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BC's Mental Health Journal

Visions

Eating Disorders and Disordered Eating

editor's message

Disordered eating is not about food. Of course, the individuals affected — mostly girls and women, but an increasing number of men — *do* struggle with food, but the real struggle is usually about something else.

The contributors to the current issue point to a number of factors. Some are broad societal issues, like the pressure applied by the 'appearance industry' to be thin. This puts women from cultures where food plays a prominent role in a position of particular conflict.

Some pressures operate more directly at the individual level, such as our discomfort with emotions, coupled with a psychological need for control. Rather than deal with emotions directly, women with disordered eating speak of controlling those emotions — using words like 'numbing' — through controlling food.

Some of our contributors link eating disorders to other clinical issues, pointing out a connection, for instance, between eating disorders and anxiety, obsessive behaviour, trauma, or addiction.

And, as many of our contributors point out, while disordered eating or eating disorders can be looked at as 'illnesses,' they are also coping strategies that help individuals deal with the other issues we've pointed to (loss of control, difficulties with emotion, pressure to be thin or perfect, for instance). This means we can't simply "treat" disordered eating without working with individuals to deal with these underlying issues.

The resources available in this province increasingly reflect this developing understanding of eating disorders; but we haven't gone far enough, and the experience of accessing care — for both individuals and their families — is too often as grueling as the eating disorder itself.

Fortunately, there is a growing movement of people who want to change things. These are the people who deal most closely with these issues on a day-to-day basis: clients, caregivers, members of community organizations, clinicians, and researchers. We thank all of these individuals for continuing their efforts to improve things, and for their contributions to this edition of *Visions*.

Eric Macnaughton

* a special acknowledgment to the 36-24-36 icon on the cover, an image from Awareness and Networking Around Disordered Eating (ANAD)'s educational advertising campaign, "Still Trying to Measure Up?""

BC's Mental Health Journal

Visions

is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the CMHA: the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of friends, family, service providers and community members. In this journal, we hope to create a place where the many perspectives on mental health issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal. Please send your letter with your contact information to:

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ALTERNATIVES AND APPROACHES

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Changing Minds, Not Bodies

Raine Mckay

Raine is the Executive Director of the association Awareness and Networking Around Disordered Eating (ANAD). She has a background in community development and women's health.

Every time I tell someone that I work for an organization doing work around disordered eating/eating disorders, they have a story to share — a story of shame, of frustration or anger, of bewilderment and loss; a rallying cry for action and changing the world; a quest for approval of actions taken; or an expression of belligerence for all who are weak.

Usually, the story will have an unrecognized thread of fat phobia and self-hatred weaving through it; and when I choose not to actively reinforce these beliefs — perhaps by asking an indirect question about the feelings that seem to accompany the story — people become uncomfortable.

They tend to expect the congenial commiseration that is the norm — praise for los-ing weight; anger at the villainous media that has us in its grip; support for how 'bad' they are for eating x, y or z; or scolding for how lazy they are for not looking after themselves.

Should I try to gently challenge this self-hatred and/or fat phobia, the reaction is almost always one of resistance. Only twice in the six years that I have been working for ANAD (Awareness and Networking Around Disordered Eating) has this not happened; and I hear these kinds of stories all the time. It doesn't matter what the occasion — I even heard a story from my bank manager when I was negotiating a loan!

I am not complaining. I consider these exchanges as an opportunity to illuminate that which usually can't be seen: can't be seen because *it* — the self-hatred, the pain, and the disconnection from our bodies — is simply a normalized aspect of our society. Like a fish in a bowl we can or won't see the water even though it's everywhere.

My job at ANAD is to support environments that challenge this normalization; yet as part of this society it sometimes takes a sustained effort for even me to see what needs to be challenged and when. Thus, for me these shared stories are like a drop of violet dye in a glass of water: present, tangible and glaring, even though the dye inevitably becomes diluted again over time.

This edition of *Visions* is filled with a range of shared wisdom, experience and perspectives around disordered eating and eating disorders. Though there is disagreement about what causes disordered eating/eating disorders, how they should be treated or dealt with, or whether they are preventable or not, everyone in the field agrees on one thing — food is not the issue. So what is the issue? Well we haven't yet made all of the connections needed to complete this particular puzzle, but as you read through this issue you will see we do have some significant pieces.

The causes of disordered eating/eating disorders are multifactorial, and the difficulty in teasing these factors out is compounded by the fact that many of them are currently considered normal practice in our society: dieting; body, food and weight obsession; gender roles; striving for perfection; and the relentless message driving our economy that we are not 'good enough.' As a society we haven't taken collective responsibility for the impact of these beliefs, because as with most mental health issues, the problem manifests itself in individuals.

ANAD deals with this paradox by actively supporting environments that ensure that everyone gets an opportunity to truly be heard and/or to participate in creating solutions; also we strive to nurture environments that guarantee individuals the support to heal in the manner that is right for them; and finally, we support environments that challenge the normalization of fat phobia/discrimination that infects all aspects of our society. This is not an easy task, but given 20 years or so and lots of help, it's definitely doable.

There are numerous issues currently challenging the community actively dealing with the issue of disordered eating/eating disorders in BC. Let's start with the conceptual framework associated with the term 'disordered eating/eating disorders.' We use this phrase to outline a continuum of concerns that need to be addressed, ranging from disordered eating behaviours — such as food and body preoccupation and yo-yo dieting — to clinical eating disorders, which include the medical diagnosis of anorexia nervosa, bulimia nervosa and compulsive overeating. The use of the continuum concept emphasizes the socially-mediated underpinnings of the issue: but is it, in fact, a continuum? Some consider disordered eating behaviours to be preventable precursors to eating disorders, while others believe that eating disorders are genetic and therefore not preventable. A definitive answer does not exist.

Another hotly-debated issue is the consideration of whether or not any issues within the disordered eating/eating disorders spectrum should be considered mental illnesses. Some would argue no, that to label them as such medicalizes

women's lived experience (females experience 90% of disordered eating/eating disorders) and thereby undermines attempts to deal with the root cause of the issue — misogyny [societally-sanctioned hatred towards women].

Another perspective is that of families and friends who bear witness to their loved one's inability to accept help while suffering with anorexia, bulimia or compulsive overeating, who see them going through endless cycles of recovery and relapse, who watch as they pull themselves out of their hell and start to live a productive life, only to then see them die young due to the damage that was inflicted on their bodies. To these individuals, yes, it is mental illness, a mental illness that kills.

These differing beliefs add to the complexity of our understanding of disordered eating/eating disorders. How we as a society then choose to act on these beliefs is what has a direct impact on our ability to effectively deal with prevention and treatment issues. So if we believe that eating disorders can be prevented, we must question why 95% of the available government funding goes into tertiary care. If we're dealing with mental illness that can't be treated through drug intervention, then we also need to question why such low priority is placed on making psychological interventions available for individuals along the continuum.

It is not pretty watching how these decisions play out for individuals trying to access appropriate health care. I can't count the number of times individuals have called our office to say that the only help their primary health care practitioner could provide was to tell them to eat more, or conversely to eat less. These doctors aren't uncaring, but even though there is currently systemic training to tell them that eating disorders are not about food, they just don't get it.

The consistent underfunding of both the tertiary and regional eating disorders programs also has a profound effect. The average regional eating disorder program is only funded for three full days a week, has a waitlist of two to three months, and usually has no ability to actively support individuals while they wait to get into the program. Our tertiary programs deal with their limited resources by admitting only the most medically compromised. In our ANAD support groups, there is always at least one individual who has been told that they are not considered sick enough to get into a tertiary program. As a consequence, these individuals make themselves sicker in order to get help. We need programs that provide support to individuals along the full continuum of care.

Currently our tertiary programs are not set up to deal with the individual who has a concurrent disorder — say alcoholism — so in order to get help with an eating disorder one cannot be drinking, or one's eating disorder needs to be stabilized to get access to health care that deals with the alcohol problem.

