools policy for mental health interventions and the appropriate next steps (e.g. Who should you report the issue to? Who will speak with the student's family?)
- What would be the best time and place to approach the student in a way to which they would be most receptive?

- How will you respond if the student is defensive and not willing to admit there is an issue (you can find scripted suggestions in the resource referenced at the end of this paragraph)?
- What is your aim (this should be to encourage the student to seek help)?

(adapted from CEED & EDV, 2004, which you can access at: www.nedc.com.au/for-schools)

Express your care and concern

The first steps toward treatment and recovery from an eating disorder are often very hard to take. A person with an eating disorder may feel embarrassed, scared or afraid. They may feel like they have their problem ‘under control,’ or they may not feel like they have a problem at all. However, if you suspect that one of your students has an eating disorder it is important that they seek help immediately. The sooner a person starts treatment for an eating disorder, the shorter the recovery process will be. Seeking help at the first warning sign is much more effective than waiting until the illness is in full swing.

Some helpful tips when talking to someone you suspect may have an eating disorder:

- Try to use ‘I’ statements (e.g. ‘I care about you,’ ‘I’m worried about you’)
- Help them to feel it is safe to talk to you
- Ask them how they feel
- Give them time to talk about their feelings
- Listen respectfully to what they have to say
- Encourage them to seek help

Some things to avoid:

- Avoid putting the focus on food - try talking about how the person is feeling instead
- Do not use blame (e.g. instead of ‘You are making me worried’ try ‘I am worried about you’)
- Avoid taking on the role of a therapist - you do not need to have all the answers, rather it is most important to listen and create a space for them to talk
- Steer clear of manipulative statements (e.g. ‘Think about what you are doing to me...’)

For information on approaching a student who might have an eating disorder, including what to say, how they might react and where to refer them on to visit: www.nedc.com.au/for-schools (to access CEED & EDV, 2004).

Seek help early

A person with an eating disorder may show resistance to getting help. Sometimes they do not want to get well as they are ashamed of their eating and exercise behaviours and fear anyone knowing about them. You can help them by remaining supportive, positive and encouraging. The importance of seeking help early cannot be overstated. The earlier an intervention occurs, the shorter the duration of the eating disorder, and the greater the likelihood of full recovery, especially in children and younger adolescents.

Involve the family whenever possible

Decisions about when to pass confidential information about a student’s health and wellbeing on to the student’s parents can be complicated as not all schools are covered by the same legislation or guidelines. Teachers should refer to their own school’s privacy policy and codes of practice to inform their decisions about communicating with parents.

Factors to consider in making your decision include the age of the student, their own thoughts about involving their parents, the severity of the student's physical and psychological condition and the resulting level of risk to their health and safety. From a recovery perspective there are many potential benefits of involving the family of a student with an eating disorder. Family and friends play a crucial role in the care, support and recovery of people with eating disorders. Clinical guidelines for best practice in managing eating disorders encourage the inclusion of families at each stage of treatment for adolescents with eating disorders, from the initial assessment to providing recovery support. For adolescents, Family Based Treatment is currently the treatment with the strongest evidence base.

Families are generally in a better position than schools to encourage children and young adults to seek professional medical and psychological help quickly and on an ongoing basis. It is important that a student with an eating disorder gets a professional diagnosis. While GPs may not be formally trained in eating disorder, they are a good 'first base' and can refer patients on to a range of clinicians with specialised knowledge, including medical doctors, psychiatrists, psychologists, nurses, dieticians, counsellors and occupational therapists who are specifically trained to help people with eating disorders.

The correct procedure for contacting parents with regards to student welfare issues will depend on your particular school's policies and procedures. For example, in some cases the responsibility for liaising with the parents will fall to the School Counsellor once a teacher has reported the problem via the appropriate channels within their school's structure. For specific suggestions about how to communicate with families with regards to eating disorders and how to provide ongoing support to families visit www.nedc.com.au/for-schools (to access CEED & EDV, 2004).

