

Understanding Eating Disorders in BC Schools:

A Guide of Trauma Informed Practices for School Professionals

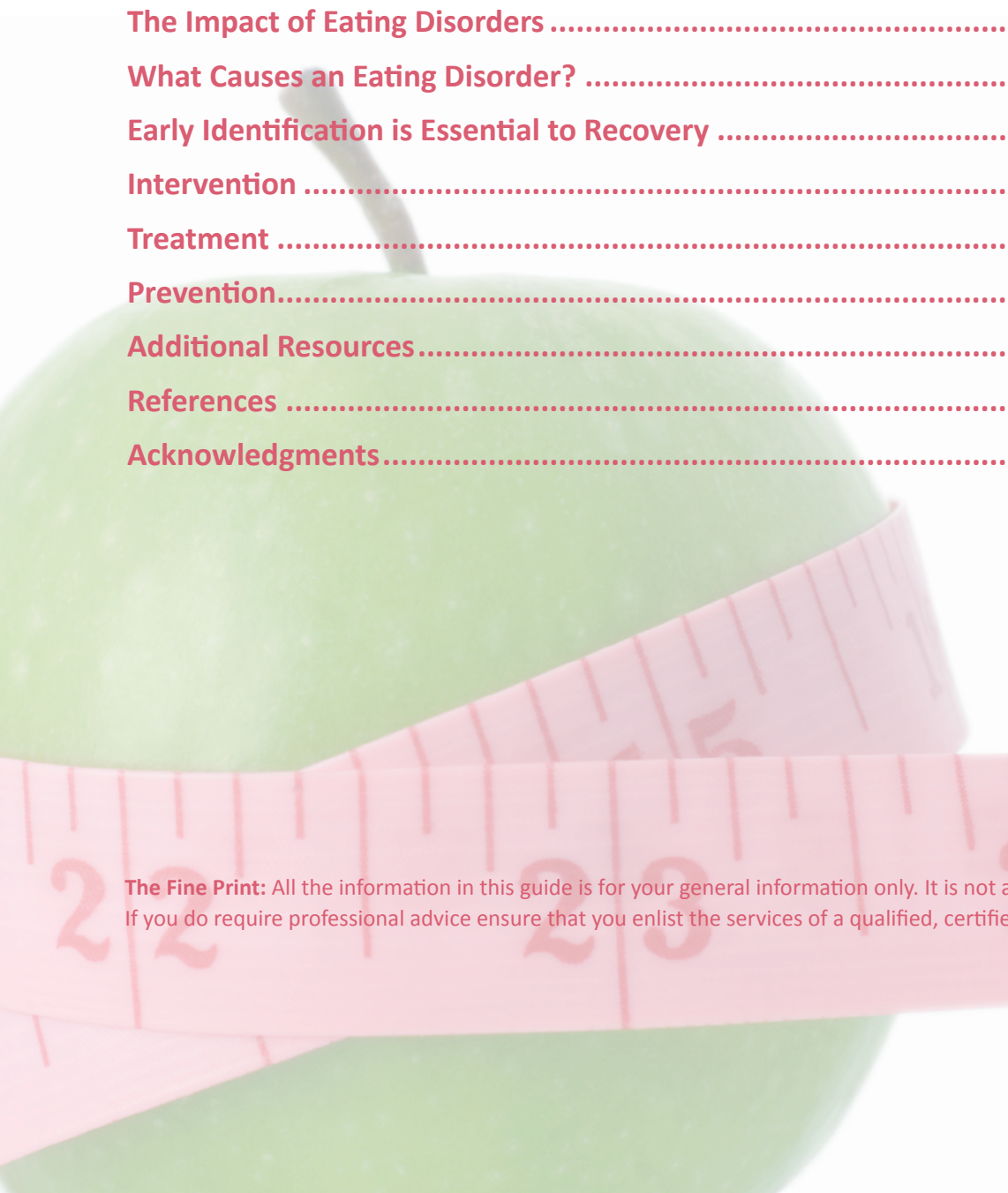
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Table of Contents

Purpose of This Guide.....	3
Test Your Knowledge about Eating Disorders	4
A Brief History of Eating Disorders	6
What is an Eating Disorder?	6
The Impact of Eating Disorders	8
What Causes an Eating Disorder?	11
Early Identification is Essential to Recovery	13
Intervention	16
Treatment	21
Prevention.....	23
Additional Resources	26
References	27
Acknowledgments.....	29



The Fine Print: All the information in this guide is for your general information only. It is not a substitute for professional advice. If you do require professional advice ensure that you enlist the services of a qualified, certified professional.

Purpose of this Guide



The purpose of this guide is to generate thoughtful discussion about eating disorders at your school. Here are some of the topics this guide will touch on:

- Prevention: what school personnel need to know (the role of school culture in promoting mental health)
- Identification at school
- Intervention at school
- Supporting recovery at school utilizing trauma informed strategies

You can use this guide on your own or in conjunction with your colleagues. Think about the unique culture and practices at your school to develop a better understanding of eating disorders and your school's intervention practices. Learn how you can individually and collectively help your students with an eating disorder on their journey to recovery.

How Serious are Eating Disorders?

An eating disorder is not a choice.

According to the National Eating Disorders Association (NEDA)...

- Eating disorders are the most deadly of all mental illnesses. The death toll for youth age 15-24 is 12 times greater than for all other causes combined.
- Children as young as eight years old have been diagnosed with eating disorders.
- Being fat is more frightening to some girls than cancer, nuclear war or even losing their parents.

The information contained in this guide pertains to children and youth, males and females. It will be useful for teachers, support staff, administrators and school personnel at all levels. Identification of eating disorders depends on the whole school being informed and working together with understanding and compassion.

Use the list of resources and links at the back of this guide to further broaden your knowledge. Check the Ministry of Education, BCTF "Teaching to Diversity" and The Kelty Mental Health Resource Centre websites to connect with teachers and other professionals across the province on the topic of eating disorders and other mental health issues concerning children and youth.

"When my daughter returned to school after being in hospital for her eating disorder, the school embraced her to assist in the transition with tutoring, modified programming and priority access to the school counselor. The support of the school was critical in her recovery."

*Mary McCracken
Parent in Residence at the Kelty Mental
Health Resource Centre
The F.O.R.C.E. Society for Kids' Mental Health*

Test Your Knowledge about Eating Disorders



To check your understanding of eating disorders go through the statements below and decide if they are **True** or **False**, then compare your answers to the Answer Key. These myths were explained and debunked by Dr. Bertrand Wicholas MD, formerly a psychiatrist of the Inpatient Eating Disorders Program at BC Childrens Hospital.

1. Children and youth who have an eating disorder are superficial, conceited and narcissistic. (T or F)
2. Children and teens develop eating disorders to rebel against their parents and/or their families. (T or F)
3. Parents cause their child's eating disorder. (T or F)
4. Parents' involvement in treatment leads to power struggles. Parents should never be involved. (T or F)
5. Teaching about eating disorders is a form of prevention. (T or F)
6. Certain aspects of the B.C. curriculum are triggering to students with an eating disorder. (T or F)
7. Eating disorders are more prevalent in females than males. (T or F)

8. Children and youth with an eating disorder who use exercise to burn calories should integrate back into a physical education class. (T or F)
9. Students with an eating disorder should not be expected to comply with the behavioural expectations of the classroom because they are in distress. (T or F)
10. The media triggers eating disorders. (T or F)
11. A child/youth who successfully completed their treatment is "cured." (T or F)
12. Students with an eating disorder often maintain good grades. (T or F)
13. Over exercising is a form of purging calories. (T or F)
14. Mirror gazing contributes to poor body image which can worsen the symptoms of an eating disorder. (T or F)
15. School connectedness is a protective factor against the development of an eating disorder. (T or F)

Answer Key

1. **F:** Self-hatred and self-doubt of eating disorders among children and youth may make them feel uncomfortable receiving praise. They may believe that they are "unlovable," or are not "good at anything."
2. **F:** Eating disorders are not about rebellion. An eating disorder is an "**emotion-regulation disorder.**" Children and youth who are unable to process difficult emotions (e.g. anger, shame, guilt) may turn to an eating disorder to help them process their feelings.
3. **F:** Parents are not the cause. There is no one cause. There are a number of risk factors. These include, but are not limited to, **perfectionism, childhood anxiety disorder, traumatic life events, high level exercise, genetics** and simply being a **female adolescent.**
4. **F:** Parents play a vital role to varying degrees

in their child's recovery and treatment.