Which beliefs get translated into funding allocations is a source of great concern and considerable tension for consumers, family members and health-care workers alike — though usually for different reasons! We hear a lot about using interventions that are grounded in 'evidence-based practice.' Yet in this field, while the medical aspect of dealing with anorexia and bulimia can be very successful, there doesn't appear to be a unified psychosocial intervention available that ensures prevention or recovery in a significant number of individuals across populations.

BC's tertiary eating disorders programs work for some individuals but not for others. This creates a lot of tension which has resulted in families going bankrupt to send their children out of country for treatment, and health care workers acting as gatekeepers, deciding who gets access to support and who doesn't.

The solution? More funding? More programs? More research? That would be a good first step! Yet in order to create a lasting change we need ongoing dialogue and clarification around which beliefs fuel the funding allocations and around the philosophical underpinnings of programs relating to which areas need to be researched.

Of course, every field of inquiry needs to do this, but in the disordered eating/eating disorders field we have the added burden of being an active part of the problem, usually without knowing it. How do we systematically deconstruct the normalization of self-hatred, our disconnection from our bodies, and the fat phobia/discrimination that may inform our choices?

Systems of whatever kind — health care, social services or our current economic system — are simply a reflection of societies' current choices. It is the societal beliefs fueling those choices that need to be changed. Where to start? Well, as you read through this issue the many contributors have offered several points of entry for you to consider and act on.

On a more subtle level, we can start by listening to the stories we share amongst our friends and family, or more importantly the ones we tell ourselves; and by learning to recognize, then question the 'normalization' of self-hatred, disconnection from our bodies and fat phobia/discrimination. When we all do this, I believe there will be enough drops of violet dye in the water of society to manifest a ribbon of understanding and compassion: one that doesn't dissipate with time, and one we can all use as a catalyst for research, activism, healing, growing and living.

The self-hatred, the pain, and the disconnection from our bodies is simply a normalized aspect of our society. Like a fish in a bowl, we can or won't see the water even though it's everywhere.

Making the Connection

Disordered Eating in our Communities

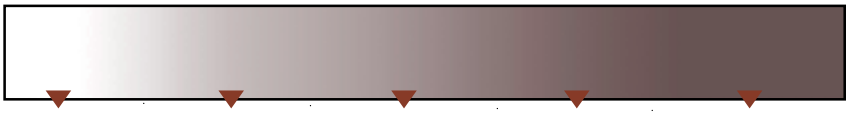
Heather Lumley, MA, RCC

Heather is a registered clinical counsellor currently working in private practice in the Lower Mainland. She completed her Master of Arts at Antioch University in Seattle, WA and has focused most of her studies in the areas of addictions and disordered eating. She has focused her work on the complexity of disordered eating, how to recognize the signs and the sociocultural influences that perpetuate negative self-image and poor body image.

Disordered eating and eating disorders are in essence a struggle for identity and a desire for increased control over one's life [1]

There are numerous factors in a person's life that combine to increase the chances of becoming affected with disordered eating patterns. Disordered eating is becoming a cultural epidemic that is affecting more and more individuals, crossing cultural, economic, gender and age groups. The question of how to prevent and recognize disordered eating arises when we acknowledge that this is an issue currently being witnessed in many arenas — but, individuals lack the information around what perpetuates disordered eating, and how it can be managed.

Continuum of Disordered Eating



body image acceptance	body image dissatisfaction	food/weight preoccupation	emotional eating	anorexia, bulimia, compulsive overeating
■ eating due to body's own needs	■ "feeling fat"	■ dieting	■ eating when sad, happy, stressed	■ starvation
■ listening and responding to hunger signals	■ not satisfied with appearance	■ fasting	■ eating for no reason	■ self-induced vomiting
		■ excessive exercise		■ guilt or shame associated with eating
		■ loss of control		

Disordered eating can be viewed as a concern that falls along a continuum with 'normal eating' on one end and clinically diagnosed and treated eating disorders on the other end. The 90% of individuals that fall along the continuum in between the two ends may still have a relationship with food or with their body that is less than healthy. For example, many of these individuals use physical appearance as a tool for measuring self-worth.

Individuals move along the continuum of disordered eating depending on their life situation, stressors and social context. Disordered eating can appear in one's life first disguised as an attempt to fit in with social standards, family pressures or individual goals; however, these efforts to meet unrealistic weights and sizes can quickly consume one's time and energy. One becomes increasingly concerned about what one eats, what one weighs and what one's body looks like. As body image dissatisfaction increases, we move closer towards clinical eating disorders.

In addition to those struggling with clinical eating disorders, there is a wide range of individuals that struggle with disordered eating without acknowledgement — due to the secrecy of the behaviours, and due to the lack of information and support for disordered eating. It was once believed that men did not suffer from disordered eating; however, research indicates that many more males are affected by disordered eating than was originally thought.[2]

The continuum of disordered eating diagram indicates the varying levels of disordered eating in and out of which people can cycle. This framework acknowledges that food is not the primary issue, but instead is the tool that one uses to cope with feelings of dissatisfaction.[1,3,4,5]

As society continues to influence our norms and cultural standards, we are bombarded with messages that indicate that we are not okay as we are, and if we just try harder, we will be able to look differently. It seems that the harder our culture tries to alter our bodies to fit these standards, the more individuals are affected with disordered eating/eating disorders. Anorexia nervosa is the mental health condition with the highest mortality rate. Over 4,000 females in BC between the ages of 14 – 25 are affected by anorexia nervosa and 12,000 by bulimia nervosa[6].

Multidimensional Model of Disordered Eating

There are numerous factors that affect and perpetuate disordered eating. The multidimensional model consists of three comprehensive categories: family and modelling factors, individual factors and social/cultural influences.[7]

Family and Modelling Factors

- poor communication
- rigidity in dealing with problems
- overprotectiveness and failure to recognize child's independence
- outward appearance of stability hiding underlying issues
- strong need for approval from others

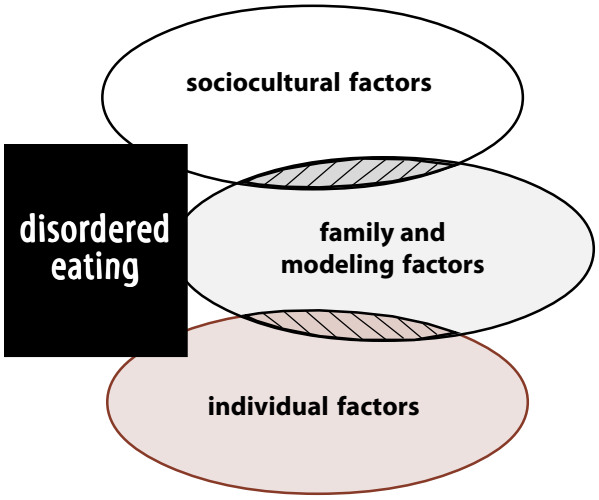
Individual Factors / Emotional Difficulties

- low self-esteem
- feeling ineffective
- feeling out of control
- drive for perfectionism
- lack of sense of self and one's individuality

Sociocultural Factors

- pressures to be thin in society and the role of the media
- discrimination against fat and fat phobia
- pressures to achieve
- individuals are taught to base self-worth on appearance

Multidimensional Model of Disordered Eating



+ **physical/biological realities:** natural weight, existence of a wide range of body sizes, ineffectiveness of dieting

How Can We Help Prevent Disordered Eating in Our Communities?

By increasing dialogue around feelings and emotions, we can help foster positive family environments and communities — communities where it is safe to be an individual and to be comfortable in our bodies, no matter what size we are. Disordered eating/eating disorders often stem from the desire to achieve unattainable goals and to be 'perfect.' Helping to recognize and honour different abilities and reinforce personal bests can promote self-esteem and increase one's feelings of self-worth.

