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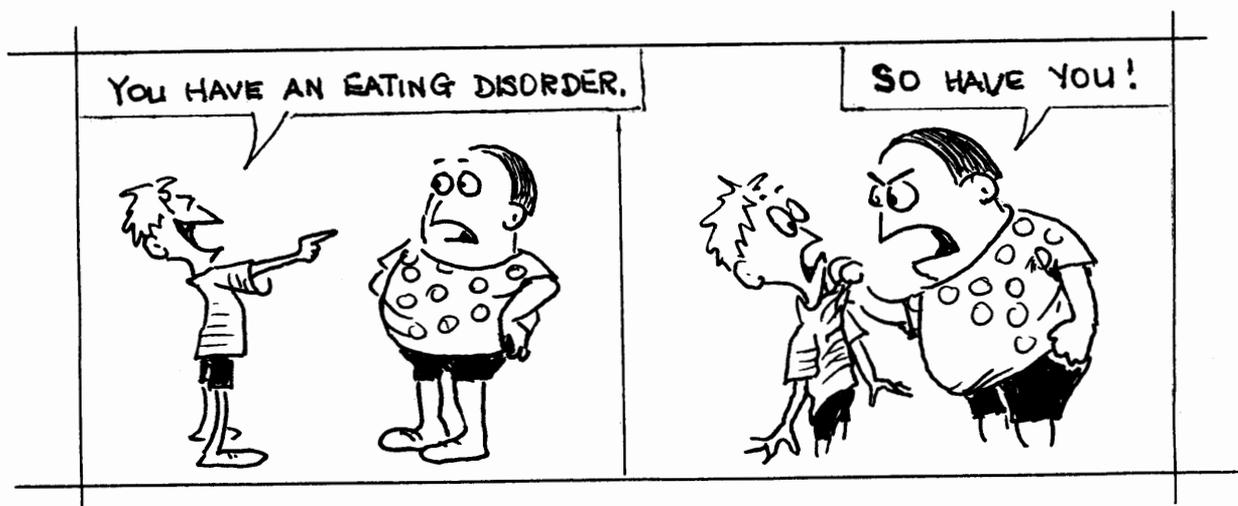
# EATING DISORDERS: WHAT TEACHERS NEED TO KNOW

**Vilma D'Rozario**

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Earlier this year, a twenty-one year old undergraduate woman died of an eating disorder. *The Straits Times* (20 Mar 96) reported that at her death, she weighed only thirty-two kilogrammes, and that she had shed nearly forty kilogrammes in the last five years. When interviewed, a family member stated that the woman began losing weight while in secondary school. Her weight loss was a result of her dieting, skipping meals and exercising. Her family also observed that she had suffered severe diarrhoea and loss of hair. Worried about her drastic weight loss, they had urged her to seek medical help. Her brother reported that the woman saw a psychiatrist as well as a physician, but that the family did not know exactly what she was suffering from.

According to medical statistics, eating disorders are less uncommon in Singapore today. This was disclosed in a television report entitled, "Anorexia nervosa: Dying to be thin" (*Talking Point*, 15 Jun 94). The report adds that although the numbers of young people with clinical eating disorders is small, the numbers have risen sharply in recent years. In addition, it is possible that more individuals may be suffering sub-clinical symptoms of disturbed eating and dieting patterns, though they may not have the clinical disorder.



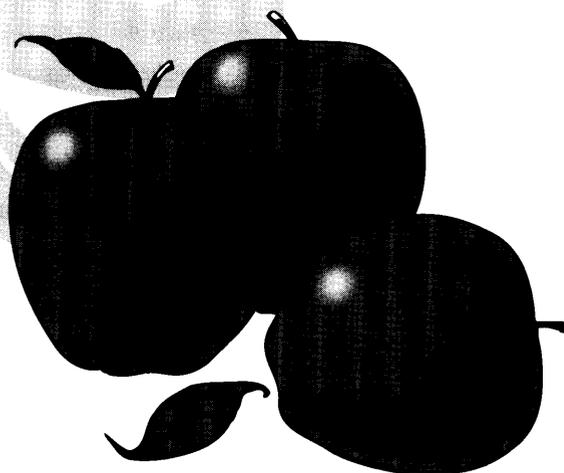
As the onset of eating disorders occurs mainly during adolescence, it is important for teachers to be able to recognise students at risk of, or with the disorder, and be familiar with the steps they can take to help. This paper will provide a guideline for identifying the symptoms of two types of eating disorder: anorexia nervosa and bulimia nervosa, as well as outline the measures teachers can take to help.

