Eating Difficulties

Understanding eating disorders

An eating disorder is an unhealthy obsession with food and weight. People with eating disorders eat, or avoid eating, in extreme ways. Eating disorders can affect anyone regardless of their age, gender and race.

There are 3 main types of eating disorders; Bulimia Nervosa, Anorexia Nervosa and Binge-eating disorder.

Experts don't truly understand what causes eating disorders. Social pressure to fit a certain ideal body shape and weight may play a role. Other causes may include personal stress and possibly certain personality traits. Fortunately you can take steps to help prevent eating disorders, both before the first symptoms appear or in the early stages.

Programs that teach children and adults about healthy eating habits and a healthy body weight are one prevention method. It's also helpful to understand that society's pressures about body weight are

Bulimia Nervosa

Bulimia nervosa is an eating disorder. It's also called bulimia. A child with bulimia overeats or binges uncontrollably. This overeating may be followed by self-induced throwing up (purging).

A child who binges eats much larger amounts of food than would normally be eaten within a short period of time (often less than 2 hours). The binges happen at least twice a week for 3 months. They may happen as often as several times a day.

Bulimia has two types:

- Purging type: A child with this type regularly binges and then causes him/herself to throw up. Or the child may misuse laxatives, diuretics, enemas, or other medicines that clear the bowels.
- Non-purging type: Instead of purging after binging, a child with this type uses other inappropriate behaviours to control weight. He or she may fast or exercise too much.

Researchers don't know what causes bulimia, however there may be things that lead to it e.g., cultural ideals and social attitudes about body appearance, self-evaluation based on body weight and shape and family problems.

Most children with bulimia are girls in their teens. Research shows that they mainly are within a high socioeconomic group. They may also have other mental health problems such as anxiety or mood disorders. Children with bulimia are more likely to come from families with a history of:

- Eating disorders
- Physical illness
- Other mental health problems e.g., mood disorders or substance abuse.

Symptoms

Each young person may have different symptoms. Most common symptoms are:

- Usually a normal or low body weight but sees him/herself as weighting too much
- Repeated episodes of binge eating, often in secret
- Fear of not being able to stop eating while bingeing
- Self-induces throwing up, often in secret
- Excessive exercise or fasting
- Strange eating habits or rituals
- Overachieving behaviours
- Scarring on the back of the fingers for self-
- Improper use of laxatives, diuretics or other medicines to clear the bowels
- In girls, irregular periods or no period at all
- Anxiety
- Discouragement because he/she is not satisfied with their appearance
- Depression
- Obsession with food, weight and body shape

Anorexia Nervosa

Anorexia Nervosa is an eating disorder which is a form of self-starvation. Children and teens with this health problem have a distorted body image. They think that they weigh too much. This means that they severely restrict how much food they eat. Any other behaviour they will stop them from gaining weight will also be present.

Anorexia has two types:

- Restrictor type: Young people with this type severely limit how much food they eat. This often includes food high in carbohydrates and fat.
- Bulimic (binging and purging) type: Young people with bulimia eat too much food (binge) and then make themselves throw up. They may also take large amounts of laxatives or other medicines that clear out the intestines.

Experts are not clear on what causes anorexia nervosa. Most of the time it starts as regular dieting, however it slowly changes to extreme and unhealthy weight loss. They may also be other things that may lead to anorexia nervosa e.g:

- Social attitudes towards body appearance,
- Family influences
- Genetics
- Brain chemical imbalances
- Developmental issues

Research indicates that most children with anorexia are girls; however that is changing as more boys are being diagnosed with the disorder. The disorder was first seen in higher and middle socioeconomic groups. But it is now found in all socioeconomic groups and in many ethnic and racial groups. Young people with anorexia are more likely to come from families with a history of:

- Weight problems
- Eating difficulties

Children with anorexia often come from families that are very rigid and critical. Parents may be intrusive and overprotective. Children with anorexia may be dependent and emotionally immature. They are also likely to cut themselves off from other. They may have other mental health problems such as anxiety and mood disorders.