5. **F:** Dr. Wicholas' research shows that teaching students signs, symptoms and specific information about eating disorders may not lead to positive outcomes for students with a predisposition for an eating disorder.
6. **T:** The Planning 10 and English 12 curricula are examples of two courses which contain materials related to healthy living, food, nutrition, advertising, body image and exercise. These materials may be triggering for students with an eating disorder as well as those at risk for developing one. The healthy living curriculum is woven throughout grades K-12.
7. **T:** According to Dr. Wicholas, eating disorders are more prevalent in females than males. Ninety percent of those diagnosed with anorexia nervosa are female; however, males also suffer from eating disorders and are largely under-diagnosed. An estimated one-fourth of children diagnosed with anorexia nervosa are male. Preliminary research for binge-eating disorders suggests that it occurs equally in males and females.
8. **T:** Physical Education classes may seem contraindicated for children and youth struggling with an eating disorder. This is not true. It is important for students to learn to engage in physical activity that is healthy and balanced. The structure of a Physical Education class is a good starting point for those well enough to participate.
9. **F:** It is important to ensure as much normalcy as possible when a student returns to school. Though **educational** expectations of teachers may shift, **behavioural** ones should not. For example, the length and frequency of washroom breaks. To make exceptions for this student by ignoring the behaviour would work against the effort to "normalize" the classroom environment. Teachers need to be mindful of expectations and be flexible enough to meet those expectations as outlined in the IEP.
10. **T:** For some children/youth, the "thin is beautiful" message conveyed through the

media will trigger them to develop an eating disorder. For others, the pressures found in the media will be inconsequential.

11. **F:** Time spent in treatment facilitates an **interruption** of symptoms; the student is by no means **cured**. In fact, the average recovery time for eating disorders is 7 years.
12. **T:** In some cases, perfectionism drives performance which compels students to over function in spite of malnutrition; therefore, grades may temporarily improve. Research also tells us that the performance of an athlete may also show temporary improvement.
13. **T:** The bulimia nervosa subtype most commonly uses vomiting to purge calories but may also over exercise to achieve the same result.
14. **T:** Mirror gazing is a form of body checking which serves to reinforce a negative self-image in the mind of the child/youth with an eating disorder (Dr. Lori Ann Vogt).
15. **T:** School connectedness is protective for child/youth mental health. Although the factors contributing to an eating disorder are complex, there is little question that a strong connection to school is crucial to a student's recovery (Dr. Elizabeth Saewyc). School connectedness is the second most important protective factor for child, youth mental health when the family is non functioning.

Having worked through the True and False exercise above, one can understand that eating disorders are complex in their cause and development. Making a diagnosis must be left to the professionals.

"'Normal' messages about healthy eating can be misinterpreted by youth with eating disorders. They often take the messages to an unhealthy extreme. Focus should be on balance and variety rather than "good" or 'bad' foods."

*Judy Lirenman, RD
Dietician, Specializing in Children And Youth
Eating Disorders*

A Brief History of Eating Disorders

Eating Disorders are often thought of as stereotypically a modern disease symptomatic of a self-absorbed society, nothing could be further from the truth.

The first documented cases of eating disorders were by an English Physician, Sir Richard Morton, in a paper titled, “Phthisologia: Or, a Treatise of Consumptions”. He described one patient as “like a skeleton clad in skin”. We can only imagine how perplexed Dr. Morton must have been to see patients in this critical condition. Another case he made note of was of a “Mr. Duke’s daughter in St. Mary Axe”, (of London, England) and her “Continual poring upon books despite her condition”. This indicates that she remained studious throughout her illness, a quality we find in many of our students with an eating disorder. Unfortunately she was dead within three months after refusing further treatment. Dr. Morton also wrote of the case of “The Son of the Reverend Mister Steel”, evidence that historically males have also suffered from eating disorders.

The next significant reference in the medical literature does not seem to have appeared again until the 1870s. At that time, Dr. William Gull of London, England, possessed a series of wood carvings memorializing the journey to wellness of a patient who was clearly suffering from an eating disorder. Dr. Gull was one of the personal physicians to Queen Victoria. He wrote an influential paper which defined the term anorexia nervosa for the first time. The term translates from Greek as “nervous absence of appetite”. He detailed a number of treatments some of which included using preparations of bichloride of mercury, syrup of phosphate and citrate of quinine. Although his treatments and concoctions were questionable some of his patients seem to have recovered.

Bulimia nervosa was likely first described in the mid-1940s by Ludwig Binswanger, a Swiss psychiatrist. In 1944 he published a case history of his patient, Ellen West, who appeared to have

exhibited symptoms of bulimia nervosa. She later committed suicide. In 1958 the case was published in a book which Binswanger edited and which was translated into English by Rollo May et al.

Since then the medical community has discovered much about eating disorders and new categories are developing along with the research. Awareness of the condition was widely publicized in the twentieth century.

What is an Eating Disorder?

An eating disorder has mental and physical components and can present as trauma in some patients. According to the DSM-5 eating disorders are categorical. Listed below are the categories:

- **Avoidant/Restrictive Food Intake Disorder**
- **Pica**
- **Anorexia Nervosa**
- **Bulimia Nervosa**
- **Binge-Eating Disorder**
- **Other Specified Feeding or Eating Disorder**

This guide will focus on the following three categories you will most often see in a school setting:

- Anorexia nervosa
- Bulimia nervosa
- Other specified feeding or eating disorder

The following categories are used by some practitioners as descriptors for some eating disordered type behaviours however, they are not listed in the DSM V nor are they recognized as a mental disorder by the American Psychiatric Association. They are listed here for your interest only:



“An eating disorder is a serious medical illness that has lifelong consequences. Early recognition and treatment will lead to better outcomes.”

*Dr. Pei-Yoong Lam, FRACP
Pediatrician, Specializing in the Care of Children and Youth with an Eating Disorder*

Anorexia Nervosa:

The type of eating disorder most of us think of when we hear the words “**eating disorder**” is **anorexia nervosa**. It involves restricting the intake of food and may involve over exercising to burn off unwanted calories, resulting in extreme weight loss. According to the literature there are **two types of anorexia nervosa**-- the **restricting**

type and the **binge-eating and/or purging type**.

The restricting anorexic child/youth presents at low weight. They are preoccupied with food and may constantly count calories. Many of these students enjoy taking Foods classes in school and ask that we re-enroll them into their Foods classes. We do this with caution. We do not want to trigger them as they transition back to their lives. Re-enrolling them is a team decision. Which is made in consultation with the medical and the school teams, the student and their family.

The restricting anorexic often develops rituals around food, such as picking their food apart or cutting it into tiny pieces. This makes getting rid of the food much easier. Small pieces of food can then be tucked into hoodies, worked into the cuffs of pants, or just brushed casually onto the floor. A hundred calories or more can be disposed of in this manner. Over the course of a day hundreds of calories can be lost.

The restricting anorexic has body image distortion. They see themselves as fat no matter how thin they are. If you are trying to support them during recess or lunch time with meals or snacks, you need to be well trained to do so. There are resources at the back of this guide to direct you. Ideally, we recommend that parents/family members provide the meal support.

The restricting anorexic is often a perfectionist. They put a great deal of pressure on themselves to achieve perfect marks. They may even be those students that teachers consider to be among their best.