Maintain your professional boundaries

It is important to maintain a normal teacher - student relationship and not become too involved with the student personally. If the issue is affecting you personally, and not just professionally, talk to your colleagues about getting some support and assistance in setting boundaries.

Establish a support network

A student places a huge amount of trust in a teacher by disclosing a mental health issue and so it is important to respect that trust and respond appropriately to any such disclosure. One element of an appropriate response is the need to respect the confidentiality of the student. However, this need can be difficult to balance with the teacher's duty of care to the student, the schools policies and procedures for responding to student welfare issues and requirements such as mandatory reporting legislation. If the student is ready to acknowledge the problem and seek help they may be responsive to you explaining the benefits of involving a number of different parties who can play different roles in the student's support network. If not you may have to explain to the student that you are obliged to share the information with certain parties, particularly if the student is a child who is at risk of harm. Always be upfront and honest about your duty of care and any responsibility you may have to report issues to other members of staff, the student's family or any external authorities. Ideally you should obtain the students permission to pass their information on, but if this is not possible be clear about who you are going to tell and why. Try to minimise the number of people who are told to show the student you are trustworthy and are respecting their privacy.

Some parties who might be involved with the management of an eating disorder within a school include:

- Principals need to be aware of mental health issues within their schools (e.g. so that they can respond to any issues that are becoming increasingly common within the school community) and are often the go to person with regards to mandatory reporting

- Deputy or Assistant Principals play an important role in overseeing student welfare and behaviour and so benefit from understanding mental health issues within their schools
- School Counsellors/ Psychologists and/or School Nurses may have previous experience dealing with eating disorders in a school context, referring students to appropriate support services for eating disorders, and providing resources which help to inform students and staff about eating disorders and how they can be effectively prevented and managed (School Counsellors are often responsible for communicating with families about issues of mental health)
- School religious leaders (e.g. Chaplains, Rabbis) often have a strong rapport with students and may play an important role in encouraging a student to seek professional help
- Year Coordinators usually have the best insight into a student's conduct across the board in terms of behaviour and achievement in various academic subjects, extracurricular interests and sporting commitments, and their social network
- Roll call teachers are usually responsible for daily pastoral care and often have a good rapport with students and their parents, and a good understanding of how students fit into the school community and interact with other staff and students, and family members
- In boarding schools, Heads of Houses and other boarding house staff members play an important role in communicating with students outside of school hours and understanding their behaviour, interests and relationships within the boarding community
- If a student's teachers, extracurricular instructors and/or sports coaches are aware of the issue they can help to promote positive messages and support recovery
- A student's friends can provide a strong support network if the student is comfortable with this and staff deem the friends to be mature enough to provide assistance without causing any detrimental effects to themselves or the person with an eating disorder

The particular details of the support network will depend on the school's policy and the individual's needs, as well as confidentiality issues and the readiness of the individual to accept help. Including a number of different staff members in the support network reduces the stress experienced by each individual. To read some specific tips for School Counsellors, School Nurses and Sports Coaches visit www.nedc.com.au/resource-direct (to access NEDA, 2008).

Other people who may need support

Friends and siblings of a person with an eating disorder may need support in adjusting to the situation and their role in supporting their friend or sibling. Friends of a person with an eating disorder can become confused about their own body image and ideas about diet and exercise. For specific ideas of how to help a student with an eating disorder's friends visit www.nedc.com.au/resource-direct (to access NEDA, 2008).