Symptoms

Each young person may have different symptoms. Most common symptoms are:

- Have low body weight
- Fear of becoming obese, even as he/she is losing weight
- Have a distorted view of his/hers body eight, size or shape e.g., the individual sees his/her own body as too fat, even when very underweight
- Refuse to stay at the minimum normal body weight
- In girls, miss 3 menstrual periods without some other cause
- Do a lot of physical activity to help speed up weight loss
- Deny feeling hungry
- Be obsessed with making food
- Have abnormal eating behaviours
- Very dry skin (when pinched and let go, it stays pinched)
- Fluid loss (dehydration)
- Constipation
- Lethargy
- Dizziness
- Extreme tiredness (fatigue)
- Sensitivity to cold temperatures
- Being abnormally thin (emaciated)
- Growth of fine, downy body hair (lanugo)
- Yellowing of te skin

Possible complications of anorexia

Anorexia can harm nearly every organ system in the body and can be fatal. It can lead to health problems with the following:

- **Heart:** Damage to the heart can happen because of malnutrition or repeated vomiting. A child may have a slow, fast, or irregular heartbeat. He or she may also have low blood pressure.
- **Blood:** About 1 in 3 children with anorexia have a low red blood cell count (mild anaemia). About half of children with this health problem have a low white blood cell count (leukopenia).
- **Digestive tract**: Normal movement in the intestinal tract often slows down with very restricted eating and severe weight loss. Gaining weight and taking some medicines can help fix it.
- **Kidneys:** Fluid loss (dehydration) from anorexia may lead to highly concentrated urine. Your child may also make more urine. This may happen when the kidneys' ability to concentrate urine is impaired. Kidney changes often return to normal when your child is back to normal weight.
- **Endocrine System:** In girls, a lack of menstrual periods is one of the hallmark symptoms of anorexia. It often happens before severe weight loss. It may continue after normal weight is restored. Lower levels of growth hormones are also sometimes found in teens with anorexia. This may explain the delayed growth sometimes seen in children with anorexia. Normal eating habits often restore normal growth.

- **Bones:** Children with anorexia are at a greater risk for broken bones. When anorexic symptoms start before peak bone formation has been reached (most often mid to late teens), there is a greater risk for decreased bone tissue or bone loss. Bone density is often found to be low in girls with anorexia. They may not get enough calcium in their diet or absorb enough of it

Binge-Eating Disorder

This is also known as compulsive overeating. People who are binge eaters eat excessive amounts of food without purging. They often eat uncontrollably despite feeling full. They may feel guilty or ashamed after a binge. They then go on an extreme diet as a result. People who compulsively eat may be of normal weight, overweight, or obese. Anorexia and bulimia aren't common in men. But binge-eating disorder does affect about as many men as it does women.

Most experts believe that it takes a combination of things to develop an eating disorder — including a person's genes, emotions, and behaviours (such as eating patterns) learned during childhood.

Some people may be more prone to overeating for biological reasons. For example, the hypothalamus (the part of the brain that controls appetite) may fail to send proper messages about hunger and fullness. And serotonin, a normal brain chemical that affects mood and some compulsive behaviours, may also play a role in binge eating.

In most cases, the unhealthy overeating habits that develop into binge eating start during childhood. These habits might be a result of eating behaviours learned in the family.

It's normal to associate food with nurturing and love, but sometimes food is used too much as a way to soothe or comfort. When this is the case, kids may grow up with a habit of overeating to soothe themselves when they feel pressured. They do this because they may not have learned other ways to deal with stress.

Some kids may grow up believing that unhappy or upsetting feelings should be suppressed and may use food to quiet these emotions. Some people feel that the amount they eat is the only thing they have control over when life seems difficult or traumatic.

Symptoms

- Binge eat at least once a week for 3 months
- Eating much more quickly than other people do
- Eating until they feel uncomfortably full
- Eating large amounts of food even when they are not physically hungry

Avoidant Restrictive Food Intake Disorder (ARFID)

Avoidant Restrictive Food Intake Disorder (ARFID) is a new diagnosis in the DSM-5, and was previously referred to as "Selective Eating Disorder." ARFID is similar to anorexia in that both disorders involve limitations in the amount and/or types of food consumed, but unlike anorexia, ARFID does not involve any distress about body shape or size, or fears of fatness.

Although many children go through phases of picky or selective eating, a person with ARFID does not consume enough calories to grow and develop properly and, in adults, to maintain basic body function. In children, this results in stalled weight gain and vertical growth; in adults, this results in weight loss. ARFID can also result in problems at school or work, due to difficulties eating with others and extended times needed to eat.