The **binge-eating and/or purging anorexia nervosa type** has all of the characteristics of the **restricting type**, however they will also purge to keep from gaining weight. They may **over exercise** as a way of purging along with self-induced **vomiting**. Frequent trips to the washroom during class time in order to accomplish their calorie reduction goals is something teachers need to be aware of. Students are known to do hundreds of jumping jacks or even sit ups in the washroom during a 5 to 10 minute break. Anorexia is an egosyntonic

disease and unlike other illnesses or diseases the patient does not wish to recover. This makes recovery a lengthy and complex process. The desire to recover emerges with an intensive, holistic therapeutic approach.

Bulimia Nervosa:

Unlike the restricting anorexic child or youth who is not able to maintain weight at a healthy level, the child or youth with bulimia nervosa often presents within or above their recommended body weight. Bulimia is characterized as an ego dystonic illness, unlike the anorexia subtype, there is a desire on the part of the patient to recover. Nonetheless, this does not in anyway mitigate the seriousness of bulimia nervosa.

Dr. Pei-Yoong Lam, explains the physiological impact of this type of eating disorder and how it wreaks havoc on the adolescent body. As with all eating disorders, “bulimia nervosa, if left untreated, causes growth and pubertal stunting, leads to fragile/brittle bones and shrinks the brain, impairing cognitive function”.

The **psychological underpinning of bulimia nervosa is a drive to control weight because of a feeling of a loss of control** such as an intense fear of not being able to stop eating.

As with all eating disorders bulimia nervosa is emotionally devastating to the family. It has the added component of creating financial hardship. Students who suffer with this disorder have been known to eat and vomit hundreds of dollars of their family’s groceries each week. This wreaks emotional and financial havoc on the individual and their family.

Other Specified Feeding or Eating Disorders:

In the medical community **other specified feeding or eating disorder** is a diagnosis used when presenting symptoms do not fit into a neat box. Those diagnosed with this “do not meet the full criteria for any of the disorders in the

feeding and eating disorders diagnostic class” (DSM V) because they may restrict or they may purge, making their presentation unpredictable.

The Impact of Eating Disorders

The prognosis of individuals with an eating disorder is in part determined by how early they receive treatment. Early treatment results in a better prognosis for recovery. If treatment is delayed, the effects of prolonged eating disorders are devastating (Dr. Ronald Manley).

The **physiological** consequences of eating disorders are divided into **acute** and **chronic**.

Acute includes:

- Hypotension (low blood pressure)
- Bradycardia (very slow heart rate)
- Arrhythmia (irregular heart rate)
- Electrolyte abnormalities, e.g. low potassium and phosphate (affects organ function)

Chronic includes:

- Osteoporosis
- Infertility
- Growth stunting
- Dental caries
- Bone marrow suppression

Other physiological implications are represented in the diagram titled, “The effects of bulimia and anorexia on the human body.”

As profound as the physiological consequences are, the psychological consequences can be more difficult to treat. The **psychological** consequences may include but are not limited to:

- Depression
- Anxiety
- Self-harm

The effects of bulimia (black font) and anorexia (white font) on the human body

Heart irregular heartbeat, heart muscle weakened, low pulse and blood pressure, heart failure

Kidneys kidney stones, kidney failure

Hormones irregular or absent period

Skin bruise easily, dry skin, get cold easily, yellow skin, hair growth over entire body, fragile nails

Mouth cavities, erosion of the tooth enamel, gum disease, sensitive teeth

Muscles, Joints & Bones weak muscles, swollen joints, fragile/brittle bones leading to fractures, bone loss, pubertal stunting

Death

Brain & Nerves difficulty thinking clearly, sad, moody, irritable, bad memory, feeling faint, changes in brain chemistry, fear of gaining weight

Stomach pain, ulcers that can rupture, constipation

Heart low blood pressure, slow heart rate, heart palpitations, heart failure

Cheeks swelling, soreness

Hormones periods stop, growth deficiencies, difficulty with conception. If pregnant, higher risk for miscarriages and C section deliveries. Baby will have a higher risk of a low birth weight. Increase chance of post partum depression

Throat & Esophagus sore, irritated can tear and rupture, bloody vomit

Hair thins and gets brittle

Body Fluids low potassium, magnesium and sodium

Body Fluids dehydration, low potassium, magnesium and sodium

Brain depression, fear of gaining weight, dizziness, shame, low self-esteem, anxiety

Blood anemia and other blood problems

Death

Muscles fatigue

Blood anemia

Intestines constipation, bloating

Intestines constipation, irregular bowel movements, bloating diarrhea, abdominal pain

Skin abrasions of knuckles, dry skin

- Irritability
- Suicidal Ideation
- Malaise
- flat affect (loss of sense of humour)
- Catastrophizing

A student with an eating disorder can also exhibit symptoms of trauma. As previously noted, an eating disorder can become a “trauma” in and of itself (Dr. Lucinda Kunkel).

Trauma symptoms include:

- Confusion
- Feelings of disconnectedness
- Denial or disbelief
- Guilt, shame, self-blame
- Withdrawal from others (becoming isolated)
- Feelings of hopelessness

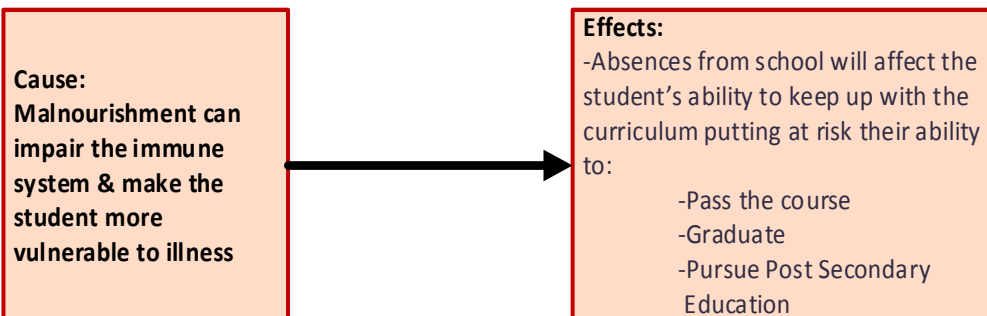
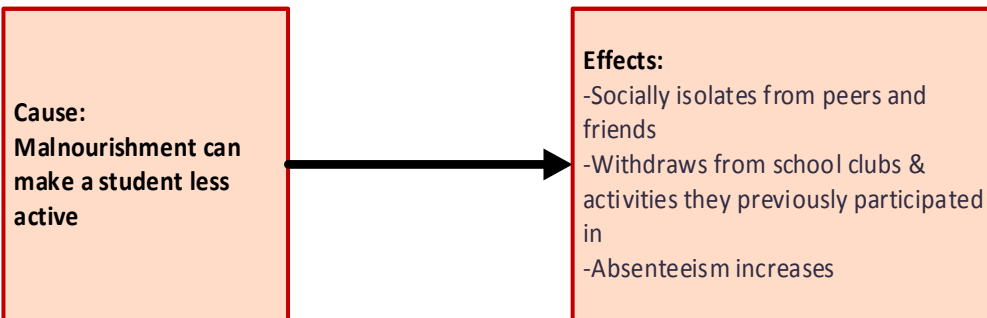
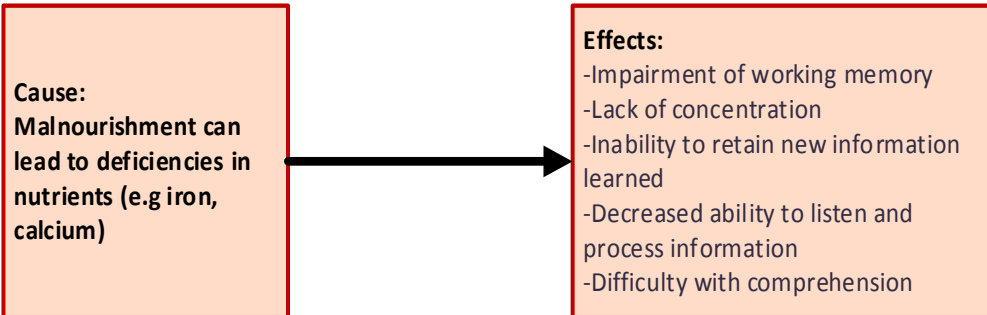
Trauma informed practices should therefore,

be implemented when and where possible in the school context. Trauma informed practices include:

