

Angela D. Bardick is a provisional chartered psychologist,

Kerry B. Bernes is an associate professor,

Ariana R. M. McCulloch is a graduate student,

Kim D. Witko is a provisional chartered psychologist,

Jennifer W. Spriddle is a graduate student, and

Allison R. Roest is a student. All are with the University of Lethbridge, Alberta, Canada.

E-mail: abardick@shaw.ca

Eating Disorder Intervention, Prevention, and Treatment: Recommendations for School Counselors

School counselors are in daily contact with the highest risk group for developing eating disorders—children and adolescents. School counselors are in a position to identify at-risk individuals, implement effective school-based prevention programs, make appropriate referrals, and provide support for recovering individuals. An overview of a theory of recovery for eating disorders reinforces the importance of early intervention.

Eating disorders need to be taken seriously because they are potentially life-threatening conditions that affect an individual's physical, emotional, and behavioral growth and development, and they may lead to premature death. Eating disorders may be seen as a slow form of suicide because self-starvation is an attempt to destroy one's body. Seemingly innocent dieting, exercise, and weight control behaviors in children and adolescents may lead to dangerous disorders such as anorexia nervosa, bulimia nervosa, muscle dysmorphia, and other disordered eating or exercise behaviors.

Girls as young as 9 years of age are concerned about their weight (Cavanaugh & Lemberg, 1999). Anorexia nervosa affects approximately 2% of the North American population, and bulimia nervosa affects approximately 4%, of which 10% are males (American Psychiatric Association, 2000a). There is a significantly high mortality rate among individuals with eating disorders—more than 12 times higher than any other cause of death in females 15 to 24 years old (Cavanaugh & Lemberg).

Early intervention is crucial to the prevention and recovery of an eating disorder. There is a relatively good prognosis for childhood and adolescent eating disorders if they are treated soon after onset. However, if these disorders are not treated, they may become chronic conditions with devastating physical, emotional, and behavioral consequences (Lask & Bryant-Waugh, 1999).

Eating disorders are of particular concern for school counselors because they are in contact with the highest risk group—children and adolescents. School counselors are in a position to provide early

intervention by recognizing at-risk individuals, implementing effective school-based prevention programs, making appropriate referrals, and providing support for students recovering from eating disorders.

The primary eating disorders referred to in this paper are anorexia and bulimia. This paper is divided into two sections and is structured as follows: The first section discusses the implications of eating disorder treatment and intervention for school counselors, with practical suggestions for implementing effective prevention programs in schools, identifying at-risk individuals, and making appropriate referrals. The second section provides an overview of a theory of recovery and a continuum of treatment for eating disorders, including practical suggestions for school counselors to support individuals who may be recovering from an eating disorder.

IMPLICATIONS FOR SCHOOL COUNSELORS

School counselors play a critical role in the prevention and early identification of eating disorders. They are in a unique position to detect students' changing attitudes around food, weight, and body shape; act as role models for students; positively influence a wide range of the at-risk population for developing eating disorders; and convey important messages about healthy behaviors and stress management (Powers & Johnson, 1999; Russell & Ryder, 2001a, 2001b; Smolak, Harris, Levine, & Shisslak, 2001).

An awareness of diagnostic criteria, medical complications, causes, warning signs, and risk factors is important for school counselors; however, knowing what to do when faced with an individual at-risk for developing an eating disorder is imperative. Therefore, it is necessary to discuss the school counselor's role in the prevention, identification, and intervention processes for the treatment of eating disorders.

Prevention of Eating Disorders in Schools

Prevention efforts focus on populations who are at-risk of developing eating disorders, eliminate risk factors, and seek to enhance mental health and well-being (Russell & Ryder, 2001a). However, the danger of current eating disorder prevention efforts in schools is that they may bring undue attention to the signs and symptoms of eating disorders with a limited emphasis on healthy attitudes and behaviors (Russell & Ryder; Steiner-Adair, 1994). Russell and Ryder assert that eating disorder symptomatology should not be addressed in school programs because of the high risk of teaching dangerous eating disordered behavior to impressionable youth. As well, practices such as weighing students, comparing athletic ability, and discussing caloric and fat content of food in school classes need to be eliminated to prevent the development of negative thoughts and behaviors in regard to body image and food intake.