## **WHAT ARE THE RISK FACTORS?**

In the United States, a substantial amount of research on eating disorders has focused on possible risk factors associated with this illness. For example, it has been established that the eating disorders have a general onset of between fourteen to eighteen years of age and occur more frequently in females than males (Wright, 1996). In many societies, including our own, it is ideal for women to be slim, as slimness is equated with attractiveness. This preference for slimness places great pressure on teenage girls and young women to strive towards being thin, thus putting them at risk of developing an eating disorder. Research studies have also reported that women with eating disorders tend to come from middle to upper-middle class homes (Anderson and Hay, 1985). Further, it has been found that families where a member has an eating disorder tend to be characterised by chaos and conflict in the case of bulimics (Schwartz, Barrett, and Saba, 1985; Boumann and Yates, 1993), and overcontrol and rigidity in the case of the anorexic (Sargent, Liebman, and Silver, 1985). It has also been established that individuals with low self-esteem tend to be more prone to developing an eating disorder (Wright, 1996).

## **HOW DO WE RECOGNISE ANOREXIA NERVOSA?**

The diagnostic criteria for anorexia nervosa presented by the recently revised *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV, 1994) published by the American Psychiatric Association include the following critical elements:

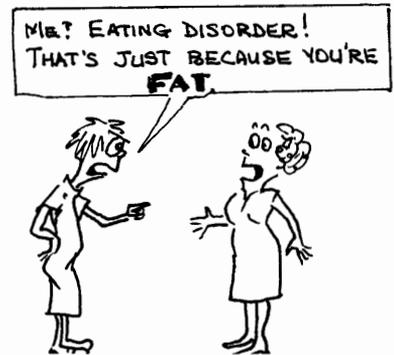


- refusal to maintain body weight at or above a minimally
- normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during periods of growth, leading to body weight less than 85% of that expected);
- intense fear of gaining weight or becoming fat, even though underweight;
- disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight; and
- in postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles;

Further, the DSM-IV specifies two types of anorexia:

- the *restricting type*, where during the current episode of anorexia nervosa, the person has not engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas);
- the *binge-eating/purging type*, where during the current episode of anorexia nervosa, the person has regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

An anorexic student may be identified by her<sup>1</sup> relentless pursuit of thinness. Her determination to restrict herself to a limited and low fat/ low calorie diet, and use compensatory behaviours, like compulsive exercising to keep her weight down, is a telling sign. However, when shown concern or questioned about her drastic weight loss, expect that she would react defensively. She will tend to deny that she is underweight. Often, students with anorexia have a distorted view of their body shape and size, and see themselves as heavy although they may, in fact, be emaciated. Her denial



<sup>1</sup> The female gender is used here and elsewhere in the paper, because it is an established fact that more women develop eating disorders than men. However, the author would like to add that her exclusive reference to the female gender in this paper does not exclude the fact that men, too, can develop the disorder.

may cause relationships close to her to be strained. She may begin to isolate herself, keeping away from social situations, with the motive of keeping secret her abnormal eating habits. Loose clothing may be used as a camouflage for her gross loss of weight. Often, she will tend to have low self-esteem. She may experience mood swings and feel depressed and anxious. Wright (1996) concludes that an anorexic prides herself on controlling her weight. Her sense of self-worth is thus closely linked with her control over food. To her, the ability to successfully lose weight becomes a sign of her achievement and self-control. It is her attempt to mask her true feelings of ineffectiveness and inadequacy (Wright, 1996). Some theorists hypothesize that an anorexic's behaviour is a means by which the individual is striving to gain control and independence from an overly critical and controlling parent (Wright, 1996).