- Clear and consistent expectations and responses which are non-punitive; rather they should be logical and natural
- Creating a sense of connectedness in the classroom and in the school context; school connectedness is a good strategy for promoting and supporting the mental health of students, as discussed later in this guide
- Establish safety: a non-threatening open and communicative environment at school where students’ voices are heard and their concerns acted upon
- Emotion regulation; making it safe for students to ask for help with their emotions and giving them the tools and the strategies to do so

Effects on Students at School

Cause and Effects of an Eating Disorder



Clinical research shows that individuals with an eating disorder spend anywhere from 70 to 100 percent of their time thinking about food and weight. With this preoccupation dominating their thoughts, the student struggles to maintain their academic functioning. In the short term you may see an actual rise in their grades due to over performing and over functioning, however this is temporary. Many students may use their studies as a distraction to the anguish they are experiencing as a result of their eating disorder.

The effect of malnourishment on **cognition** is depicted in the diagram titled, "Cause and Effects of an Eating Disorder."

What Causes an Eating Disorder?

"An eating disorder goes far beyond food. It's about the person, their values, their beliefs and everything that has made them who they are."

*Brooke Bury,
Youth and Family Counselor, Specializing in
Children and Youth Eating Disorders*

Although there is no single cause for developing an eating disorder, there are a number of factors which put a student at risk. Biological, psychological and social/cultural aspects all need to be taken into account in order to understand the complexities surrounding an eating disorder. Some of these factors may overlap.

The following is considered in **the formulation of a treatment plan; by the medical/psychological team** in the Eating Disorders Program at BC Children's Hospital.

Predisposing factors may include family history and genetics.

Precipitating factors may include bullying or turmoil within the family.

Perpetuating factors, such as ongoing discord

within the family, may maintain the symptoms of the eating disorder.

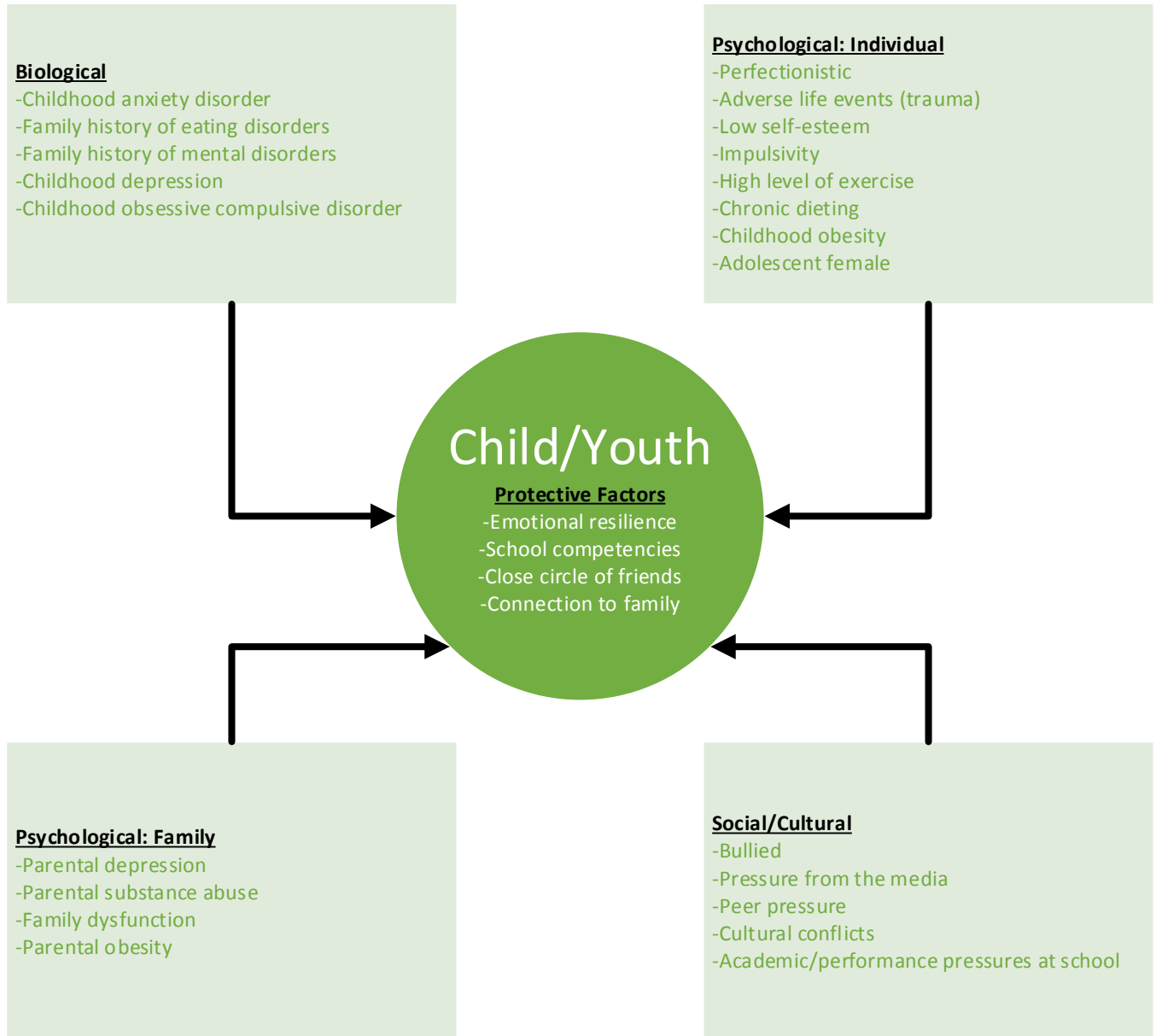
However, there are also positive factors that support resilience and recovery. Examples of **Protective factors** are a strong social network at school and having a supportive family.

"Eating disorders, like most mental health issues, have biological, psycho-social and spiritual components all of which need to be addressed therapeutically. "

*Wieslawa Kastelik, MA, MSW
Family Therapist-Social Worker
Specializing in the Field of Eating Disorders*
The following material is for your interest and



Formulation Factors for Diagnosing an Eating Disorder



information only. The diagnosis of an eating disorder must be left to the medical professionals, psychologists and qualified health care professionals. It is not the role or responsibility of teachers, counselors, or any other school personnel to diagnose whether or not a student has an eating disorder.

Early Identification Is Essential To Recovery

“Youth often keep eating disorders a secret from parents, so teachers, counselors, or other students often see the symptoms of an eating disorder before parents do. Research shows that early detection, treatment, and involvement of parents are important factors in recovery. Voice any concerns you have to parents—do not assume that they already know.”

*Tom Bauslaugh
Youth and Family Clinical Resource Educator,
Specializing in Counseling Children and
Youth diagnosed with an Eating Disorder
and their Families*

Although the diagnosis of an eating disorder must be left to the medical/psychological professionals, teachers, counselors and other school professionals have proven invaluable as early identifiers, in some cases intervening even before families. **Early identification** is of the utmost importance. The longer the delay in identification, the more difficult and prolonged the treatment, the greater will be the risk to the overall health of your students. A clear, quick school process of intervention becomes a protective factor to your student’s well-being. Please see the Intervention section of the guide.