Ways to Help Promote Positive Body Image and Decrease Disordered Eating[1]

- overcoming fat phobia and prejudice
- modeling a healthy lifestyle of eating
- encouraging active living
- learning self-love so that you can model it for children and youth
- decreasing remarks and words on one's appearance and physical attributes
- understanding that beauty, health, and strength come in all sizes
- defining good health as a positive state of physical, mental, and social well-being, as wellness and wholeness achieved by:
  - ☐ eating well
  - ☐ living actively
  - ☐ feeling good about yourself and others ■

footnotes

1 ANAD (Awareness & Networking Around Disordered Eating). (2001). *ANAD friends and family information package*. Unpublished.

2 Andersen, A.E. (1990). *Males with eating disorders*. Brunner/Mazel.

3 Brown, C. & Jasper, K. (ed.), (1993). *Consuming passions: Feminist approaches to weight preoccupation and eating disorders*. Second Story Press.

4 Friedman, S. (1997). *Helping girls through adolescence*. Salal.

5 Kano, S. (1989). *Making peace with food: Freeing yourself from the diet/weight obsession*. Harper and Row.

6 Eating Disorder Resource Centre of BC. (2002). *Preventing disordered eating: A manual to promote best practices for working with children, youth, families and communities*. Vancouver: St. Paul's Hospital.

7 Vancouver Richmond Health Board. (1999). *Healthy Attitudes Program*.

Fat is Only a Three Letter Word

Sandra Friedman

Sandra is a therapist, educator and author in the area of eating disorder/obesity prevention and girls' issues. For information on her latest book *Body Thieves: Helping Girls Reclaim their Natural Bodies and Become Physically Active* and on her other publications, please visit her web site at www.salal.com.

It's hard to grow up female today without being concerned about fat. Girls today feel fat, fear fat and have to deal with the psychological distress of being fat, in a world that worships thinness and has a tremendous distaste of fat.

Adolescence can be a difficult time for girls. As girls go through puberty, their bodies begin to accumulate the fat necessary for reproduction, all the while living in a society that defines the 'ideal' girl as a pencil with boobs and muscle tone. Instead of celebrating their changing bodies, girls are socialized to see them as abnormal. Where once they were able to experience or feel their bodies from the inside out, girls begin to judge their bodies from the outside and define themselves in terms of how they look. In the process, they disconnect from their bodies.

Girls also experience major changes in their lives during adolescence. They are taught by society, including people like us, that it's better for them to hold back their feelings and opinions instead of hurting someone else. Girls are faced with a dilemma: if they are open and honest, they run the risk of losing the relationship, but if they hold back parts of themselves they keep the relationship but lose their selves. Because girls develop their identity in the context of their relationships, changes in these relationships often come at the expense of their sense of self.

Girls are socialized to internalize their distress; thus, many girls learn to deflect feelings that are unacceptable to society and express them in a negative voice. Because fat is considered bad in our society, girls encode their feelings in a *language of fat*. Every time they feel angry, sad or insecure, for example, girls 'feel fat.' Focusing on body size becomes a way of turning concerns about something real on the inside into something artificial on the outside.

As professionals, we need to help girls become aware of when they feel fat, encourage them to express the feelings, and tell the stories that lie underneath. Once they have done this, we need to validate their feelings, help girls see these in a social context, and let them know that they are not alone in how they feel. When girls are not aware of and can't decode the 'language of fat,' they associate the discomfort caused by their feelings with feeling fat. They alleviate this discomfort by dieting.

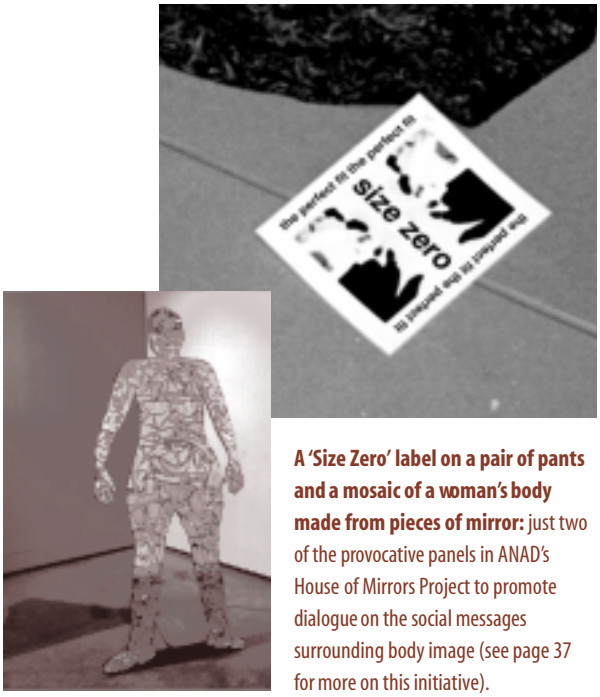
When girls diet, people compliment them on their weight loss and they feel a sense of accomplishment. Some girls begin to feel power over controlling their hunger and begin to restrict their food even more, starting down the slippery slope of anorexia. Some girls binge and purge when restriction doesn't work for them, putting themselves

at risk of bulimia. Some girls begin a cycle of yo-yo dieting. Every time they lose weight they gain it back and more. Repeated cycles of losing and regaining weight put them at risk of cardiovascular disease and high blood pressure. While dieting can make girls sick, no matter which path they follow, there is a fundamental paradox in our beliefs and attitudes about dieting: what is diagnosed as an eating disorder in thin girls is also what is prescribed for girls who are fat.

It's impossible to turn on the TV or open the newspaper without being bombarded with messages that fat is bad. Yet for every study about the dangers and risks of obesity there is one that shows that fat is not the issue: rather, it is the constant cycle of weight loss and gain — as well as the lack of exercise — that puts people at risk.

Girls may be fat for a multitude of reasons. Weight is a complex mix of biological, social, environmental, psychological, and lifestyle issues. Many girls are genetically fat. Some are fat because of faulty hunger mechanisms which develop when their mothers (and sometimes fathers) restrict their food when they are young. Some girls learn to deal with emotional situations in their lives by using food to anaesthetize their feelings, purging food to get rid of their feelings or controlling their food intake in order to gain a sense of control in their lives. Some girls are fast food junkies in a culture that encourages them to order a bigger serving of fries or a double sugar-laden drink for just pennies more. Some girls are fat because they diet and binge. Some girls are fat because their families are poor and choose less expensive foods laden with carbohydrates, rather than fresh fruit and vegetables. Many girls are fat because they don't get enough exercise. Today, playing outdoors has been replaced by sitting at the computer or watching TV. Many schools don't have regular physical education, and when they do, it doesn't meet the needs of girls.

Society's prejudice towards fat is internalized by girls at an early age and becomes entrenched as they grow up. Prejudice robs fat girls of their self-esteem and makes it difficult for them to feel loved and accepted in a society that rejects them because it finds their size unacceptable. Their low self-esteem and hatred of their bodies is often caused not by being fat, but by the shame that they are made to experience in a culture that only values people who are thin.



A 'Size Zero' label on a pair of pants and a mosaic of a woman's body made from pieces of mirror: just two of the provocative panels in ANAD's House of Mirrors Project to promote dialogue on the social messages surrounding body image (see page 37 for more on this initiative).

We need to help girls be fat with dignity. We need to let fat girls know that they are beautiful and help them find their passion, so that they don't define themselves only by how they look. We need to help girls deal with teasing and bullying by giving girls skills to fight back and by lobbying our schools for zero tolerance. We need to teach girls that fat is a body type and not a character type. They need to learn about genetics and metabolism. We need to put an end to teachers who weigh girls, measure their fat with callipers or choose only the thin kids. We need to encourage our girls to be active and ensure that there are activities for everyone, not just the girls who are thin.

Most important of all, we need to examine our own beliefs and attitudes about body size. As professionals we too are products of the culture in which girls mature, and we are influenced by these same prejudices and biases. Despite our best intentions, we pass our attitudes along to the girls. Often we have difficulty getting past the belief that fat relates to bad lifestyle choices; and we also have difficulty not viewing the situation as a failure of will, or with resisting our need to make someone 'healthy,' instead of focusing on the real needs of the girl.