Symptoms

Behavioural and Psychological

- Dramatic weight loss
- Dresses in layers to hide weight loss or stay warm
- Reports constipation, abdominal pain, cold intolerance, lethargy and/or excess energy
- Reports consistent upset stomach, feeling full etc. around mealtimes that have no known cause
- Dramatic restriction in types or amount of food eaten
- Will only eat certain textures of food
- Fears of choking or vomiting
- Lack of appetite or interest in food
- Limited range of preferred foods that becomes narrower over time (picky eating that progressively worsens)
- No body image disturbance or fear of weight gain

Physical

Because both anorexia and ARFID involve an inability to meet nutritional needs, both disorders have similar physical signs and medical consequences.

- Stomach cramps, other non-specific gastrointestinal complaints (constipation, acid reflux, etc.)
- Menstrual irregularities—missing periods or only having a period while on hormonal contraceptives (this is not considered a "true" period)
- Difficulties concentrating
- Abnormal laboratory findings (anaemia, low thyroid and hormone levels, low potassium, low blood cell counts, slow heart rate)
- Post puberty female loses menstrual period
- Dizziness
- Fainting/syncope
- Feeling cold all the time
- Sleep problems
- Dry skin
- Dry and brittle nails
- Fine hair on body (lanugo)
- Thinning of hair on head, dry and brittle hair
- Muscle weakness
- Cold, mottled hands and feet or swelling of feet
- Poor wound healing
- Impaired immune functioning

How to help

Staff Awareness	♦ All staff should be given the same basic awareness as the pupils. ♦ I encourage you to use a validated body confidence program so that they too have education on body confidence, on zero-tolerance of weight-shaming, on avoiding fat-talk, and using food-neutral language. ♦ They should know that the school has a policy and a designated member of staff with more expertise. They should make this person aware of any concerns without delay. ♦ The staff members who are most likely to observe behaviours around food or exercise should take the time to read the guidance notes here on signs that a pupil may have an eating disorder. These may include physical education or home economics teachers, and staff who spend time in the dining hall.
Pupil showing signs of eating problem	Tell the pupil that you have concerns, describing one or two particular behaviours you have observed. Say you care for their wellbeing and that you are about to inform their parents. Give them a chance to tell you what's going on, but make sure they understand that you cannot give them confidentiality in this matter. Resist giving any kind of advice, as they may twist it around and this will make treatment harder. You don't need to say you suspect an eating disorder, as this may put you out of your depth when the pupil assures you they are fine. A pupil may not recognise that they have a problem, may think they'll solve it alone, may be ashamed, or may be scared of treatment. Don't be swayed by a pupil's pleas that they'll be fine. The most delightful young people can lie outrageously when they are in the grip of an eating disorder.
Pupil discloses problems with eating	If a pupil tells a staff member about a problem with their eating, your stance should be empathetic as well as action-driven. Show your concern for their wellbeing. A pupil might open up about minor difficulties with eating, without admitting to a much bigger problem. Because eating disorders are secretive, this is an area where you should err on the side of safety and let experts assess what action is or isn't required. Explain that as difficulties with eating can be dangerous, confidentiality doesn't apply. Explain that you will talk to the parents

	so that the pupil gets access to an expert, and it is this expert who will work out what type of the help the pupil does or does not need to be safe and happy. I suggest that at this stage you just use the term 'difficulties with eating' or 'difficulties with your body confidence', with pupils who are not themselves using words like anorexia or bulimia. It's just as true and it means you don't get into an argument about diagnosis.
Dealing with fat talk	If you use a validated program for body confidence, you will learn to recognise negative body talk, or 'fat talk' and you will have strategies to deal with comments on people's weight and appearance. Examples of 'fat talk' or diet talk to be discouraged are: "I'm so fat", "She's so skinny", "I'm so bad, I had a doughnut" "Now I've eaten so much, I must go to the gym" "I'm getting beach-body-ready" "I'm on a diet" "How many calories in this?" "Her tummy sticks out" "He's got a great six-pack" "Tonight we go clubbing and burn calories" Such talk reinforces body dissatisfaction, identifying one's value with one's looks. It creates pressure to force one's body into an unhealthy mould. It contributes to shame among larger pupils or among anyone who thinks they should be thinner. It 'triggers' those battling an eating disorder. Consider size-ism and fat talk to be just as rude, discriminatory and harmful as racism or sexism.
How to help a pupil who is being treated for an eating disorder?	Your school plays an important role during treatment because it provides positives such as: ♦ distraction from the misery of the eating disorder and of treatment ♦ a social life, fun, normality ♦ academic interests, passions and the building of a future For the young person to be able to attend school, you need to provide an environment that is compatible with treatment. Get the following right and you will be part of a pupil's recovery. The converse is that if you don't attend to these, recovery may be extra difficult or impossible: ♦ you make it possible for the pupil to eat as required while in school ♦ you attend to the stress of school work or difficulties with peers