School counselors, teachers, coaches, and parents need to explore their own values, beliefs, and practices about weight, dieting, and body image to identify how their attitudes may inadvertently affect children (Graber, Archibald, & Brooks-Gunn, 1999; Powers & Johnson, 1999; Russell & Ryder, 2001a). Well-intentioned comments about a child's appearance or physical ability and/or ill-considered comments about weight or laziness have the potential to cause serious damage to a child's emerging body image and self-concept. Impressionable youth may internalize such comments, which in turn may trigger harmful dieting and unhealthy, compulsive exercising (Beumont, Arthur, Russell, & Touyz, 1994). Adults who work with children are role models who can cushion the blow of negative societal messages about body image, perfectionism, and achievement as well as encourage and reinforce positive attitudes and behaviors (Russell & Ryder; Vitousek, Watson, & Wilson, 1998).

The primary goals of school-based eating disorder prevention programs are to develop critical thinking abilities (i.e., decoding media messages about the ideal body), challenge the glorification of thinness, develop a healthy body and self-image, increase self-confidence and autonomy with peers, improve communication skills, and learn how to effectively use media for the promotion of healthy body image messages (Levine, Piran, & Stoddard, 1999). Smolak (1999) and Steiner-Adair (1994) assert that discouraging weight- and shape-related teasing and sexual harassment is important in eating disorder prevention programs. "If girls and boys in first grade can be taught that it is hurtful and unjust to exclude someone because of a color, religious background, or physical challenges, then children can be taught that weightism is equally harmful" (Steiner-Adair, p. 388). School counselors may encourage students to

develop a healthy resistance to eating disorders by discussing the importance of self-acceptance, positive body image, healthy eating, and good exercise behaviors as well as critically examining perspectives of unhealthy behavior (Russell & Ryder, 2001a).

Despite prevention efforts, some individuals may slip through the cracks and develop eating disordered thoughts and behaviors. When this occurs, the identification of at-risk individuals is critical to prevent further damage.

Identification of At-Risk Individuals

Individuals with an eating disorder may present as highly organized, fully functional, enthusiastic, perfectionistic, and intelligent individuals involved in a wide range of activities (Vitousek et al., 1998). There is a tendency to look for extreme bingeing and purging behaviors to detect an eating disorder; however, these often are private behaviors that may be well hidden from family and friends. A large number of more readily observable behavioral, psychological, and social behaviors may signal a potential eating disorder that requires immediate assessment by a professional.

Dieting is a primary trigger of the downward spiral into an eating disorder (Thompson & Sherman, 1993). Other than dieting, behavioral warning signs may include, but are not limited to, excess intake of low-fat or "healthy" foods (e.g., diet drinks, protein shakes, energy bars, herbal or nutritional supplements); counting calories and fat grams; vegetarianism (Lindeman, Stark, & Latvala, 2000); fasting; obsessive rumination about food; skipping meals or refusing to eat; avoiding food in social situations; complaining of food allergies or hypoglycemia; substance abuse; and becoming the family cook without eating what he or she has made (Kilbourne, 1999; Thompson & Sherman). Other behavioral signs may include wearing oversized clothing (due to thinking that one requires that size or having a desire to hide one's body); exercising excessively and/or in a solitary manner; exercising while ill or injured (Davis, 2000); participating in competitive sports, especially where appearance is important (Noden, 2002; Ryan, 1995; Thompson & Sherman); reading fitness and health magazines and books; weighing oneself several times each day; repeatedly touching one's stomach or arms or feeling the amount of "fat" under one's chin; and spending an excessive amount of time in front of a mirror (Weiner, 2000).

Psychological warning signs of eating disorders may include perfectionism, competitiveness, a sense of overresponsibility, emotional distress, criticism of self and others, conformity, external locus of control and low self-esteem, mood swings, complaining of "feeling fat," an inability to express emotions, and demonstration of "black-and-white" thinking

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(Andersen, 2001; Kaye, Klump, Frank, & Strober, 2000; Rogers & Petrie, 2001; Vitousek et al., 1998).

Social warning signs may include isolation or withdrawal from friends and family because of excess work or preoccupation with exercise, avoidance of social or recreational activities due to a compulsive need to maintain exercise and dieting schedules, and a desire to hide one's compulsive behaviors from family and friends (Vitousek et al., 1998).