Many children and teens have disordered eating patterns which must be distinguished from an eating disorder. Many children skip meals, are hooked on so-called junk foods, eat an excessive amount of snack foods and unconventional meals. Many adolescents engage in dieting techniques that can seem

dangerously similar to that of an eating disorder. They may count calories, smoke to curb their appetites, and even experiment with self-induced vomiting. These behaviors are risky.

“However, not all adolescents with disordered eating develop a diagnosable eating disorder”, according to Dr. Ron Manley.

Below are two illustrative examples demonstrating **risk factors** and **protective factors**. Keep in mind that every eating disorder starts with dieting or some form of caloric restriction.



Illustrative Example: Amber

Amber is a 15-year-old student at your school. She is involved in school activities and does well academically. Amber has made it known to all her friends that she wants to get in shape and get really healthy in time for the spring dance. She’s already picked out her dress and she wants to lose at least 10 pounds or two dress sizes in the next two weeks. She has started skipping lunch, counting calories, and some of her friends have become aware that she has cut all meat and dairy out of her diet. She is working out every day, by herself. You have even heard through the grapevine that she is using laxatives and has

started smoking to control her weight. You see her sitting in the school cafeteria eating salad and fruit, while her friends are eating pizza and hamburgers. She and her friends are all honour roll students.

At the spring dance you notice that Amber has lost a considerable amount of weight. She is dancing and having fun with her friends. The next day in class you overhear her telling her best friends that she will do whatever it takes to keep the weight off, even if she has to eat salad and fruit for the rest of her natural life. She then makes a face, starts laughing and heads off to the school store where she and her friends volunteer after school.

Amber is at risk for developing an eating disorder. Her behaviours are troubling. These concerns need to be brought to her attention quickly, in private and with compassion. Who will do that may vary depending on which staff member has a connection with her. It may be you, the counselor or another adult in the building. The point is that it must be done without delay and without being judgmental. For more information on this topic, see the **Do's and Don'ts of talking to a student who you suspect may have an eating disorder.**

“Eating disorders can happen to both females and males. This is not just a female disorder. Teachers are with the kids six hours a day, five days a week. As far as I’m concerned, they have such a high impact on their lives and well-being.”

Amy Pezzente, BHK, MPT-Eating Disorders Peer Counselor., and Provincial Eating Disorder Awareness Campaign Coordinator

Amber’s risk factors:

- Female: her chances of having an eating disorder are greater than if she

were male

- Dieting: every eating disorder starts with caloric restriction
- Smoking to curb appetite
- Laxative use
- Dramatically altering her food choices
- Possible over-performing academically

Amber also has important protective factors which work in her favor:

- A good circle of friends, interpersonal connection
- A volunteer job at school (School Connectedness: the second strongest protective factor after a healthy functioning family, according to the McCreary Report, 2011)
- Good attendance at school

Remember, despite these protective factors you will still need to speak with her as many students with eating disorders exhibit these behaviours. She may attempt to convince you that she is not at risk. Her situation merits deeper investigation, which will likely initially take place with the school counselor.

What are some strategies for approaching Amber’s case?

Illustrative Example: Sam

Sam is your school’s star male athlete. He is on the track and field team and is committed to his training. He shows up at school 3 times a week at 7:30am for the Extreme Morning Workout Club. Sam was very close to his physical education teacher, Mr. Fromme, who also used to coach him in track 4 days a week after school. Since Mr. Fromme transferred to another school



mid-year, Sam has been extremely depressed.

In spite of his high performance as an athlete, Sam just really isn't that popular with the other kids. He is bullied from time to time by the larger boys in his class who call him 'gay' since he came out last term. He doesn't seem to have any close friends except for one or two teammates. Sam is good at ignoring the bullying. His whole life is sports. He doesn't connect or relate to the other gay youth at school. As usual Sam is sitting by himself in the school cafeteria in layers of baggy sweats. He has a whole pizza in front of him and a litre of water. He carefully removes the sliced black olives from his pizza, stacking them ever so neatly on his paper plate. You marvel at his sense of balance and his huge appetite. He can really eat considering how lean he is. Except for the fact that Sam is an athlete you have often thought that he is much too thin for such a tall boy. You reassure yourself that he's just fine. After all he is an athlete and he's supposed to be thin because that's what his sport of choice requires of him. His leanness gives him a performance advantage, right?

You are glad to see him in class after lunch. He has missed a lot of school, but you become annoyed when he asks three times to use the washroom in a 40-minute period. What's up with that kid anyway? It's the third bottle of water he's consumed since the start of the period. As he sips more water you notice that Sam wraps his hand around his wrists. He does

that several times. He then uses the index fingers on both hands to seemingly take a measurement of his upper thigh area.

Sam is always on the go. You understand he's got energy to burn so you allow him to stand at the back of the room to stretch his legs out from time to time. On those occasions you notice him admiring himself in the windows at the back of the class. Clearly that kid has no self-esteem issues. Or does he?

"Just like any physical illness, eating disorders are not a choice. Students need mentors, support and environments free from blame or guilt in order to heal from their eating disorder."

*Aidan Scott
Founder and Executive Director of
Speakbox*

Some of his risk factors are listed below:

- He has lost his coach. Often athletes have an emotional bond to their coaches. Coaches may even play the role of a surrogate parent. This loss represents a risk factor for Sam
- He is or at least seems to be depressed
- He is bullied
- He is socially isolated
- He drinks an inordinate amount of water
- He is a track star. This is a risk factor due to stereotypes surrounding his sport and what a runner's body should look like (lean)
- He misses a lot of school
- He is body checking by measuring his wrists and thighs and checking out his reflection in the window at the back of the classroom, i.e., mirror gazing

His protective factors are few:

Although his participation in the track and field team comes with risks it is also an important protective factor. It connects him to school and potentially his teammates.

Sam will also need to have someone speak with him about these risk factors in exactly the same way as Amber. Neither one of these students may have an eating disorder at this point. It is clear, however, that they are both at risk.

Other indicators which school personnel should be aware of in identifying the possibility of an eating disorder include, but are not limited to:

- Mood swings
- Obsessive and ritualistic behaviors around food
- Perfectionism
- Social isolation
- Depression
- Constant trips to the washroom
- A preoccupation with body image and weight
- A preoccupation with body-checking behaviours such as mirror gazing
- Trouble with school, e.g. attendance and grades

Keep in mind that some students do experience a spike in their academic performance at early onset. This is noted in athletic performance as well. This improvement in performance is temporary. Eventually, as the eating disorder deepens, there will be a noticeable decline because lack of proper nutrition will inevitably take its toll on cognitive function.



Other symptoms generally include:

- Difficulty sitting (restlessness)
- Excessive water and tea consumption
- Wanting to eat alone
- Pale or sickly pallor
- Baggy clothes
- A recent convert to vegetarianism, veganism or any other kind of diet related “isms.”
- Light headedness and a tendency to fall (lack of balance)
- Weight loss
- Low self-esteem
- Poor body image
- Exercising in secret
- Depression
- Wearing inappropriate clothing for the season (e.g. heavy clothing in the summer).

Intervention

“I think one of the most important things for school personnel to know is that to best promote the recovery of these youth, a team approach is essential (the team being parents, educators, mental health professionals, and of course, the youth). Each member of the team must remain vigilant against the eating disorder symptoms creeping back into the youth’s life, and be prepared to respond quickly to circumvent their destructive effects.”

*Karen Dixon, MSW, RSW, Social Worker,
Specializing in the field of Eating Disorders*

Once a student is suspected of being at risk for developing an eating disorder, it is vital that **immediate steps are taken to intervene**. As stated in Amber’s example, the first step is to identify someone at school who has a connection or a relationship with the student. Counselors are often the person selected to

take on this role. However, **all school staff members** have the capacity to be the one expressing their concerns to the student at risk. Once you have determined that you will be the early intervener and before contact is made with the student, you should have clear discussion goals in mind. The following points will give you some ideas of how best to approach your conversation with the student.