	♦ your school gives helpful messages and avoids harmful ones
Designated Staff Member and their Role	I recommend that your school has one or more designated members of staff who are the go-to people for any issues around eating disorders. It makes sense that they are also in charge of disordered eating, body confidence and obesity. The designated staff member should: ♦ Shape the school's policy and make other members aware of the essentials ♦ Teach other members of staff how to spot signs of an eating disorder ♦ Be a central point of contact for parents, clinicians and other school staff ♦ Coordinate the care of a pupil in collaboration with the pupil, parents and clinicians (setting up meetings, keeping records) ♦ Review what the school is doing in terms of prevention
Teamwork with parents and clinicians	Treating a young person for an eating disorder requires teamwork. Take your lead from those who have the expertise: the parents and the clinicians. One of the roles of the health service is to liaise with schools to provide general information, as well as to discuss the management of an individual's care. You can ask them to train staff members. It can also be especially useful for parents to have direct access to catering staff. Schools sometimes wish all communications to go through a designated teacher, but this can create delays. Most often, parents need quick access to somebody who can tell them what's on the menu, or what their child purchased at lunchtime.
Understand the parents	It's helpful when parents are comfortable with the main person they are to liaise with. If they are not finding it easy to connect with the usual designated teacher, I suggest you appoint someone they can better relate to. Parents appreciate someone whom they can reach easily at short notice, who is efficient and shows respect and empathy. Your non-judgemental, supportive stance will be a breath of fresh air for parents. They are going through an intense time. They fear for their child, they may have put work, play and sleep on hold, their life is all about clinical appointments and supporting meals, and the delightful pupil you see in school may be behaving like a possessed alien at home. On top of that, parents will be surrounded by people who don't understand them.

Confidentiality: Who needs to know?	Until people receive up to date information about eating disorders, they can unwittingly add to a pupil's misery and shame, or they can make unhelpful comments. This could be a reason to limit the number of people in the know. Quite often, once a pupil is receiving treatment, the agreement is that other members will only be informed of the illness on a need-to-know basis. The pupil and parents will let you know of their wishes around confidentiality. What is supportive for one pupil may be awful for another.
Removing unnecessary stressors	The pupil is likely to be in a near-constant state of anxiety and alarm. This leaves little room for extra stressors in school. When the person can't cope with stress they resort to eating disorder behaviours, or some may tip into self-harm, suicidal ideation or even suicide attempts. And during all this time they may still be getting great grades… Discuss with parents what is needed. For instance some young people with an eating disorder have moments of high anxiety, and the parents may give you the information you need to deal with it. One way the school can help is shuffle the composition of various classes so that a pupil is with peers or teachers they feel safe with. I suggest that your school be ready to stretch deadlines. It is not helpful for a pupil to have extra stress about homework when they are also having meltdowns at home because they are made to eat or prevented from bingeing, vomiting or exercising. Pupils may be driven by a strong need to please teachers, so reassure them that a piece of work can wait. You can help a person's recovery by being flexible around some of the rules that normally apply. This will not be for ever, so don't worry about the 'slippery slope' argument. Pupils with an eating disorder are often conscientious and anything but 'soft' on themselves.
Maintaining link with an absent pupil	For young people who are in hospital or who have to stay at home, it is helpful when the school maintains links. In some cases the young person is not in any fit state to study and needs to concentrate on their health. Other times, school work is part of their morale and sense of hope. You might provide study materials or arrange visits from teachers. You could also consult parents and clinicians to see if it would be