We need to be able to acknowledge our own weight prejudice and monitor our language and actions for signs of it. We need to be aware not only of overt fat prejudice but also of the subtle messages that seemingly promote size acceptance, but only as long as that size is not too large. When we find the body size of a particular girl disturbing, our reactions often are more about our own fear of fat than they are about her body.

Girls come in all sizes and shapes. Until we can celebrate this and until fat becomes only a three letter word, eating disorders and obesity will continue to rise despite our efforts to stop them. Our girls deserve better.

Food, Emotions and Emotional Literacy

Pat Kitchener

Pat is a psychotherapist in private practice in West Vancouver, specializing in the treatment of eating disorders and relationships. She personally suffered from disordered eating.

Many of us are puzzled by our relationship to food. We are even more puzzled by the relationship between food and emotions. On some level, we know that some of our eating or not eating is not about being hungry or full. We try to find a rational explanation for our behaviour, and see that the link between food and emotions is a sensible one because being nourished (food/feeding) and being nurtured (feelings/emotions) are linked. From the time we are infants, we are held and fed at the same time. When our bodies feel discomfort or hunger, our mother or caregiver comforted and fed us. Thus from the beginning of our lives, our emotional needs are met at the same time as our food needs — and so the two become linked and inseparable in our lives.

As we develop, we quickly learn that when we are uncomfortable, we can control that discomfort through food and eating. If we can't control our discomforts in other ways, we achieve control using the basic formula of food and comfort. For example, we have a dinner with friends and later, even though we know we are not hungry, we find ourselves in front of the television eating ice cream directly from the carton. Perhaps the contrast of being with others and then coming home alone leaves us feeling lonely, and unconsciously leads us to fill that emotional need with the ice cream. Or maybe the dinner left us feeling emotionally unsatisfied because we didn't connect with someone the way we expected; or there was tension, and we came away unsatisfied. Yet, we couldn't name the vaguely uncomfortable feelings in our bodies, and thus we satisfied ourselves by using food.

As we grow older, this relationship becomes more complicated, as unrecognized feelings and unmet needs get further translated into not only eating behaviour, but also body dissatisfaction. When we are invited to a special occasion — a high school reunion or a family wedding — or we're simply out with others, why do we become preoccupied with how we look and our weight? We don't acknowledge how we feel emotionally about the event. Instead we believe if we lose a few pounds, we'll feel better at the event. So we begin to restrict our food using whatever diet is currently in favour, and if we are successful in losing weight, we attend the event feeling more confident and focused on our weight loss. But did our confidence simply divert us from our feelings of nervousness or excitement? If we don't lose weight, we are convinced the feelings we experience are because of our failure to lose weight.

Although it makes sense that food becomes linked with emotion, why can't we separate the two as we grow out of infancy? For one thing, throughout life, food continues to be associated with emotions. If Mommy loves me she'll make my favourite foods, give me a cookie, or buy me a treat.' Besides families, many religions and cultures have strong traditions about food — fasting or feasting — to mark the intensity of special occasions. This reinforces the link between food and emotions. It is almost as though we cannot go through any highly emotional event without using either the restriction or consumption of food.

The link between food and emotion becomes obvious during the pressure of exams, when a student can consume a bag of cookies or box of potato chips while studying, hardly remembering opening the package. When a relationship breaks up, we find our weight going up or down dramatically without noticing any change in our eating habits. At such times, we are preoccupied with intense emotions and pay little attention to eating food for nutrition. We may be curious about this, but we usually don't value our feelings enough to examine what is happening.

Over the last 20 years, two other things have happened that have increased the focus on restricting and/or consuming food, and distracted us from seeing the relationship between food and emotions. First, the incidence of anorexia nervosa and other eating disorders has increased, and secondly, at the same time, fast food has become so readily available. Therefore, it is has become easier for us to focus on either food refusal or consumption as the issue, instead of dealing with emotions.

However, more recently, there has been a move towards 'emotional literacy,' and we are being encouraged to be aware of our feelings and emotions. This awareness could be a valuable resource for making decisions about our behaviour, and about how we go about getting our emotional needs met. Emotional literacy quite possibly is the way to separate food from emotions. Then we could eat food for nutrition and get our emotional needs nurtured more appropriately. Once aware of feelings, we recognize and label them, as well as understanding the underlying needs. Then we can act on getting our needs met in a healthy way.

Exploring the Role that Ethnicity and Culture Play in Disordered Eating

Esther Kane, MSW, RCC

Esther is a psychotherapist in private practice in Vancouver and Burnaby specializing in women's issues. She combines feminist and multigenerational family systems theory in her work. She can be reached at (604) 512-4789 or estherkane@hotmail.com

My journey over the past 15-plus years to understand disordered eating has been extraordinary. It started in my teens when I suffered with bulimia that seemed impossible to cure. I began a quest to find recovery and healing for myself, which then led to a professional journey to assist others in their healing as a psychotherapist.

As a young woman struggling with disordered eating over a decade ago, my own recovery consisted of a multitude of factors: namely, support groups which emphasized emotional and spiritual growth; learning how to 'eat normally'; and individual therapy which emphasized the role that past experiences and family issues played in my obsession with food and body image.

As food and weight became less and less of a focus for me, I realized that many other women like myself struggled with the same problem. I began to shed the shame and self-blame which I had been carrying around with me regarding my struggles with food and body image.

As a social work student in my 20s, I began to research all of the theories and approaches used to understand and treat disordered eating. I began to question the biomedical approach that tends to pathologize the individual sufferer and blames her for her 'illness.' In my work with young women with disordered eating in a Toronto hospital, I was disturbed that treatment focused exclusively on nutrition and family therapy. This seemed too narrow a focus when the girls in my group spoke at length about the societal pressures they faced on a daily basis that promoted being dangerously thin.

It was at this point that I turned my attention to the underlying forces in our society which have so many women completely obsessed with 'being thin.' I began to read everything feminist that I could get my hands on and became excited about viewing eating problems through a much broader lens which blamed society, *not* individual women, for their troubled relationships with food and body image. While I was greatly upset by the enormity of this phenomenon, viewing eating problems as predominantly a 'women's issue' helped me to empower myself and the women I worked with to take action by fighting back, through challenging outside forces which demand perfectionism and an anorexic body ideal.

However, through working with a diverse group of women, I soon realized that not all of us experience eating problems in the same way: it seems to me that eating problems are experienced in unique ways depending on many factors besides gender; most specifically, one's cultural background. For my graduate research at UBC, I decided to study something more close to home: I had the personal experience of growing up as a Jewish woman with an eating problem and knew many other Jewish women who had experienced eating problems as well. My logic was that if I could better understand my *own* culture's struggles with food and body image better, that perhaps I could begin to understand and work effectively with the experiences of other women with eating problems whose cultures were different than my own.

After conducting in-depth interviews with four Jewish women of various ages and backgrounds who had struggled with serious eating problems, it became clear that all of them linked their eating problems to the experience of being Jewish. They all contextualized disordered eating within the specific ethnocultural environment in which they were raised. The four major themes that emerged were:

- **Theme #1:** eating problems were passed down within families, and were about needing to appear perfect to the outside world.
- **Theme #2:** the centrality of food in Jewish culture.
- **Theme #3:** Jewish women not matching the North American beauty ideal.
- **Theme #4:** conflicting role expectations which are characterized by internalized negative stereotypes of Jewish women such as 'The Jewish American Princess' and 'The Jewish Mother.'

In the four years since publishing this research, I've found that the findings on Jewish women and problematic relationships with food and body image are applicable to many minority cultures. After working with a number of women from a multitude of cultural backgrounds, the consensus appears to be that ethnocultural factors play a very significant role in the development and maintenance of disordered eating. Thus, it makes sense that those of us in the helping professions educate ourselves on the role that our clients' culture plays in their struggles with food and body image.