Be aware of relevant legislation

Legislation in some states requires teachers, as mandatory reporters, to report the disclosure of eating disorders under certain circumstances. For example, according to the NSW Government Mandatory Reporter Guide (2013) a teacher must report a student's mental health situation if 'a child/young person is causing significant self-harm' (e.g. 'child/young person has disrupted eating patterns, such as refusing to eat for prolonged periods to the extent that he/she is losing weight, or child/young person is forcing self to vomit') and 'the parents/carers are refusing to provide or access the mental health care that the child/young person requires'. Reporting guidelines depend on a student's age. In the above example mandatory reporters must report concerns about a child (0-15 years of age) being at suspected risk of significant harm and may also report concerns about a young person (16-17 years of age), but are not required to do so unless they work for certain agencies. Many symptoms of eating disorders, such as significant weight loss, persistent fatigue and the wearing of baggy clothing that hides the body, can be difficult to distinguish from indicators of other reportable scenarios, such as neglect or abuse. The following contacts can provide more information on the reporting requirements of each state. Things to consider if a report needs to be made include who the appropriate person is to make the report (e.g. The Principal, The School Councillor) and whether or not it is appropriate for the parents to be informed (some states have strict guidelines about this).

ACT: Office for Children, Youth and Family Support - Care and Protection Services

24 hours: 1300 556 729 (public), 1300 556 728 (mandatory)

Website: www.communityservices.act.gov.au/ocyfs/services/care_and_protection

NSW: Department of Family and Community Services

24 hours: 132 111 (public), 133 627 (mandatory)

Website: www.community.nsw.gov.au/welcome_to_docs_website.html

NT: Department of Children and Families

24 hours: 1800 700 250

Website: www.childrenandfamilies.nt.gov.au/

SA: Families South Australia

24 hours: 13 14 78

Website: www.families.sa.gov.au/

TAS: Department of Health and Human Services – Child Protection Services

24 hours: 1300 737 639

Website: www.dhhs.tas.gov.au/children/child_protection_services

VIC: Department of Human Services – Child Protection

Office hours: contact details for your local government area are available on the website

Out of hours: 131 278

Website: www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection

WA: Department for Child Protection and Family Support

Office hours: 08 9222 2555 or 1800 622 258

Out of hours: 08 9223 1111 or 1800 199 008

Website: www.dcp.wa.gov.au/Pages/Home.aspx

QLD: Department of Communities, Child Safety and Disability Services

Office hours: contact details for your local Child Safety Services Centre are available on the website

Out of Hours: 07 3235-9999 or 1800 177 135

Website: www.communities.qld.gov.au/childsafety



eating
disorders
info
.org.au

Getting help for
someone you're
worried about.



**#Talk to the
person you're
worried about.**

Encourage them to talk
about how they're feeling.
Listen openly and respect
what they say.



**#Talk to a
professional.**

Professionals can discuss your
concerns with you and help
you decide what steps to
take.

They can include doctors,
school counsellors, or
teachers.



**#Speak to
someone who
cares for the
person.**

Share your concerns with
someone they trust.
You could talk to a parent,
sibling, carer or another
friend.



**#Call a
helpline.**

The ED Hope Support Line
provides phone, email and live
chat support. You can speak
to them on **1800 ED HOPE**
(1800 33 4673).



ed
National
Eating Disorders
Collaboration

The National Eating Disorders
Collaboration (NEDC) is an
initiative of the Australian
Government Department of Health



HOW TO SUPPORT A STUDENT RECOVERING FROM AN EATING DISORDER

Recovering from an eating disorder is often a slow process and can take many years. Each stage brings triumphs and challenges to both the person with an eating disorder and their carers. Having a good understanding of eating disorders will help you to identify what is happening to the person you are helping care for.