It is important in the initial conversation not to be judgmental. Express concern for the student's overall well-being and show compassion, warmth and caring. **Listen** in order to gain an understanding of the student. **The purpose is not to convince the student that they have a problem or to make a diagnosis. It is simply to initiate the intervention.** Initiating this intervention does not obligate you to be involved any further.

Before approaching the topic with the student, you need to be prepared that they may react in anger, shut down and refuse to talk, or deny that there is anything wrong. They may even try to convince **you** that you are **overreacting**. They may attempt to persuade you that they have everything under



control. If the student is **not** willing to engage, listen, or want to see you again, **do not** push the issue. Acknowledge their discomfort, but do let the student know that you will be bringing your conversation forward to the school team. As you approach the topic, keep in mind the following tips.

Tips

- Express your concerns about their overall health and well-being in clear and simple language.

"I noticed you have not been hanging out with your friends as much lately and appear to be somewhat withdrawn."

"You appear to be quite tired lately and your energy level seems to be lower than usual."

- After sharing your concerns, **give the student the opportunity to absorb and process your comments.**

"I know this is a lot of information. I'm going to pause for a moment to let you take this all in."

- Reassure them that they have done nothing wrong and emphasize that you are not judging them.

"You are not in trouble. I may come across as if I am judging you, but I am simply concerned about you."

- Ask for their thoughts, feelings and reactions.

"How do you feel about what I've said today?"

"Have you noticed any of the changes I've shared with you today?"

- **LISTEN, LISTEN, and LISTEN!**

- If the student discloses to you that they are on a new diet to "lose a few pounds" **only then** do you begin an open and honest dialogue about weight, shape and eating and recommend a visit with the school nurse or doctor.

"What changes have you made to your eating lately?"

"How satisfied are you with your current weight and shape?"

"How much do you worry about what you eat?"

- Even if the student does not disclose any problems concerning their loss of weight, still recommend a visit with the school nurse or doctor.
- After the student shares their thoughts

"I am angry that I starved my brain and that I sat shivering in my bed at night instead of dancing or reading poetry or eating ice cream or kissing a boy..."

*Laurie Halse Anderson
Winternights*



with you, explain to the student that you are obliged to inform their parents and the school team about your concerns.

Practices to avoid

- Over-simplifying the seriousness of the situation.

“All you have to do is start eating and accepting yourself.”

- Being judgmental.

“What you are doing to your body is not only harmful but stupid as well. You should know better.”

- Commenting on weight or appearance. The eating disorder will manipulate such comments to its benefit.

“You are looking rather thin lately. Are you ok?” *The eating disorder will in turn trick the student into believing,* **“My counselor/teacher noticed I’ve been losing weight, I need to lose even more now.”**

“You’ve put on some weight. You look great!” *The eating disorder will in turn trick the student into believing,* **“Even my teacher thinks I’m BIG and FAT.”**

“You look terrible lately. What’s up?” *Negative comments given to a person that is already obsessed with their body is not helpful.*

“You look so healthy now! You were simply too thin before.” *Although the student may in fact be and look healthier, comments like that will only reaffirm their distorted belief that they are indeed, gaining weight and getting FAT.*

- Attempting a diagnosis. Telling the

student you think they have an eating disorder. The student will likely misinterpret your comment as:

“Even my counselor/teacher thinks I am a bad person.”

“My counselor/teacher must think that I am doing this for attention.”

“I bet my counselor/teacher thinks that I am shallow.”

- Refrain from giving advice on weight loss, exercise or appearance.

“I know another diet that is much healthier for you.”

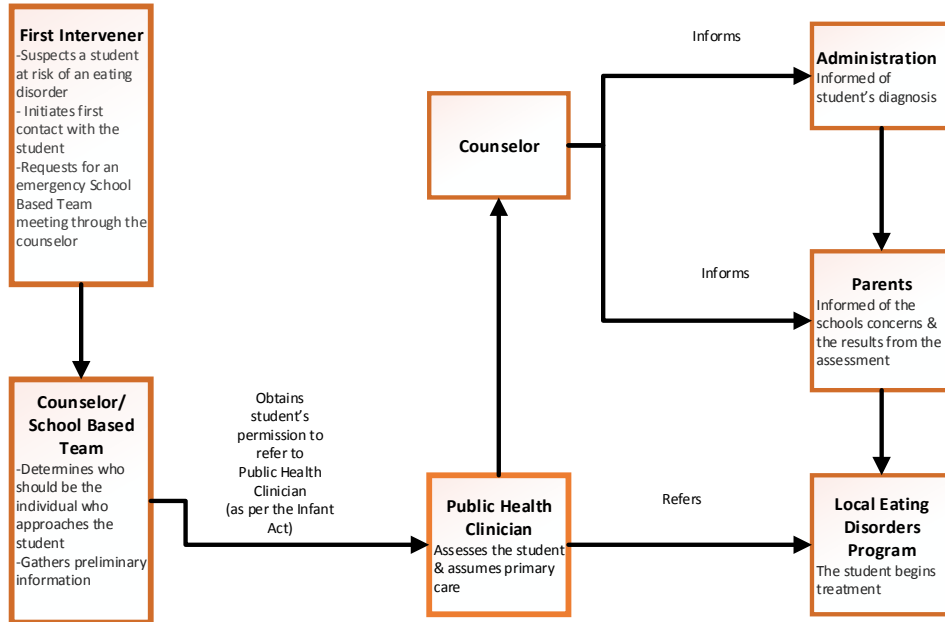
- Speak to the student individually. In a group setting, the student may feel attacked, cornered or embarrassed.
- You are not the student’s therapist or confidante. Explain you cannot keep this a secret.
- Avoid arguing with the student if they deny that there is anything wrong.

It is important to note that the steps taken to intervene may vary from school to school, district to district and also between elementary and secondary. If your school has a protocol in place it is important to evaluate it based on your new knowledge. If your school does not have a protocol in place, consider developing one with your colleagues and implement it as a school-wide staff policy. **A good intervention protocol becomes a protective factor for student health.**

Consider how the Infant Act and the Mental Health Act intersect with the School Act with an emphasis on confidentiality and the autonomy of the student (www.bclaws.ca will take you to all three Acts).

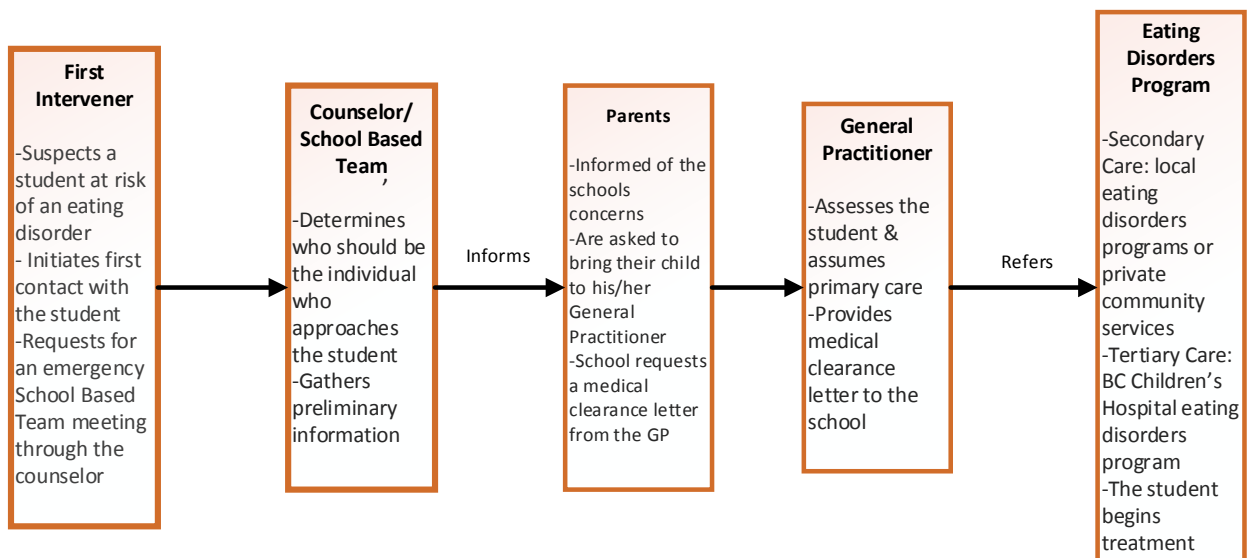
Intervention Protocols

Sample #1



Intervention Protocols

Sample #2



“If you suspect that a student is struggling with any mental health issues (especially eating disorders), please take the appropriate steps to engage & ensure that this student and yourself are aware of resources available to them in your local area & provincially (e.g. Kelty Mental Resource Centre).”