Once an at-risk individual has been identified, it is important to intervene as soon as possible.

Early Intervention

When a child's health is at risk, early intervention is crucial to recovery. There is a greater chance for an individual to recover completely from an eating disorder if significant others intervene to combat the illness as early as possible (Lask & Bryant-Waugh, 1999; Peterson & Mitchell, 1999; Powers & Johnson, 1999; Vitousek et al., 1998). Early intervention efforts attempt to identify individuals at the beginning stages of developing an eating disorder and are intended to prevent the development of more serious symptomatology (Russell & Ryder, 2001a).

Difficulties arise when the problem has been hidden for a long period of time and obsessive behavior is mistaken for "dedication and strong character" (Thompson & Sherman, 1993, p. 17). Individuals with eating disorders have a strong tendency to deny that there is a problem, to resist treatment efforts, and to insist that their behavior is legitimate and necessary (Vitousek et al., 1998). The more resistant the individual and the stronger the individual circumstances meet the criteria relative to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision), the more likely that intervention is required (American Psychiatric Association, 2000b). Significant others need to take the responsibility for treatment away from individuals under the age of 18 because the effects of starvation may render them unable to make decisions concerning their health and well-being (Lask & Bryant-Waugh, 1999; Vitousek et al., 1998). This responsibility may begin with a school-based resource person.

Establishing a school-based resource person. The presence of a school-based resource person alleviates difficulties of not knowing what to do when a student seems to be on the verge of an eating disorder. Smolak, Harris, Levine, and Shisslak (2001) posit that every school will likely have at least one person interested in eating disorders, negative body image, and dieting, and that this person may be willing to dedicate extra effort to addressing these problems in school. A school-based resource person

would have an understanding of how to confront the at-risk individual, discuss concerns with parents, and make a referral to an appropriate professional source (Smolak et al.).

Talking to at-risk students and parents. Communicating concern to an individual who may have an eating disorder is extremely difficult because people often do not know what to say and may be afraid of offending the individual. However, people who keep their concerns to themselves may be creating a conspiracy of silence that enables the individual with an eating disorder to continue with unhealthy behaviors and thus prolong the illness, perhaps endangering his or her life (Thompson & Sherman, 1993).

Demonstrating support and concern, expressing empathy and understanding, and telling the truth are three important factors to remember when confronting an at-risk individual (Bock, 1999). Expressing concern for a child's health and well-being begins with honest, objective statements defining the behaviors of concern followed by insisting on obtaining the opinion of a trained professional. The following nonjudgmental, empathetic, and truthful statements may be useful when approaching an at-risk individual and his or her parents: "I'm sorry, Chris, you are not fine. You are alone all the time, you never have fun, and you seem tense and worried"; "Jennifer, I can't keep this a secret. Throwing up your food is dangerous. Can I go with you to talk to your parents, or do you want me to tell them myself?"; "Susan, you seem so tired and exhausted, and you know I care about you. ... I need to insist that you are not well. ... Please let us take you for some help" (Bock, p. 44).

If honest statements from a caring and concerned individual fall on a ready heart, the journey to recovery may begin. Unfortunately, denial is often the first reaction to expect when an individual with a potential eating disorder is confronted.

Dealing with denial. When an eating disordered individual is first confronted about his or her condition, denial and resistance frequently are inevitable (Rogers & Petrie, 2001; Vitousek et al., 1998). The individual may insist that everything is fine and that his or her weight loss is rational and/or necessary. Symptoms may be defended out of fear and helplessness because the possibility of gaining weight during treatment is extremely threatening. Starvation also makes it difficult for individuals with an eating disorder to rationally appraise their condition (Vitousek et al.).

School counselors need to recognize that denial and/or resistance is not directed against them. It is directed against the fear of irreversible weight gain, losing control, feelings of helplessness, and fear of change (Vitousek et al., 1998). Knowing that denial

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will likely be the individual's first response when initially confronted should not stop a concerned adult from expressing concerns to the student, and his or her parents, as well as referring the individual to a professional trained in the assessment and treatment of eating disorders.