	helpful to have peers make some sort of gesture, such as a get-well card. Pupils who have been away usually need a phased return to school. Plan this in collaboration with parents and clinicians.
Any other way the school can help a pupil in treatment	♦ **You can help prevent vomiting** Parents may ask you to supervise that their child doesn't go to the toilet after a snack or lunch. Vomiting is quite an addictive behaviour and it may take some teamwork to stop it. ♦ **You can help prevent bingeing** Likewise parents or clinicians may make specific requests to reduce a pupil's bingeing or other eating disorder behaviours. Such measures are only needed for a while until a particular habit is broken and the pupil moves onto another phase of treatment. ♦ **Deal with bullying, weight teasing, fat shaming** Sometimes an eating disorder begins with a diet triggered by name-calling or bullying. Whether or not you classify an incident as bullying, if it is making the pupil regularly feel unsafe, the eating disorder will be hard to shift. ♦ **You can prevent access to harmful websites** Check that your school's internet system is, as far as possible, blocking access to sites that encourage eating disorders or give tips for self-harm or suicide. For pupils who are in treatment, recovery is difficult when they obsessively consult dieting or 'fitness' websites. Instagram images can be problematic too. The parents may have blocked internet access from their child's phone, and may ask for your collaboration in keeping their child supervised while on the school's internet. ♦ **Do not comment on weight gain** While a pupil is in treatment it's crucial that they regain weight fast. To maintain health they may need to reach a weight that is significantly higher than their previous weight. Weight is not a question of looks — the parents and clinicians will be working on a weight that corresponds to full recovery of the pupil's physical and mental processes. If any of the staff are uncomfortable with the pupil becoming curvy, please remember that this is a health issue. The young person will most likely want to remain much thinner, partly because of the illness and partly because of our society's bias towards thinness. Any well-meaning comment you make on a pupil's increasing weight could jeopardise treatment.

	♦ **Do flag up apparent weight loss** While I recommend you abstain from commenting on weight gain, it is helpful if you flag up weight loss to the parents. It may highlight a blip in treatment or a relapse. It may be obvious to you that a pupil has become thinner (especially after a holiday), but sometimes parents don't see gradual weight loss.
Worry Box	Worry box is a small box which can be decorated with the young person. Ask the young person to write down or draw any of their worries and post them in the box. At the end of the day/week or month, the young person can sort through the box with a trusted adult and try to find solutions to solve those worries.
Safety **Pupil Support Plan (PSP)**	Safety concerns come into play when symptoms are severe. Establishing and maintaining their safety and ensuring a stable school environment should take priority, especially in an acute episode when symptoms are severe. Each pupil should have a Pupil Support Plan (PSP) which should identify triggers which school staff should be aware of. If school does not provide a PSP, this then could lead to members of staff working with the student not being aware of their triggers and needs and causing significant stress to the student. The PSP should also include strategies school staff should be using with the child at all times. Risk assessment is another item which should be included in a PSP. The risk assessment should highlight the risks involved around the young person and their diagnosis. This then should be RAG rated – Red, Amber & Green. Red will indicate high risk which will mean that there are current indicators of risk present, suggesting the risk outcome could occur at any time. Amber should be indicating medium level of risk; Current indicators are present but the risk outcome is unlikely to occur unless additional risk factors intervene/arise. Green should be indicating low risk; No current significant indicators of risk.

Further Reading

https://www.urmc.rochester.edu/childrens-hospital/adolescent/eating-disorders/teens/anorexia-nervosa.aspx

https://www.eatingdisorderhope.com/treatment-for-eating-disorders/special-issues/teen-adolescent-children

http://www.healthyteenproject.com/adolescent-eating-disorders-ca

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2851329/

Places you can get help:

YoungMinds Crisis Messenger

- Provides free, 24/7 crisis support across the UK if you are experiencing a mental health crisis
- If you need urgent help text YM to 85258
- All texts are answered by trained volunteers, with support from experienced clinical supervisors
- Texts are free from EE, O2, Vodafone, 3, Virgin Mobile, BT Mobile, GiffGaff, Tesco Mobile and Telecom Plus.

B-eat

- www.b-eat.co.uk
- If you have an eating disorder, or someone in your family does, b-eat is the place you can go to for information and support.
- Helpline number for under 25's: 0808 801 0711 (Daily 3pm-10pm)
- Email: fyp@b-eat.co.uk
- To know what local help and support you can get, put your postcode into HelpFinder

Anorexia and Bulimia Care

- www.anorexiabulimiacare.org.uk
- If you're being affected by an eating disorder, you can ring the helpline.
- Helpline 03000 11 12 13 (option 1: support line, option 2: family and friends)

Men Get Eating Disorders Too

- www.mengetedstoo.co.uk
- Information and advice for men on eating disorders.

Youth Access

- www.youthaccess.org.uk
- A place for you to get advice and information about counselling in the UK, if you're aged 12-25.

The Mix

- www.themix.org.uk
- If you're under 25 you can talk to The Mix for free on the phone, by email or on their webchat. You can also use their phone counselling service, or get more information on support services you might need.