Remember recovery is possible

Eating disorders are serious, potentially life threatening mental and physical illnesses, however with appropriate treatment and a high level of personal commitment, recovery from an eating disorder is achievable. The path of recovery from an eating disorder is a personal journey, unique to each individual. There is no set time for recovery and it is not uncommon for the process to slow down, or to go sideways or backwards. While this may seem frustrating, it can help to remember that with recovery as the ultimate goal even the setbacks can be a valuable part of the journey. It may take time to find the right treatment and the right therapist to meet the needs of the person with an eating disorder and their family or carers. Everyone responds differently to different types of treatment and no one treatment suits all. You can offer support by giving the person with an eating disorder the time they need to find and respond to the recovery program that best suits them. The best type of treatment is one that is long term and focussed on the needs of the person with the eating disorder and their family or circle of support, with recovery as the ultimate goal. For some people, recovery signifies an end to eating disorder attitudes and behaviours and the development of a healthier physical and psychological state of being. This can include returning to social activities, discovering a sense of purpose, and integrating back into daily life.

Understand the recovery process

Focusing on the process of recovery from an eating disorder can feel less overwhelming than focusing on the end result, which may feel far away and unattainable. Many people who have recovered from eating disorders have identified the following themes which have helped them through their journey of recovery:

- **Support** – feeling supported by those around them helps a person’s treatment and recovery. A circle of support also decreases the isolation often experienced by people with eating disorders.
- **Hope and motivation** – having a strong sense of hope coupled with the motivation to change eating disorder behaviours is the foundation of recovery.

- **Healthy self esteem** – remembering they are worthwhile reminds a person recovery is too.
- **Understanding and expressing emotions** – it is normal for a person with an eating disorder to feel a range of emotions and it is helpful for them to acknowledge and express these feelings.
- **Acknowledging set-backs** – with the focus on recovery, even taking a step backwards can still be making progress.
- **Coping strategies** – developing a list of coping strategies that calm a person down and help them regulate their emotions can help them during stressful or triggering situations.
- **Engaging in activities and interests** – revisiting the things a person enjoyed before their eating disorder will build self-esteem and reconnect the person with the world around them (e.g. if a person used to enjoy drawing, taking a pencil and paper to their favourite place can be a helpful, and enjoyable experience).

Understand the stages of change

Motivation is a very important part of the treatment and recovery process for eating disorders. Changes need to be made to the attitudes and behaviours that prevent a person from achieving good physical and mental health. The Stages of Change model can be applied to eating disorders to explain why some people may feel more ready than others to introduce changes that lead to recovery from eating disorders. This model seeks to understand a person's motivation towards achieving change and recovery and is made up of five stages of change that people may move through. Everyone is different, and some people may pass backwards and forwards between these stages. Throughout each stage there may be behavioural signs which will help you identify what stage the person is in and how you can best approach them.

Pre Contemplation

In the pre-contemplation stage a person with an eating disorder will most likely be in denial that there is a problem. You may have noticed some of the warning signs and feel concerned about the person, but they will have little or no awareness of the problems associated with their disordered eating. Instead, they may be focused on controlling their eating patterns. A person with an eating disorder in this stage may not be willing to change or disclose their behaviour and may be hostile, angry or frustrated when approached. This is because the person's eating disorder is currently serving as a way to control or avoid strong, unpleasant emotions. The person may feel unwilling or afraid to let go of these behaviours.

What you can do:

- Stay calm and try to see things from their point of view
- Show compassion and understanding
- Take the focus off their disordered eating - talk about their interests, goals in life and the things they may be missing out on as a result of the eating disorder

Contemplation

A person with an eating disorder in the contemplation stage will have an awareness of their problems and may be considering the benefits of changing some of their behaviours. They swing between wanting to change and wanting to maintain their disordered eating habits. This can be difficult and confusing for you and the person you are caring for.

What you can do:

- Demonstrate that you are listening to what the person has to say, and you understand their struggle - you can even say it back to them (e.g. 'I hear you saying that part of you feels like you want to change, while another part of you feels scared of changing...')
- Show them you respect their ideas, particularly the ones in favour of change
- Try to boost their self esteem and confidence - this will help them believe they can change

Preparation/Determination

In this stage the person with the eating disorder has decided they want to change their behaviour and is preparing to make these changes.