#### **HOW DO WE RECOGNISE BULIMIA NERVOSA?**

According to the DSM-IV (1994), the critical elements for bulimia nervosa include:

- recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
  - eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances);
  - a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control how much one is eating);
- recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise;
- the binge eating and inappropriate compensatory behaviour both occur, on average, at least twice a week for 3 months; and
- self-evaluation is unduly influenced by body-shape and weight.

The DSM-IV also distinguishes two types of bulimia nervosa:

- *purging type*, where during the current episode of bulimia nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas;
- *nonpurging type*, where during the current episode of bulimia nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

A bulimic student will engage in a tragic cycle of bingeing and purging behaviour. Wright (1996) states that bingeing may be a response to a need to nurture oneself, or indulge oneself after restricted food intake—the binge tends to help soothe and reduce anxiety, and this, unfortunately, leads to repeated binges. The fear of gaining weight is often the cause for the accompanying purging behaviour. Wright (1996) states that binges are normally planned, and therefore, the bulimic student will tend to avoid social activities with family and friends, because she has, instead, to schedule her private binge and purge activities. Wright (1996) concludes that her binge and purge cycle becomes her way of handling painful emotions.

The bulimic student will tend to feel a loss of control over food, and extend this feeling to embrace a loss of control over life in general. Her body image will tend to be distorted and she will be extremely conscious of her weight. Unlike the anorexic, the bulimic student's weight will tend to remain stable, though it may fluctuate a little above or below her usual weight. However, she will begin to look unwell, and may exhibit a swollen face and neck due to the repeated stimulation of the gag reflex. The back of her palms may appear bruised because of their constant abrasion with her teeth while she is forcing herself to throw up. Similarly, her teeth may appear chipped and moth-eaten. Psychologically, a student with bulimia may be prone to depression, low self-esteem, anxiety, feelings of worthlessness and suicidal thoughts. The bulimic student also tends to be ashamed of her bulimic behaviour.

**Psychologically, a student with bulimia may be prone to depression, low self-esteem, anxiety, feelings of worthlessness and suicidal thoughts. The bulimic student also tends to be ashamed of her bulimic behaviour**

**Successful treatment for students with an eating disorder requires the collaboration of multidisciplinary team members**

## **TREATMENT**

It is imperative for teachers to realise that eating disorders are complex psycho-physiological disorders and can be life-threatening if treatment does not come in time.

Treatment is often long-term and relapses are common. It has become apparent in research studies in the United States that no one professional group can handle all aspects of a given eating disorder patient's needs—a multidisciplinary approach is needed (Stephenson et al., 1988).

Successful treatment for students with an eating disorder requires the collaboration of multidisciplinary team members. Multidisciplinary teams for eating disorder treatment usually consist of medical doctors, psychiatrists, clinical or counselling psychologists, skilled nursing staff, social workers, dieticians, and school personnel. Only with a team approach can the student begin to establish acceptable healthy body weight, medical and nutritional status, as well as decrease and eventually eliminate all unhealthy eating and dieting patterns—especially purging activities (Stephenson et al., 1988). Other goals sought by the multidisciplinary team approach would include achieving at least enough psychological change within the student and family to allow for symptom remission without someone else in the family developing problems, and enabling the family to reach a better level of functioning, so that it can better withstand external and developmental stressors, and to work with family members towards greater emotional closeness with the student without sacrificing the student's identity (Stephenson, 1988).

## **TEACHER AS REFERRAL PERSON**

It is necessary for teachers to play a key role in the multidisciplinary team approach to the treatment of eating disorders. When teachers observe symptoms of an eating disorder, their appropriate role would be that of referral agent.

Here are some guidelines to consider:

- speak privately to the student concerned and openly share your concern for her behaviour;
- encourage her to see a medical doctor as well as to seek either psychiatric or psychological help;
- with the student's consent, involve the student's parents, the principal, and perhaps the school counsellor (if there is one) or the pastoral care coordinator;
- assist the student in making the initial contact with a doctor and psychiatrist or psychologist; and
- continue to maintain daily contact with and support the student while she is in school—this is crucial in demonstrating your continuing concern for her.