The women all contextualized disordered eating within the specific ethnocultural environment in which they were raised.

Spirituality and Eating Disorders

Kristina Sandy

Kristina graduated from the University of Victoria with an M.A. in Educational Psychology. She currently facilitates a woman's group through Awareness and Networking Around Disordered Eating (ANAD) in West Vancouver. Her interests include women's health issues, self-development, eating disorders and spirituality.

Some years ago, I walked into the eating disorder clinic in Victoria BC, books in hand, ready to do research for a psychology course. Several frail looking women were waiting in the reception area accompanied by — one could only assume — their mothers, who were noticeably distressed and concerned. My heart went out to these women who were watching their children disappear before their eyes, unable to stop the terrifyingly destructive nature of this illness. What turmoil lived inside these young girls who, like ephemeral angels, did not allow themselves to be nourished by life so they could grow into beautiful vibrant women?

The short and long term health risks of this illness impact the individual, their families and communities and warrant serious attention from the medical community

According to ANRED (Anorexia Nervosa and Related Eating Disorders, Inc.):

- the mortality rate for anorexia is higher than for any other psychological disorder
- it is the number one cause of death among young women
- 1 out of every 100 young adolescents between the ages of 10 and 20 suffer with anorexia nervosa
- 1 out of every 4 college-age women suffer with bulimia.

Given the secretive nature of eating disorders, these figures are quite likely underestimated.

Ideas about the causes of eating disorders have been divided by Harvard researchers into four types: biological theories, family theories, individual/personality theories and cultural theories. Feminist theorists believe that all women suffer with disordered eating of some kind, varying only in degree. They believe that the illness is a response to a woman's experience in a world in which she feels devalued. Sharlene Hesse-Biber, author of *Am I Thin Enough Yet?,* refers to this world as the "cult of thinness,"[3] where one believes the myth that when one achieves thinness then one will be beautiful, successful and loved. This world holds great appeal to the millions who are inundated with the messages of media advertisers marketing consumer products.

When I learned about all these theories, as much as I agreed with them all, something still seemed to be missing. I found this missing piece in books about the effectiveness of spiritual intervention in counseling, and for my Master's thesis, I explored the role of spirituality in the lives of women who had recovered from an eating disorder. Each woman defined spirituality in her own unique way. For one, it meant a sense of being free, for another, a feeling of being connected to the source. Yet another called it a sense of 'letting go.'

The word spirituality comes from the Latin root *spiritus,* meaning breath of life. Individuals who communicate with whatever object of belief —*Brahman* or the *larger self*, the *Tao, Jesus* — all testify to the immediate experience of the smaller self expanding into a larger self. It is a loss of many small selves in union with a greater whole that is at the root of the spiritual experience.[7] Have women suffering with eating disorders become disconnected with this larger self?

In Western society, health has been defined in strictly clinical terms by physicians, with the fate of the spirit being relegated to religious authorities. However, from early times of humanity, and for many societies around the world today, the priest and physician continue to be considered as one. It is understood that the condition of the spirit determines the physical state of the body.

Eating disorders have their roots as far back as the 13th century, seen in religious women referred to as 'holy anorexics.' These women held high status in the church and society; some like Saint Catherine of Sienna sadly ended up starving themselves to death.

Joan Brumberg, historian and author of *Fasting Girls,*[2] compares the fasting girls of the past and eating disordered women today, claiming that they both use their bodies as a vehicle for making a statement about their identity. While fasting girls of the past sought perfection in the eyes of God, today's women with anorexia seek perfection through society's perception of physical beauty.

Many of the women I spoke to found the tools available for dealing with their eating disorders inadequate. Perhaps the traditional medical approach that focuses on the emotions and cognitive functions is not enough. The use of spirituality, whether through meditation, dance, yoga, visualization exercises or simply learning to connect and trust one's inner intuition may prove to be particularly valuable tools.

A closer look at the spiritual and emotional worlds of those who have transcended their eating problems reveals many similarities. All the women seemed to learn that connecting to their true selves is the real answer. To them, this meant seeing, accepting, and loving themselves for who they were, and ceasing to starve themselves of their Self.[4] Women are starving themselves to be thin and to be 'well,' as they hunger for a sense of fulfillment and well-being.[1] The women in my study learned to redefine their hunger and listen to the hunger of their spiri ■

footnotes

1 Bruch, H. (1979). *The golden cage: The enigma of anorexia nervosa.* NY: Vintage Books.

2 Brumberg, J.J. (1998). *The fasting girls: The history of anorexia nervosa.* NY: Random House.

3 Hesse-Biber, S. (1997) . *Am I Thin Enough Yet? The cult of thinness and the commercialization of identity.* Oxford: Oxford UP.

4 Kesten, D. (1997). *Feeding the body, nourishing the soul: Essentials of eating for physical, emotional and spiritual well-being.* Berkeley, CA: Conari Press.

5 Leichner, P., Brown., Atkinson, S., Henderson, R.,& Jacek, D. (2001). *Spirituality groups for people with eating disorders.* Abstract obtained from St. Paul's Hospital and BC Children's Hospital, Vancouver.

6 Normandie, C.& Roark, L. (1998). *It's not about food.* San Francisco: Berkley Publishing Group.

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Only Media Subjecting Women?

In the present day, power holds a smoother language, and whomsoever it oppresses, always pretends to do so for their own good.

— John Stuart Mill, *The Subjection of Women*, 1869

Dana

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Historically, women have been more identified with their bodies than men. When we look at today's women's magazines, television shows, and advertising, we are surrounded by women of the same colour, shape and weight. As the Anorexia Nervosa and Related Eating Disorders (ANRED) web site points out, reading between the lines of what the media are offering us reveals a message: "You are not acceptable the way you are. The only way you can become acceptable is to buy our product and try to look like our model." When thinking about this message, we necessarily come to wonder about its origins. The ones to blame are usually the media themselves; however, the media is created by us, the constituents of the society.

We need to start looking at the broader cultural implications of what we see and what happens to women in general. A victim of anorexia asks: "Why are we letting society do that to us?" However, posing a question like that assumes that society is a body with a life of its own. What is it in us, human beings, that enslaves us to the messages offered by the media? This 'slavery' is a particular issue with eating disorders, which somehow surface in societies with the greatest abundance and material well-being.

Feminist view

Feminism has interpreted this phenomenon in terms of power and privilege in society . Susan Bordo in her book *Unbearable Weight* reveals a deep societal contradiction when she says: "When a patient complains of her body and insists on being thin … she is accused of flawed reasoning and misperception of reality that the therapist must work to correct," but we need to realize that there is a widespread cultural disorder where, "culture not only has taught women to be insecure about their bodies, constantly monitoring themselves for signs of imperfection, constantly engaged in physical 'improvement'; it also is constantly teaching women (and, let us not forget, men as well) how to see bodies." So how 'flawed' is that patient's reasoning, then?

This 'seeing' is done primarily through the media, because what we see around us is not what we see in the magazines or on TV shows, even though we are surrounded by diversity of ethnicity, age or body shape. Why then do we forget about this diversity once we open the fashion magazines or turn on our favourite TV show? What happens to our minds? Do we just like to pamper the part of us that wants a simplistic view of reality devoid of any imperfections and project ourselves into a fantasy of what it would be like if…? Many make every possible step in the direction of this fantasy, no matter what the cost is; and they are encouraged on the way there — with sermon-like messages reinforcing that this is the right way — in the quest for the ideal look that will bring them so much credit in the eyes of the opposite sex and among women themselves. This credit is equated with success, since society defines success as being a thin, almost artificial individual. Ironically, in Western societies like ours that base their existence in plurality and freedom of expression, it takes real courage for women to be different.

Change

What can be done about this? Some advertisers are leading the way in the attempt to alter this perspective by running positive body-image campaigns. From time to time, women's magazines publish articles featuring stories of women successfully overcoming eating disorders. Unfortunately, the articles usually reflect the overall perspective of the magazine, and come across in a rather simplistic way, focusing on the individual and not the wider societal implications, and are often followed by ads promoting the very ideal or dieting products that nearly killed the victim.