Making a referral. Referring an at-risk individual to professionals who are capable of assessing and treating eating disorders is essential to beginning the recovery process. Treatment of an eating disorder may be beyond the capabilities of school personnel, and therefore a school counselor's responsibility lies in working with the family to make a referral for assessment and treatment (Russell & Ryder, 2001b). Suggesting a consultation or assessment (e.g., "I am concerned about your/your child's health and well-being and recommend further assessment by a professional") may be more acceptable to an at-risk individual and his or her parents than explicitly stating, "You have a problem and need help."

A school-based eating disorder resource person should have names and phone numbers of eating disorder specialists at his or her immediate disposal to ensure that the at-risk individual has access to appropriate help. A local hospital or mental health facility may be an excellent reference for obtaining the names and phone numbers of local specialists.

Referral for specialized treatment is important because often a treatment team is required to address the multifaceted nature of an eating disorder. The treatment team may involve a medical doctor, a nutritionist, a mental health professional (i.e., psychologist or psychiatrist) who specializes in eating disorders, and/or a family therapist. Together, the treatment team will make decisions about assessment, treatment options, resources for treatment, and when to involve the family and school staff (if necessary).

RECOVERY AND TREATMENT

Recovery from an eating disorder involves a continuous balancing and rebalancing of the self. It is an ongoing process even when unhealthy behaviors are diminished and a stable weight is established (Garrett, 1997; Pike, 1998; Reindl, 2001). The primary focus of treatment for any eating disorder is to restore the individual to a more normalized, moderate, and functional lifestyle while reducing the fluctuation between extremes of behavior and thought (e.g., "If I'm not thin, I must be fat").

Treatment for eating disorders is highly specialized. A highly focused, systematic, and often multimodal approach is used to facilitate a more organized and predictable lifestyle for individuals who may feel chaotic. Treatment plans are likely to coordinate and integrate a variety of approaches depending on

the specific needs of each individual based on age of onset, severity, and longevity of the eating disorder.

After a thorough assessment, three primary phases are addressed in the treatment of eating disorders: (a) restoration of a healthy weight and/or normalization of eating, (b) significant changes in thought and behavior, and (c) relapse prevention (Garner, Vitousek, & Pike, 1997; Mehler & Crews, 2001; Russell & Ryder, 2001a; Vitousek et al., 1998; Wilson, Fairburn, & Agras, 1997). Although these phases appear to center on different goals, they require varying degrees of focus due to the interrelated and cyclical nature of eating disorder recovery.

Assessment

A thorough assessment is required to determine the severity of the disorder and to provide a framework for treatment. School counselors may find self-report questionnaires and/or structured interviews useful in identifying the presence and severity of eating-related symptomatology in individuals at risk for an eating disorder. A sample of well-researched and valid structured interviews and self-report questionnaires for the assessment of eating disorders includes the Clinical Eating Disorder Rating Instrument, the Eating Disorder Examination, the Interview for Diagnosis of Eating Disorders, the Structured Interview for Anorexia and Bulimia Nervosa, the Eating Attitudes Test, the Eating Disorder Inventory-2, the Bulimia Test Revised, and the Binge Scale (Crowther & Sherwood, 1997). Individuals with eating disorders are notoriously unreliable when initially reporting the severity of their symptoms (Vitousek et al., 1998). Individuals with anorexia tend to falsify information for self-protective reasons and individuals with bulimia may omit information because of an overwhelming sense of shame (Vitousek et al.). Therefore, a thorough clinical interview and a client history conducted by a trained eating disorder therapist are crucial to understanding the depth of the disorder and informing the next stage of treatment.

Treatment

Researched and proven treatments for eating disorders include cognitive-behavioral therapy (Garner et al., 1997; Peterson & Mitchell, 1999; Williamson & Netemeyer, 2000; Wilson et al., 1997), a psychoeducational approach (Vitousek et al., 1998), pharmacotherapy (Kaye et al., 2000; Peterson & Mitchell), nutritional counseling (Kahm, 1999), guided imagery (Hutchinson, 1994), interpersonal therapy (Fairburn, 1997; McIntosh, Bulik, McKenzie, Luty, & Jordan, 2000; Peterson & Mitchell; Wilfley, Dounchis, & Robinson-Welch, 2000), family therapy (LeGrange, 1999), feminist therapy (Tantillo, 2000), group therapy (Davis, Olmsted, Rockert,

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Marques, & Dolhanty, 1997; Tantillo), and narrative therapy (Garrett, 1997; Paley, 2000; Reindl, 2001). Although primary care for the treatment of an eating disorder is with trained professionals, school counselors may become an important part of the treatment team. Examples of cognitive-behavioral therapy (CBT), guided imagery, and narrative therapy will be discussed as useful interventions for school counselors.