What you can do:

- Be informed - learn as much as you can about the steps you and the person you are caring for need to take in order to recover
- Work with the person to identify their goals and develop a detailed approach of how you will manage the changes together

Action

A person with an eating disorder in the action stage has decided they want to change and will need support to help them take the first steps towards recovery. The person can move backwards and forwards in their development during this stage and relapse can be common.

What you can do:

- Acknowledge how difficult it is to change and recover from an eating disorder
- Support the person through challenges and let them know you believe in them - this will help build their confidence

Maintenance

In the maintenance stage a person with an eating disorder will have changed their behaviour and may be focusing on maintaining their new, healthier habits while learning to live without an eating disorder. This takes time and requires commitment. It is still possible for a person with an eating disorder to relapse at this stage.

What you can do:

- Work together with the person to identify triggers that may impact their recovery
- Put systems and strategies in place to help avoid relapse
- Show care, patience and compassion

Remember who the person is

Do not let the eating disorder take over the person's identity. Remember that they are still the same person they have always been. Separating the person from the illness can help you and the person with an eating disorder.

Be patient

People with eating disorders can experience a range of different and conflicting emotions all in one day. This can be hard to manage in a school environment. The road to recovery is littered with emotions and setbacks and can be a long journey. It is important to be as calm and patient as possible throughout their recovery and remember that there is no quick fix. Recovery takes time and patience.

Communicate

Communicate openly, without judgement or negativity and allow the person to express how they are feeling. Avoid focussing on food and weight and instead try to talk about the feelings that may exist beneath the illness. Pay attention to the person's nonverbal reactions and body language and encourage them to trust and speak openly with you.

Be positive

Draw attention to the person's positive attributes. Talk about things they enjoy and are good at. Reminding a person of life outside of their eating disorder helps them realise there is more to them than an eating disorder.

Develop a care plan for supporting the student's recovery

The path to recovery from an eating disorder is long and challenging but schools can help to support students along this path. Eating disorders profoundly affect cognitive and learning ability. The physical, psychological and behavioural effects of eating disorders will limit a student with an eating disorder's ability to function normally at school in terms of keeping up to date with their work and participating fully in activities. To read about the impact of eating disorders on cognitive ability and functioning in school visit www.nedc.com.au/resource-direct (to access NEDA, 2008). Feeling like they are falling behind or not fitting in can contribute to some of the mental health issues that a student with an eating disorder may be experiencing. Hence, it is important that staff be flexible and supportive of the student, and their friends and family, as they are recovering from their eating disorder. To find guidance for schools on education plans for students in treatment for eating disorders visit www.nedc.com.au/resource-direct (to access NEDA, 2008). Whilst flexibility is important, it must be balanced with that teacher's responsibility to maintain the behavioural and academic standards expected by the school. Rather than being accommodating of the eating disorder itself, the aim should be to support the student in their recovery from the eating disorder. This can be achieved in a number of different ways.

If a student at your school is diagnosed as having an eating disorder the school should develop an individual care plan detailing the ways in which particular members of the school community can provide ongoing support as the student seeks help and undergoes treatment for their eating disorder. The care plan should include details such as who will be the primary support person that communicates with the student, who will liaise with the student's family (if confidentiality permits), who will communicate with treating health care professionals and the hospital in the case of hospitalisation (if confidentiality permits), how will the school ensure that the student doesn't fall behind in their studies as this might increase their levels of stress upon returning to school, and how can the school scaffold the students return after a period of absence from school by supporting the needs of the student and their family. For case study examples, classroom strategies to support students with eating disorders and detailed guidelines of the types of procedures a school might need to consider implementing visit www.nedc.com.au/for-schools (to access CEED & EDV, 2004) or <http://www.bced.gov.bc.ca/specialed/edi/ed1.pdf> (to access Ministry of Education, 2000).