The first few positive campaigns on the road to changing women's perspectives appeared at the end of the 1990s, and include Kelloggs' cereal ads featuring men talking about their bodies the way women usually do, with the implicit message stating that it doesn't have to be so. One man says, "I have my mother's thighs. I have to accept that." The underlying message is "Men don't obsess about these things. Why do we?" The company also launched the "Reshape Your Attitude" campaign in 1998 with educational videos. The Body Shop tries similar tactics by using a Rubenesque version of Barbie, size-18 figure, in their posters. Their motto is: "The media tells us that we're the wrong shape, the wrong colour, the wrong class, the wrong hair type, the wrong salary, the list goes on…we believe that we should all be celebrating our individuality."

One can find some useful documentaries of personal accounts of people's fight with eating disorders, such as *Dying to Be Thin* by NOVA television. There are also organizations that focus on analysis of advertising and lobbying for improvement of media standards such as Media Watch (www.mediawatch.ca) and Ad Busters (www.adbusters.org).

I hope that this article has inspired you to think about the role of the media and the broader societal implications of the phenomenon of eating disorders. I will conclude with a simple quote that says it all and sends us smoothly to the way of living we should pursu

One cannot think well, sleep well, love well, if one has not dined well.

— Virginia Woolf, *A Room of One's Own*, 1929

critical reading

If you are a regular reader of women's or bridal magazines, maybe you no longer consider what quotes like these will do to your mind and body:

- "Need to lose a little weight before your wedding?… Every day, enjoy a delicious shake for breakfast and lunch, followed by a sensible dinner… Lose Weight. Feel Great." Dietary supplement ad in *Weddingbells*, several pages after pictures of wedding dresses for plus-size women.
- "Join us and get Beach Beautiful for about a dollar a day. Lose 2–5lbs in the first week!" Ad in the *Georgia Straight* immediately after an article on eating disorders.
- "I have to watch what I eat as I'm naturally prone to curviness." Claudia Schiffer in *Marie Claire* — as if curves on a female body were a bad thing.
- "I plan to be photographed in the gown every five years. It is the carrot I'm using to keep my weight under control and my body fit." Article on how to preserve your gown from *Today's Bride* — as if we can never allow our bodies to age and change shape as we age.
- "Celebrate the first day of autumn. Play touch football (and burn 488 calories an hour) or take a hike late in the afternoon (366 calories)." Calendar suggesting what to do on a specific day of September in *Self* magazine.

LEFT: sample print ad from Kelloggs' "Look Good on Your Own Terms®" ad campaign (to see all the TV and print ads, vist www.specialk.ca)

RIGHT: Tonner's new size 12 Emme doll gives children a more realistic figure than Barbie

An ad for a dietary supplement depicting a figurine of a bride falling through a wedding cake has the caption "Need to lose a bit of weight before your wedding?"

Growth-Fostering Relationships

Supporting Liberation from Eating Problems

Lynn Redenbach, BA, RPN, MA(cand.)

Lynn Redenbach is in private practice where she works with persons whose lives have been impacted by eating problems, trauma and depression. She facilitates groups incorporating the Relational Cultural Model.

Eating problems include a range of difficulties involving dissatisfaction with the appearance of one's body, attempts to alter food intake, (restricting/cutting back on certain foods, dieting, bingeing/overeating) and, sometimes output, (purging, over-exercising). For some people, body dissatisfaction is less the reason, with their difficulties with food resulting from other experiences such as trauma or oppression. The reasons for eating problems are complex and there are different ways of thinking about these reasons. For example, the biomedical model focuses on the physical aspects of eating disorders and family therapy models work with family dynamics. Other theories focus on the relationships people have with significant persons in their lives as well as their communities, society and culture. One such approach, which entertains the impact of the multiple relationships that people have, is the Relational Cultural Model.

This relational model of development stresses that healthy psychological development occurs when people receive opportunities to participate in *growth-fostering relationships*. The researchers of this theory also defined the dynamics of growth-fostering relationships. They found that connection is a key process. Connection is defined as, "…an interaction between two or more people that is *mutually empathetic* and *mutually empowering*…" (Miller & Stiver, 1997, p. 26). Thus, the creation of a growth-fostering relationship is a mutual process whereby all of those involved are present and participating fully. Mutuality doesn't mean that all the persons involved in a relationship have the same role, nor participate in exactly the same way. However, both/all persons involved benefit from the relationship. An example of this is the relationship between parents and children. Parents obviously have very different responsibilities and ways of participating in their relationship with their children. However, mutual involvement means that parents *and* their children are free to express themselves authentically, empathize with each other and feel empowered by the relationship.

This is contrasted with disconnections in relationships, which

From T.O.P.S. to Wreck Beach

A Journey of Disordered Eating

Dena Ellery, BPR, MDiv

Dena is a candidate for Unitarian Universalist ministry and was an educator with the Canadian Mental Health Association in Nova Scotia and BC.

Disordered eating: that's what I've come to call it. And I don't think I'm alone. Most women I know have a disordered relationship with food. I have struggled through many downward spirals of bingeing and purging, and food is still an addiction that I use to avoid facing squarely my real turmoils and troubles.

Each person who struggles with disordered eating has their own reasons. My own journey through disordered eating has been and continues to be a spiritual, emotional and a political one. In my reading, reflection and experience, I've come to understand that food is not just a physiological need. It is also intimately bound up with our emotional and spiritual sustenance and our identity. And the relationship to food becomes disordered when food becomes confused with other needs.

Beginnings

In elementary school, I remember waiting for my mom to come home from work. I was alone in the house, an only child. My only friend was food. I ate for two hours until Mom came home. By the time I was 12, my weight was a source of constant ridicule by other students ("Fatty, fatty, two-by four, can't get through the bathroom door.") So in Grade 6, I started attending a weight-watching program called T.O.P.S. (Take Off Pounds Sensibly) that met weekly and gave out prizes to people who lost the most and booby prizes to people who gained the most.

Identity

I remember the first years of being on my own in my late teens and early 20s, dissatisfied with my life, my body image and sexual attractiveness. I would travel to two, sometimes three fast food outlets and eat a meal at each . . . then to an all-night store to pick up laxatives. The physical aspect of the purging was always secondary to the psychological ones of nurture in the face of uncertainty and risk, and of release — letting go of emotional pain and baggage. I knew that some people purged by vomiting, but on the one occasion when I tried (after a cancelled date led to a binge), I couldn't. Hands down my throat, a voice in my head said, " You don't have to do this. Your mother loves you."

Yet, the messages that I am

Growth-Fostering Relationships (cont'd from previous page)

are found to create psychological distress. "Disconnection can range from a minor feeling of 'being out of touch' to a major experience of trauma and violation." Relational disconnections can occur in personal relationships or on a larger scale within our communities or society, for example, with people who face the challenges of racism, classism, ableism and the discriminatory beliefs and practices of our homophobic and fat phobic culture.

How Can this Relational Model Be Used to Better Understand Eating Problems?

Instead of looking at eating disorders as problems that exist within the individual, the Relational Cultural Model encourages us to consider eating problems within the context of people's relationships. Put simply, when people have chronically or seve rely disconnected relationships with significant persons, their communities and/or their society, they develop ways to survive or get through. Eating problems can be one of these strategies. In the absence of connected relationships and in a cultural climate that often requires people to disconnect from their own experience, the body becomes the vehicle of expression. This makes even further sense when we consider the current cultural pressures targeted directly at the female body, i.e., pressures to be thin, emphasis on bodies as objects, media focus on appearance, etc. For males, pressures of strength, muscles and being 'big.'

However, this strategy, (namely an eating problem), ultimately works against psychological and relational wellbeing. Instead of resolving the original disconnections, eating problems further disconnect people from their families, friends and ultimately themselves. As a result, new relational strategies that ultimately support liberation from eating problems are indicated.