Cognitive-behavioral therapy. CBT is a widely researched and highly effective treatment for eating disorders (Garner et al., 1997; Williamson & Netemeyer, 2000; Wilson et al., 1997). CBT addresses the behavioral, cognitive, and affective areas of an eating disorder, including strict dieting, unhealthy weight loss behaviors (e.g., binge eating, purging, self-induced vomiting, excessive exercise), concerns about shape and weight, low self-esteem, and maladaptive and self-defeating thoughts and behaviors (Wilson et al.). CBT examines contradictions in thought and behavior, specific purposes of eating disordered symptomatology, advantages and disadvantages of beliefs and behaviors, as well as the costs and benefits of change (Vitousek et al., 1998).

Phase 1 treatment for eating disorders (i.e., stabilization of weight and normalization of eating and exercise habits) is non-negotiable, especially with anorexia (Garner et al., 1997; Mehler & Crews, 2001; Vitousek et al., 1998). Stabilization of body weight must be obtained before underlying issues can be addressed effectively. Hospitalization and specialized medical treatment may be required at this point if the individual is severely malnourished and unwilling to begin Phase 1 treatment on an outpatient basis (Mehler & Crews). School counselors are not responsible for Phase 1 treatment of eating disorders (e.g., monitoring food intake). However, they may provide support for individuals at this phase of treatment by reinforcing the importance of becoming healthy, helping to plan manageable course loads at the school level, and providing reassurance that an individual will be better able to meet academic demands when he or she is healthy.

Once weight becomes stabilized, other issues may begin to take precedence over eating disordered behaviors, thus moving the treatment into Phase 2. A psychoeducational approach is recommended to provide objective information to challenge the irrational thinking associated with eating disorders. Issues likely to be addressed during this phase are teaching problem-solving skills and new coping strategies, cognitive restructuring (identifying and specifying problem thoughts, disputing validity of thoughts, shifting the thinking), addressing shape and weight concerns, self-esteem, self-concept, perfectionism, impulse regulation, affective expression, family conflicts, and interpersonal functioning

(Garner et al., 1997; Wilson et al., 1997). Self-monitoring is an important aspect of eating disorder recovery that helps individuals to develop a sense of control over their thoughts and behaviors. Individuals learn to self-monitor food intake, exercise, activity levels, and other eating disorder-related behaviors (Crowther & Sherwood, 1997; Garner et al.; Tantillo, 2000; Wilson et al.).

At this stage, school counselors may be better able to address daily concerns that arise for individuals recovering from an eating disorder by offering different points of view to counteract the black-and-white thinking (Wilson et al., 1997) that often accompanies an eating disorder. School counselors may encourage individuals to monitor their daily activities to develop a balance between work and relaxation (e.g., playing on one sports team versus three), and academically challenging courses and optional courses, as well as to meet socialization needs. Continued support is crucial at this stage to encourage the student to continue developing healthy cognitive and behavioral changes, to deal with the process of change, and to address occasional setbacks appropriately.

Phase 3 of eating disorder treatment involves the exploration of relapse prevention strategies (Garner et al., 1997; Reindl, 2001; Wilson et al., 1997). Relapse is common in eating disorders, even 4 to 12 years after recovery (Schneider & Irons, 1997). Individuals with eating disorders may continue to show signs of weight and dieting preoccupation, obsessive thoughts and behaviors, emotional restraint, a drive for thinness (especially with anorexia), a psychopathology related to eating habits, perfectionism, and negative affect (Kaye et al., 2000; Pike, 1998). Symptoms may be less intense after recovery, but concerns are likely to remain the same.

Future difficulties and potentially stressful circumstances must be anticipated (e.g., stress related to graduating, leaving home, going to college), because an individual with an eating disorder may be vulnerable to a recurrence of eating problems, feelings of inadequacy, emotional and physical dysregulation, and dissatisfaction with body weight and shape (Garner et al., 1997; Reindl, 2001). A maintenance plan includes continual self-awareness and self-monitoring, practicing problem-solving strategies, recognizing the onslaught of irrational thinking, utilizing cognitive restructuring strategies, and setting short-term, realistic goals (Wilson et al., 1997). School counselors may contribute to maintenance plans by helping individuals prepare for inevitable challenges by exploring an individual's stress triggers and encouraging him or her to develop rational and healthy plans for action.