Shirley Jones, R.N. Specializing in the field of Eating Disorders

Treatment

“Like everyone, people recovering from eating disorders want to be seen and re-

spected for who they are, not a diagnosis. Knowing support and care are available if needed when transitioning back and continuing school goes a long way. ”

Dr. Lucinda Kunkel

Psychiatrist, Specializing in Children and Youth Eating Disorders

Supporting Your Student’s Journey

If a student faints or appears to be in medical distress, CALL 911. **DO NOT call and ask the parents to pick up their child/youth and bring them to the doctor or to emergency**, it may be too late. Chances are the student requires immediate care by a physician. **Contact the parents as you are assisting the student in medical distress.**

Students receiving **secondary care** for an eating disorder will periodically miss school to attend medical appointments. This will necessitate a great deal of flexibility on the part of teachers.

For students presently receiving **tertiary care** from the Eating Disorders Inpatient Program at BC Children’s Hospital, or returning from the program, this level of flexibility is even more important. Eating disorders are a life-threatening condition and **“full recovery is the primary**

goal, which must take priority over educational goals” (Ministry of Education, Volume 1, Eating Disorders, 2000). The student’s time in the Inpatient Eating Disorders Program has facilitated only an **interruption** of their eating disorder. This is called **symptom interruption**. The student is by no means **cured**. A student returns to their local medical team upon discharge to continue with treatment. A student may be involved with their local medical team for some time. Recovery from an eating disorder can be a **lifelong journey**.

Since the student has been absent for a significant period of time, it is important to ensure as much normalcy as possible when returning to school. “Though **educational** expectations of teachers may shift, **behavioural** expectations should not. A student with an eating disorder should be able to meet the same standards of behaviour as other students in the class,” (Ministry of Education, Volume 1, Eating Disorders, 2000). To make an exception for this student by ignoring behaviours, such as trips to the washroom outside the normal frequency, and unnecessary movement in the room, would work against the effort to ‘normalize’ the classroom environment. A culture of clear and consistent expectations and responses in your classroom is not punitive, rather it reflects logical and natural consequences and is characterized by a compassionate/trauma informed practice.

The effects of poor nutrition may have also impaired the student’s cognitive functioning and ability to concentrate on schoolwork. This will likely have been evident prior to their admission to a treatment program and may still be in evidence upon discharge.

When receiving treatment as an outpatient or when a student returns from an intensive treatment program, the following are some recommendations that address the academic, social and emotional supports that will be needed. Many of these recommendations are already practiced by teachers and school staffs.

Academic Recommendations:

- It is recommended that teachers modify the expectations for missed schoolwork by making the student responsible for only the **essential learning outcomes**.
- Encourage the student to let their teachers know in advance about absences due to medical appointments so that accommodations can be made with the student's workload and/or deadlines.
- There may be emotional fatigue associated with the student's treatment. This will necessitate flexibility and compassion on the part of the subject teacher in extending deadlines and adapting assignments.
- Avoid exposing the student to curriculum content, activities, and discussions that draw attention to weight or body image as this may trigger eating disordered thoughts.

Social/Emotional Recommendations:

- Be aware that low self-esteem is often a problem for those with eating disorders. Do not make comments or comparisons about appearance or academic achievement. Even positive comments can trigger eating disordered thinking. Also, avoid self-deprecating remarks, even in jest.
- The student may need to have regular appointments to 'check in' with the counselor. This provides the student the opportunity to review how things are going on a regular basis and to access the support and help they need. Regular set appointments help reduce anxiety.
- Be aware that the student may have experienced bullying at school in the

past. Proactive measures are required in order to prevent future bullying.



- The student may benefit from having some non-academic based activities within the school (e.g., chess club) to provide a more rounded experience. This will help them achieve more balance and school connectedness. A discussion on the importance of school connectedness can be found under the prevention section of this guide.
- The student may need extra time for nutrition or snack breaks. Counselors should make arrangements for longer times if that is needed. In the initial weeks back at school, the student will need supervision at lunch time. Consult parents about supporting their child or youth.
- School personnel will need specialized meal support training if supporting a student at lunch time. Food is medicine. Children and youth who are unable to eat at school should not be at school, according to some experts.

Recommendations for School Based Team:

- Decide whether or not the School Based Team will apply for a Ministry

Designation (e.g. categorical funding H). If the decision is made to apply obtain a Letter of Diagnosis from the treating Psychiatrist.

- The Individual Educational Plan (IEP) should be written as soon as possible once the student returns to school. IEP planning should be informed by a diagnosis made by a qualified mental health clinician, the student's medical information, as well as information outlined in Section E5 of the Special Education Manual of Policies, Procedures and Guidelines (www.bced.gov.bc.ca).
- Identify people on the school staff or in the school district who can serve as part of the student's support team (e.g. Counselors, Resource Teachers, Subject Teachers and Administrators)

the McCreary Centre hosted a BCTF workshop in partnership with the BC Teachers Promoting Mental Health in Schools. Listed are six internationally embraced overarching strategies for promoting connectedness to school as indicated by Dr. Saewyc's research. Under each strategy is a sampling of ideas suggested as good practice by the teachers who were in attendance.

Strategy #1: Create decision-making processes that facilitate student, family, and community engagement; academic achievement; and staff empowerment.

- "Student led parent teacher conferences."
- "Give students and all school personnel an opportunity to provide input to improve school climate."
- Empower students

Prevention

Building a Culture of Connection and Inclusion at School:

Discussion of prevention necessitates an examination of school connectedness. It is an important protective factor in the general mental health of not only those with eating disorders, but of the entire school community. Consider the following statement:

"Given that children and youth spend more than six hours daily and over 180 days a year in school, the educational context provides key opportunities for delivering activities and comprehensive initiatives related to positive mental health. As children move into their early and later teen years, schools may play an even greater role than the home context in influencing youth, given the powerful influence that teachers, support and peer networks have within the education settings." (Stewart, 2008; Stewart et al, 2004)

In the spring of 2011, Dr. Elizabeth Saewyc of



Strategy #2: Provide education and opportunities to enable families to be actively involved in their children's academic and school life.

- "Many schools plant a community garden. They utilize the food grown in the school lunch menu. Encourage students and their families to tend the garden."
- "Welcome parents into the schools to run homework clubs and other after school activities."

Strategy #3: Support students to develop academic, emotional, and social skills necessary to be actively engaged in school.

- “Implement the ‘Worry Dragon Program’ and the ‘Mind Up Program’.”
- “Districts to provide workers in each school to specifically support students with mental health needs, such as the ‘Choices Program’ in the North Vancouver School District.”
- “Provide Gay/Lesbian support groups.”

Strategy #4: Use effective classroom management and teaching methods to foster a positive learning environment.

- “Create ‘rituals’ that will give students opportunities to touch base with an adult on a daily basis.
- Provide clear expectations

Strategy # 5: Provide professional development and support for teachers and other school staff to enable them to meet the diverse cognitive, emotional and social needs of children and adolescents.