Given the findings that connection in relationships is key to psychological well-being, people dealing with eating problems can be supported by the development of more mutually empowering and empathic relationships. For some people, this might mean that they begin to develop new relationships that hold the potential and ability for connection: for example, new friendships, support/therapy groups, finding a good therapist. Working with significant others towards greater empathy and mutuality in relationships can also be helpful, for example, through family therapy or couples therapy. Also, having opportunities to explore one's own strategies of disconnection and connection in relationships can be an important part of building more connected, growth-fostering relationships.

Ultimately, a relational approach to understanding and dealing with eating problems encourages us to consider the multiple relational contexts of our lives. None of us develop and live in a vacuum. Thus, we are invited to consider eating problems as solutions to the relational and cultural disconnections in our lives rather than an individual disorder or pathology. This also gives us hope in being able to develop greater connection with each other and within ourselves.

Backyards to Play In

"Have you gained weight?," my aunt asked when we met this afternoon. "No." I attempted to end the conversation before it started. She persisted though, insisting for several minutes that I had gained weight and that she could tell.

I was initially upset by this experience; I cried when she left. Then back home, looking into the mirror, I saw, just as I thought, that I am the perfect size. I love my body, for how I look and move, for my beauty and strength.

Serena

Serena is a fourth year English student at UBC.

Young women are pressured to be thin; I know because having felt the pressures, I struggled with bulimia for a year of my life. It was a difficult experience with a challenging road to recovery. Having fully recovered, I see that we each have the power to heal disordered eating, and the rewards are worth the effort.

From some time in elementary school until my second year of university, eating was my magic cape which protected me from the judgment of others. I was a skinny child and knew that my body type drew both admiration and resentment. "Does she eat?," I would hear adults ask my parents; my extended family would ask me outright, and in late high school and early university I noticed some peers watching me for answers to this same question. I felt that if others could see me eating — especially in large quantities — they would not judge me. So I ate more than I was hungry for, and felt safe.

When I began university, my workload increased. A chronic procrastinator at the time, by October mid-terms, my stress level was so high that I began binge eating to find relief from that stress. However, still believing that my body shape defined me, I also began purging to counterbalance the disaster of gaining a pound or two.

Thus I began my experience of bulimia with a certain nonchalance, the way I imagine some people begin smoking. Though I had seen one of my closest friends suffer immensely from anorexia, be hospitalized, and eventually drop out of high school, I believed that my own experimentation with bulimia was not a big deal, and that I would always be in control of my own choices with regard to disordered eating.

The danger with bulimia is that it initially makes binge eating acceptable, because a remedy exists (purging) — and so the cycle can deepen very quickly. I was soon bingeing and purging daily

I felt the effects on my body right away. My throat burned, my mouth hurt, and my teeth ached. The damage to my teeth is the one battle scar I carry always. Until the end of high school my teeth were white, strong, cavity-free; now I have five or six fillings, and with my dentist puzzling how the enamel has worn away so drastically, I did not tell him that I had thrown stomach acid over them for nearly a year

essentially unlovable plague me. Everywhere in magazines, TV, movies and billboards are the so-called models of sexual attractiveness, telling me that if I don't have this lotion or potion or product, I'll never be like them. Never be loveable or desirable. It has taken years to build up an arsenal of protection for my fragile self-image. Below are some of these steps toward wholeness.

Addiction

I spent several years attending 12-Step groups of Overeaters Anonymous. I came to see food as an addiction, something I turn toward to avoid, to ignore, to numb. The emotional connection became clear, but there were times I wished my addiction might be alcohol or drugs, something I could do without altogether. I still needed to eat in order to live.

Reintegration

It was a women's film festival that helped me reintegrate my relationship to food. Here, at every planning meeting, women gathered to eat and share and work at planning the festival. I watched as women ate with gusto and vigour, sharing in the sensual delights of our food. It was a spiritual experience: food as a sensual and community event helped me to reintegrate my sense of nurturing. I recognized that nurturing comes from community, and that food is the vehicle, not the source of healing. I no longer feared my food, but embraced it with loving intention in preparation and in eating.

Body Image

I became a representative for MediaWatch, a national feminist organization that monitors the portrayal of women in the media. As I learned and presented materials about women in the media, it became clear that our media culture has an influence on our psyches. I found my critical eye. I read Naomi Wolf's *Beauty Myth* and began to deconstruct the consumer ad culture that plays on women's self-esteem. I went on a media diet, giving up cable, all fashion magazines and lived boldly by Wolf's motto, "The woman wins who calls herself beautiful and challenges the world to truly see her." I developed body image workshops for women to help them untangle themselves from soul and psyche-degrading media messages.

Body Acceptance

When I moved to Vancouver, a friend introduced me to Wreck Beach, a clothing-optional beach near the University of BC. In stages, I became comfortable being at this place where body acceptance is the goal, and any kind of voyeurism is frowned upon. I looked around and saw that I was just one imperfect body among all the imperfect bodies there. And I realized that there is beauty in *all* our shapes and sizes and colours and imperfections. When I saw a woman there who could have been a billboard model, she seemed somehow out of place among nature's beautiful imperfections.

My disordered eating has taken me on a healing journey I've found moments of wholeness — a self-acceptance and sense of balance and perspective that, ironically, I might not have found otherwise. In some ways, I'm grateful for this spiritual teacher in my life.

After several months, I knew that the physical and emotional toll of this disorder was too high. It was time to give it up. Thus I began a tumultuous and trying year-long road of recovery.

There was progress and regression; the last four months, which coincided with my first term of second-year university, were the most difficult months of my life to date. I spent much time crying. Knowing that my eating patterns were not quite acceptable, I kept my greatest heartache private and struggled to continue with my life.

My real turning point came at the end of December when I called my closest friends and told them about my battle with disordered eating. Breaking my isolation barrier, I finally opened myself up to a support network. I decided to accept my body and over the following three years, this resigned acceptance has transformed into appreciation. I rock climb, practice yoga, and enjoy my grace and strength and the places it takes me.

"Once you get past this," a trusted friend once told me, on another matter, "there's a big backyard out there." I agree, and add that each backyard leads to a bigger one. For a time, disordered eating was my whole world; it was harsh and isolating. As I moved through and past it, my life opened up to more succulence and joy.

Though I was influenced by the attention others paid to my body, I do not mean to caution readers to watch their words around children, for I do not think this is a solution. Rather, I believe that as we each take responsibility for loving our own bodies as they are *right now*, we will naturally stop projecting our issues about our own bodies on to our children. We each have the power to heal in this way, and the rewards for doing so are the big backyards that we will find ourselves playing in.

You Go, Girl

Tiffany

Tiffany lives in Vancouver.

Eating disorders are not necessarily related to having a problem with food. When I was 13, I experienced my first puppy-love crush on a boy who was 15. For six months I ohhed and ahhed over this dark-eyed, dark-haired boy wonder. I thought I knew everything about him. He ended up becoming my best friend's boyfriend. So, not only did I not get to go out with this boy, I also never got to spend time with my best friend anymore because they were always together. I felt devastated, betrayed and hurt.

So, while I stayed home and watched TV by myself, I began to eat. I loved eating my sorrows away with huge bowls of buttered popcorn while watching *Three's Company* on TV. I gained 25 pounds that first year that I lost my puppy-love crush. This made me more depressed. I was not only chubby, but no guy would want to go out with me now for sure. I made sure that anyone I decided to like while I was in high school was so far out of my league or they were unavailable. I wasn't going to feel that betrayal again.

In the tenth grade, I took prescription diet pills. It was horrible: I was a total zombie. I couldn't sleep and I was so nauseous that I couldn't eat. One week of that and I just flushed them down the toilet.

I spent a lot of my high school years getting excellent grades, working after school, not getting into sex, drugs or alcohol, and I didn't smoke.