### WHERE CAN PROFESSIONAL HELP BE FOUND?

Listed below are some resources teachers may obtain information from, as well as refer students to:

Referral agency	Who it is for	When to call	Number to call
Child Psychiatric Clinic	Young people (0-18 years) who have emotional and behavioural problems. Assessment, diagnosis, and treatment conducted by a multidisciplinary team of psychiatrists, psychologists, social workers, teachers and nurses.	Mon - Fri 8.30 am - 4.30 pm  Sat 8.30 am - 12.30 pm	322-2538
Counselling and Care Centre	Individuals, couples and families experiencing psychological, marital and family problems	Mon - Fri 8.30 am - 5.00 pm	337-7748
Total Wellness and Counselling Centre	Individuals, couples and families experiencing psychological, marital and family problems	Mon - Fri 8.30 am - 5.00 pm	466-7777

The following are telephone hotlines that students can use to call in for information and help. Teachers may also use these helplines for information and enquiries about referral.

Helpline	Who it is for	When to call	Number to call
Eating Disorders Helpline	Individuals with disturbed eating and dieting patterns	Mon - Fri 9.00 - 5.00 pm Weekends: Phonemail	345-3435
Studentline	Students from primary to pre-U level with problems	Mon - Fri 9.00 am - 12.00 noon 2.00 pm - 4.30 pm	1-800-281-2522

**Affirm students for their internal qualities and encourage them to do the same for their peers**

### PROACTIVE MEASURES

Teachers need to be proactive in establishing an environment of trust within their classrooms in order for students with problems to approach them. Safe and non-threatening classroom environments promote students' personal and social development, and encourage peer relationships. Healthy classroom environments provide support and encouragement to students who may be facing psychological problems.

To be helpful to students who may be at-risk of developing an eating disorder, teachers need to encourage the development of positive self-image, by picking out the good in their students, teaching them to see the good in themselves and in their peers; and avoid feedback which centres only on the external qualities of physical appearance and academic achievement. Instead, look for internal positive qualities like courage, honesty, perseverance, and cheerfulness. Affirm students for their internal qualities and encourage them to do the same for their peers.

### CONCLUSION

The teacher's role in a multidisciplinary team approach requires the development of specific helping skills. To be effective, teachers need to ensure that they are familiar with:

- the risk factors associated with eating disorders, for example, that these disorders tend to occur during adolescence, to mainly female students, students who have dysfunctional families and who tend to have low self-esteem;
- the symptoms of anorexia and bulimia as specified in the guidelines provided;
- appropriate referral agencies and procedures for referral of students with disturbed eating and dieting patterns; and
- skills of working with families

At the school level, education and prevention programmes can be drawn up within the school curriculum, especially for at-risk groups. These programmes could come under the auspices of pastoral care.

## REFERENCES

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Boumann, C.E. and Yates, W.R. (1993). Family risk factors for bulimia nervosa: Negative outcome for three variables. *Eating Disorders, 1*, 62-64.
- Sargent, J.A., Liebman, R., and Silver, M. (1985). Family therapy for anorexia nervosa. In D.M. Garner & P.E. Garfinkel (Eds.) *Handbook of psychotherapy for anorexia nervosa and bulimia*. New York: Guilford press.
- Singapore Broadcasting Corporation (1994, June 15). Anorexia nervosa: Dying to be thin. *Talking Point*. Singapore: Singapore Broadcasting Corporation.
- Stephenson, J.N., Ohlrich, E.S., McClintock, J.H., Foster, S., Reinke, J.A., Allen, M.A., and Giles, G.M. (1988). The multidimensional team approach to the treatment of eating disorders in youth. In K. Clark, R. Parr, and W. Castelli (Eds.), *Evaluation and management of eating disorders* (pp 261-278). Champaign, IL: Life Enhancement Publications.
- Swartz, R.C., Barrett, M.J., and Saba, G. (1985). Family therapy for bulimia. In D.M. Garner & P.E. Garfinkel (Eds.) *Handbook of psychotherapy for anorexia nervosa and bulimia*. New York: Guilford Press.
- Wright, K. (1996). The secret and all-consuming obsessions: Anorexia and bulimia. In D. Capuzzi and D.R. Gross (Eds.), *Youth at risk: A prevention resource for counselors, teachers, and parents* (pp. 153-181). Alexandria, VA: American Counseling Association.

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