Guided imagery. Guided imagery may be a useful clinical tool for the treatment of eating disorders

(Hutchinson, 1994). The use of guided imagery is a subtle, respectful, and nonintrusive intervention that may be used with individuals who lack a solid sense of self. Relaxation through guided imagery is healing, and the use of imagery has a strong connection to shaping reality (Hutchinson). Specific examples of guided imagery may include imagining enjoying a relaxing meal with friends, allowing one's body to become nourished and healthy, and viewing a problem from multiple perspectives. Guided imagery may be a useful intervention tool for school counselors to use with a student recovering from an eating disorder by helping the student to imagine different outcomes for stressful situations, develop relaxation techniques, and diminish anxiety.

Narrative therapy. Narrative therapy, or the retelling and rewriting of personal narratives as therapeutic process, may be a useful intervention in eating disorder recovery (Garrett, 1997; Reindl, 2001). Rizzuto (1998) notes that individuals with eating disorders "believe that their words have no impact on other people" (p. 370) and thus require permission to experience their authenticity and to speak their truth. School counselors may encourage individuals to share their personal truth openly, honestly, and without judgment to develop self-acceptance and to begin to narrate a positive outcome to their personal story. This may be a precursor to goal-setting, as individuals may imagine the life story they would like to have and begin to set goals to create the desired outcome—a balanced and healthy life.

School counselors may implement the suggested interventions to support a student recovering from an eating disorder, keeping in mind that recovery is often a long and difficult process that requires continuous monitoring by trained professionals. School counselors also may implement other interventions as suggested by specialists to more effectively meet the needs of the recovering individual. ■

CONCLUSION

School counselors play an important role in the prevention, identification, and treatment of eating disorders. The recommendations in this paper are meant to provide school counselors with an awareness of how to identify at-risk students, implement school-based prevention programs, make appropriate referrals, and support students who may be recovering from an eating disorder. Early intervention and prevention efforts implemented by school counselors are important to increase positive body image and encourage children and adolescents to develop healthy lifestyles, free from the physical and psychological dangers of eating disorders.

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APPENDIX

Additional Resources

Grades 1-6 Suggested Resources

Russell, S., Ryder, S., & Marcoux, G. (2001). *BRIDGE: A resource collection for promoting healthy body image, grades 1-3, grades 4-6*. Available from Alberta Mental Health Board, www.amhb.ab.ca

Grades 7-12 Suggested Resources

Barrett, C. (1999). *The dangers of diet drugs and other weight-loss products*. New York: The Rosen Publishing Group, Inc.

Burby, L. (1998). *Bulimia nervosa: The secret cycle of bingeing and purging*. New York: The Rosen Publishing Group, Inc.

Davis, B. (1998). *What's real, what's ideal: Overcoming a negative body image*. New York: The Rosen Publishing Group, Inc.

Edut, O. (1998). *Adiós Barbie: Young women write about body image and identity*. Seattle, WA: Seal Press.

Kaminker, L. (1998). *Exercise addiction: When fitness becomes an obsession*. New York: The Rosen Publishing Group, Inc.

Russell, S., Ryder, S., & Marcoux, G. (2001). *BRIDGE: A resource collection for promoting healthy body image, grades 7-9, grades 10-12*. Available from Alberta Mental Health Board, www.amhb.ab.ca

Smith, E. (1999). *Anorexia nervosa: When food is the enemy*. New York: The Rosen Publishing Group, Inc.

Recommended Websites

About Face: Combating Negative and Distorted Images of Women
www.aboutface.org

Anorexia Nervosa and Related Eating Disorders
www.anred.com

Calgary Regional Health Authority: School Health and Eating Disorders
www.crha-health.ab.ca/schoolhealth/eating.htm

Dads and Daughters
www.dadsanddaughters.org

Eating Disorders Awareness and Prevention
www.edap.org

National Association to Advance Fat Acceptance
www.naafa.org

National Eating Disorder Information Center
www.nedic.ca

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