WHERE TO LEARN MORE ABOUT EATING DISORDERS

Where to go for more information

The National Eating Disorders Collaboration (NEDC) is an initiative of the federal Department of Health. It is a collaboration of people and organisations with an expertise and / or interest in eating disorders. Our purpose is to develop a nationally consistent, evidence based approach to the prevention and management of eating disorders in Australia. The NEDC constantly reviews research evidence on eating disorders. Recent research can be found at www.nedc.com.au/research-resources Each of the publications of the NEDC also draws on an extensive review of evidence and expert opinion. NEDC publications and their bibliographies can be found at: www.nedc.com.au/nedc-publications

Where to go for professional development

Within Australia there are opportunities for professionals to advance their knowledge and expertise in the field of eating disorders. You can find information about professional development and upcoming events at the NEDC's knowledge hub: www.nedc.com.au/research-resources

Where to find resources

You can find a database of resources available for educational professionals to use in school environments at: www.nedc.com.au/for-schools. These resources have been assessed for relevance to the prevention, identification, early intervention, management or care of eating disorders.

Resources for rural schools

For information specific to rural schools visit: www.nedc.com.au/for-schools (to access CEED & EDV, 2004).

Where to find help

To find help in your local area visit www.nedc.com.au/helplines or call the National Support Line: 1800 ED HOPE (1800 33 4673)



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Online resources referred to in this resource

ACT Office for Children, Youth and Family Support – Care and Protection Services: www.communityservices.act.gov.au/ocyfs/services/care_and_protection

National Eating Disorders Collaboration - Helplines: www.nedc.com.au/helplines

National Eating Disorders Collaboration - Common Misconceptions: www.nedc.com.au/myths-about-eating-disorders

National Eating Disorders Collaboration - Professional Development: www.nedc.com.au/research-resources

National Eating Disorders Collaboration - Publications: www.nedc.com.au/nedc-publications

National Eating Disorders Collaboration - Recent Research: www.nedc.com.au/latest-research

National Eating Disorders Collaboration - Resources for Schools: www.nedc.com.au/for-schools

National Eating Disorders Collaboration – Resources: www.nedc.com.au/resource-direct

NSW Department of Family and Community Services: www.community.nsw.gov.au/welcome_to_docs_website.html

NT Department of Children and Families: www.childrenandfamilies.nt.gov.au

QLD Department of Communities, Child Safety and Disability Services: www.communities.qld.gov.au/childsafety

SA Families South Australia: www.families.sa.gov.au/

TAS Department of Health and Human Services – Child Protection Services: www.dhhs.tas.gov.au/children/child_protection_services

The Australian Curriculum, Assessment and Reporting Authority: www.australiancurriculum.edu.au/

The Mental Health First Aid Training and Research Program’s Mental Health First Aid guidelines for Eating Disorders: www.mhfa.com.au/documents/guidelines/8244_MHFA_eatdis_guidelines_Sep09.pdf

The National Eating Disorders Collaboration - Fact Sheets: www.nedc.com.au/fact-sheets

VIC Department of Human Services – Child Protection: www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection

WA Department for Child Protection and Family Support: www.dcp.wa.gov.au/Pages/Home.aspx



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The National Eating Disorders Collaboration is a collaboration of people and organisations with expertise in the field of eating disorders, individuals from a range of healthcare and research sectors and people with a lived experience of an eating disorder.

Through the contribution of its members, the NEDC has the resources to lead the way in addressing eating disorders in Australia.

nedc.com.au brings research, expertise and evidence from leaders in the field together in one place.

It's a one stop portal to make eating disorders information a lot more accessible for everyone.

Become a member

We welcome individuals and organisations to become members of the NEDC. As a member you can get involved in one of the working groups and contribute to project deliverables. You will also be informed on collaboration activities and receive access to the members only area of the website.

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The National Eating Disorders Collaboration
103 Alexander Street Crows Nest NSW 2065
Phone: +61 2 9412 4499 Fax: +61 2 8090 8196
Email: info@nedc.com.au

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