- “Develop more in-depth opportunities for learning about specific mental health topics such as eating disorders.”
- “Provide Professional Development opportunities on how to create a positive school culture.”

Strategy # 6: Create trusting and caring relationships that promote open communication among administrators, teachers, staff, students, families, and communities.

- “Schools should adopt an ‘Open Door’ or ‘No Wrong Door Policy’ for all their staff members. A student should be able to go to any adult in the building and be referred as needed.”

Specific Prevention Strategies for Eating Disorders:

- Be a good role model. Do not talk about your latest diet or criticize your own body in front of your students.
- All body types should be represented in the culture of the school. Be aware of images posted in hallways and classrooms. Do not tolerate teasing of any kind around body type. Teasing for any reason is unacceptable. Many schools have developed a school wide zero tolerance policy already.
- Examine the amount of time allotted for eating at your school. How long



does your school allow for eating at lunch time? Are students overbooked at lunch time with clubs and sports activities? Some schools have cancelled lunch on Fridays to accommodate a 1:30pm early dismissal time. Evaluate this practice at your school if that is the case.

- “Teach about mindful exercise NOT mindless exercise.” Use caution when naming your sports club activities. For example, naming your club ‘Early Morning Extreme Blast Workout Club’ sends the wrong message. Name it

instead something more neutral like, 'Early Morning Health Club'.

- Never expect the student athlete to lose weight. According to the literature, this is not appropriate for any athlete at any age.
- Develop workshops and/or print materials in a number of different languages for parents.
- **Professional development** must be available to teachers expected to teach material based on nutrition and eating disorders in various aspects of the curriculum. For example, the topic of eating disorders is part of the grade 12 English curriculum. **Teachers need the benefit of professional development.** We cannot stress this enough. While the teaching of eating disorders is presented as an 'option', many teachers do not have the adequate professional development to address the subject without potentially triggering their students. Many of our students in our Inpatient Eating Disorders Program at BC Children's Hospital tell us that their eating disorder was triggered by learning at school about cutting out junk food and starting an exercise regime. Primary and intermediate curricula teach topics around food and exercise. Professional development will help teachers identify those students

who may be triggered during the presentation of such material.

- Show compassion in your educational practices. Emphasize cooperation over competition in the culture of your classroom and your school.
- Implement trauma informed practices in your classroom (resource to be found at the back of the guide).

Eating Disorders and the Very Young

We know from our patients/students that many eating disordered thoughts and behaviours start in the elementary school years. We also have many requests from elementary school teachers for professional development aimed at this age group. Early awareness and intervention is critical.

Although eating disorders are considered rare in elementary school aged students, a disturbing rise of anorexia in this age group has been noted. Many young children are picky about what they eat and it is often difficult to recognize when a young child progresses from disordered eating into having an eating disorder. According to the National Eating Disorders Association (NEDA), by age 6, girls are concerned about their weight or shape. A full 40-60% of elementary aged girls worry about becoming too fat (Smolak, 2011).



Young children at risk for developing an eating disorder mirror their adolescent counterparts in that they are highly anxious, are perfectionists and may have obsessive compulsive personalities. The effects of an eating disorder on a young child's body are equally as devastating as that for adolescents. Risk to organ health, the nervous system and the development of the brain are a huge concern in the very young. Brain shrinkage resulting from an eating disorder can lead to developmental delays in children and youth, a devastating effect.

Childhood obesity is on the rise in North America and many young children are being put on diets as early as grade one by well-meaning parents. However, starting a child on a diet too early can trigger obsessive feelings about food and this can be the beginning of a slide into a full-blown eating disorder.

Schools, the media and concerned families are using education to combat childhood obesity trends. Once again the 'good food/bad food' paradigm is interpreted in black and white terms by the highly anxious, perfectionist child who strives to please teachers and parents by never eating "bad food". A better solution to the problem of childhood obesity is to allow for more physical activity and more outdoor playtime. Professional development on the topic of eating disorders is needed for both elementary and secondary teachers.

Kelty Mental Health Resource Centre

www.keltymentalhealth.ca

A provincial information centre that helps BC children, youth and their families find resources dealing with mental health and substance use issues.

Looking Glass Foundation's Online Service

www.lookingglass.umeetsupport.com

An online support group for adolescents aged 16 years and over who have an eating disorder or are experiencing difficulties with food.

Something Fishy

www.something-fishy.org

Offers background information and support for families and teens dealing with eating disorders.

Body Image Health

www.bodyimagehealth.org

Provides a model for healthy body image and curriculum materials for grades 4-6. Lesson concepts and activities can however, be adapted for any age group.

Healthy Buddies

www.healthybuddies.ca/index.htm

A program designed for Elementary School children encouraging positive attitudes towards physical activity, nutrition, and mental health.

Additional Resources

Mindcheck

www.mindcheck.ca

Offers youth and young adults the ability to assess their mental health status.

Jessie's Legacy Eating Disorder Prevention Program, Family Services of North Shore

www.familyservices.bc.ca/professionals-a-educators/jessiess-legacy

Provides eating disorders prevention education, resources and support for BC youth, families, educators and professionals.



Special Education Services: A Manual of Policies, Procedures and Guidelines

www.bced.gov.bc.ca

A manual that will aid in the development of services for special needs students.

Brave Girl Eating: A Family's Struggle with Anorexia, by Harriet Brown, 2010.

"I'm, Like, SO Fat!" Helping your teen make healthy choices about eating and exercise in a weight-obsessed world, by Dianne Neumark-Sztainer, 2005.

"Intervention in School and Clinic", by Heidi Rickson, Dr. Ron Manley and Bill Standeven, 2000.

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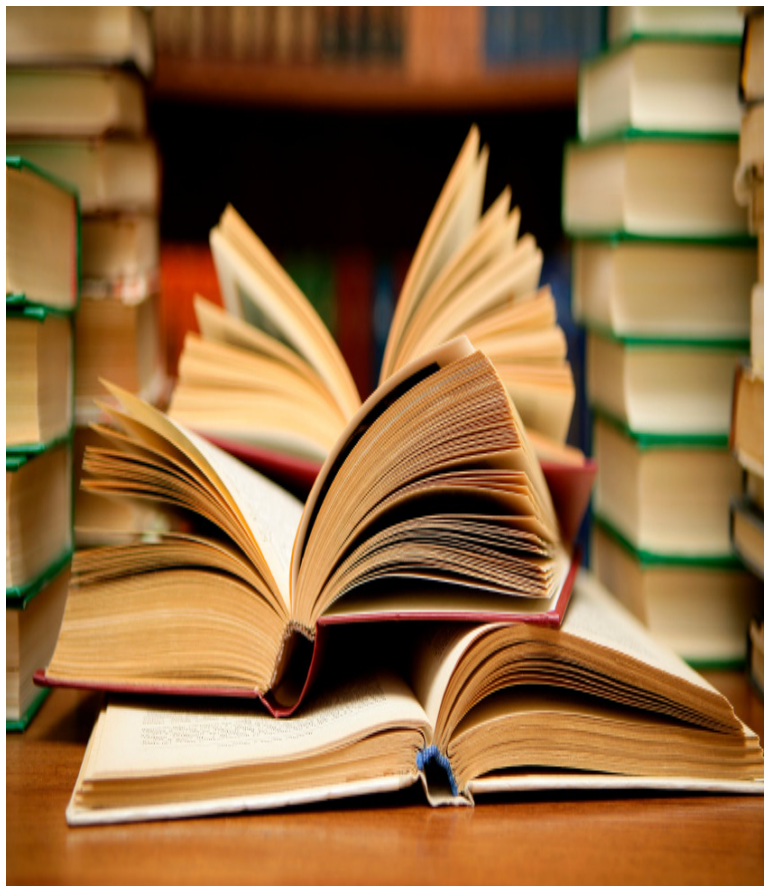
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Notes

Notes