In the 12th grade, I experienced an enormous amount of disappointments: I was chubby, never had a date, and I was full of depression and anger. I often thought of taking my own life, but I didn't act out on those thoughts. So, again I turned to food and I developed bulimia. I would eat a whole box of *Frosted Flakes* with liquid whipping cream and the toilet bowl and I became best friends.

At first, this was a once-a-month binge and purge, then once a week, until in its later stages a year later, I was up to 15 times a day. By then it had become an obsession and also a huge stress reliever to binge and purge so often. My journey into mental illness also began at this time as I was diagnosed with bipolar disorder.

Wolfing back one and a half pounds of chocolate a day also did a huge number on my complexion and teeth. I had been a person who never had a cavity who now had seven cavities in one check-up. The acid from throwing up really wrecks one's teeth. I still do have all my teeth but they're all filled now.

My recovery from bulimia occurred during a hospital stay as the nurses made me remain at the table for an hour after I ate so I could no longer throw up. With the combination of medication and the huge amounts of food I was eating, I gained 45 pounds throughout the first year at the hospital. Now, I was not only chubby: I was short and fat. However, I no longer had bulimia.

A couple of years later, when I was 22, I developed anorexia. I lived off of apple juice and corn. I worked two full-time jobs and exercised at every opportunity. While on this diuretic diet and also experiencing a period of mania, I lost 16 pounds in one week.

Anorexia was more challenging to cure. This was not because of my anger so much but because I so wanted to be slim and attractive. Eventually, I returned to a chubby weight again.

Throughout my 20s and into my 30s, even though I've left overeating and bulimia behind, I still have to watch that I don't fall back into lack of eating and sway back into anorexia. I still can't get up in the morning and eat breakfast. I can go many hours without food. If I do gain weight, I'm obsessive and angry with my imperfections. I know I have to make sure I eat healthy foods, and avoid sugars, starches and caffeine. I also drink a lot of water, but I've picked up a vice since my high school years — smoking. It's a double-edged sword — I believe it helps with anxiety and stress, but it's an appetite suppressant. I'm a serious nicotine addict and although I've made several failed attempts, I'm terrified to quit: my biggest fear is that if I quit I'll get fat, and boy, will

that depress me.

However, back to my original statement, my eating disorders had nothing to do with having a problem with food: food was not the enemy. My emotions, and my lack of coping tools and confidence to deal with many facts of life led me to my battle with food — and now my battle with the cancer stick.

Life at the best of times can appear cruel and unfair. To this day, I can't be around a toilet bowl too up-close and personal for any length of time. Going to the dentist is a nightmare — even though all my teeth are filled, all the tubes and tools in my mouth easily make me gag from past bulimia experiences. If I gain 5 pounds it may as well be 50 or 500 pounds — the emotional hell I put myself through would be the same. To this day, I hate telling anyone what I weigh.

However, I am getting better. I've gone to a lot of therapy over the years and now I make my health and well-being the number one priority in my life. I'm all I've got, so I had better treat myself with love, understanding, kindness, and above all, forgiveness.

My advice to those of you who have or know a loved one with an eating disorder, is to be patient, and (help) get to the core of the problems. Many times the problem is about feeling rejected, afraid and unloved — or about having low self-esteem or anxiety. If you think you may have an eating disorder, talk it over with someone you trust, like your family doctor, a friend or parent. Get help and get to the root of the behaviour, so that you can be in control of your health and emotions.

We live in a very jaded society where it seems everyone wants us to be thin and perfect like a Malibu Barbie — but that isn't realistic. God made each and every one of us unique and special. Celebrate your uniqueness and your beauty and be exactly who you are. Be proud to be different and out of the mold. After all, there's only one of you on this whole planet. Live life to the fullest, seek help and learn to forgive, love and love again ■

Silence the Judge, Release the Victim

A Lesson In Living

Holly Whalen, CMA

Holly is the author of *Silence The Judge, Release The Victim,* an autobiography describing her recovery from her twenty-two year battle with eating disorders. Holly is a successful executive, and the founder of Clear Intentions Strategic Consulting Ltd, and of Inspirit Productions, a company dedicated to communicating well-being techniques to parents.

I was a career woman, making a six-figure income by the time I was thirty years old. I had a professional degree. I traveled the world with the freedom to come and go at my leisure. Yet with everything I always thought I wanted, I was the loneliest, most unhappy soul. I sabotaged my personal life for fear that if anyone got close enough, they would discover my shame. The shame was that my life centred on a deep and out-of-control secret. My secret had my time and attention 24 hours a day.

I had voices inside my head that criticized my every move. Whether awake or asleep, whatever I was doing, all I could think about was whether I was doing it right. I was constantly trying to make people happy through meeting their expectations of who I was supposed to be. When I felt I let someone down, I found a way to deal with my shame. I had struggled with anorexia and bulimia for over twenty years and this was my centre of existence. My eating disorders gave me a way to take control of judging myself before anyone else could. My punishment or reward was whether I would binge, purge or not eat at all.

My recovery began when I started to meet those rare people who appeared truly happy, those people who carried a glow about them. Whether they were wealthy, earning an average income or unemployed, they were very thankful for just being. They lived in the moment. They enjoyed the simple things. They never engaged in meaningless chatter. For them, the glass, no matter what the circumstance, was always half full.

It was these people who intrigued me and at the same time saddened me, because I thought what they had was only given to those worthy and good enough to have it. I began to know different when I gave myself the opportunity to meet and speak to one of these people. She would later become my personal guide to self-healing.

This angel took me through a three-month process of learning to nurture and care for my self. She would help me understand that the hatred and anger I had for the world around me was a mirror reflection of my inability to accept myself. I had for so long been trying to please everyone around me that I lost touch with the person I wanted to be. She helped me understand that all the traumatic events and drama in my life were responses to my own deepest desire: to continually bring myself the loneliness and despair I thought I deserved.

My angel helped me to see my life as being a reflection of my thoughts, words and actions played out through the choices I made, and helped me to see that the person I had become had nothing to do with the person I could be. I would replace my need for judgment with acceptance, and change my role from victim to survivor. All it would take was for me to choose to make my life different.

It amazes me how Western society has neglected to see unhealthy coping mechanisms, like eating disorders for the symbols they are: symbols which reflect spirits broken down over time through gener-

My eating disorders gave me a way to take control of judging myself before anyone else could. My punishment or reward was whether I would binge, purge or not eat at all.

A Journey to Recovery

Interview by Christina Wong

Christina is a Communications and Anthropology student at Simon Fraser University.

This interview relates the experience of a woman who speaks from a dual perspective. Having struggled with an eating disorder, she is now helping others with their struggle. Because of her position as a therapist, she wishes to remain anonymous, feeling that if her identity is revealed, it may take away from her clients focus on their own recovery. Now, in her 40s, she tells a story about a lifetime journey of self-discovery and finding her self-worth. "In no way is this ever going to give justice to the complexity of the experience," she states, emphasizing, "you can't fit everything that contributes to eating disorders in one article. But people need to know that life is so freeing without anorexia." And she begins to tell me her experiences.

"I had three personality traits for being at risk. I was a perfectionist and had obsessive-compulsive traits — things always had to be a certain way for me. The third trait was that I always had this nagging self-doubt that I was never good enough. But having personalities doesn't make you have an eating disorder. Your family environment always puts you at a higher risk.

I was neglected emotionally, because we were poverty-stricken and my parents were always working. To me, as a child, my parents not being there meant that I was not loved. My mother's emotional and physical abuse also added to my sense of not being good enough. In my teen years, there were so many adjustments to get used to, and my mother was always commenting on my body in a negative way. I was always being compared to my sister who developed earlier. I was skinny, but even in the 70s, our society and the media were obsessed with thinness. Going through adolescence with all these challenges in play, I didn't know how to deal with them. I was so limited in my knowledge about who I was and how to cope with abuse.

> I had no sense of myself, and I used anorexia as a way of feeling like I was really good at something.

Being a perfectionist, I was dealing with trying to be perfect. As I tried to cope with the stresses of life, I had never heard of anorexia, but the only way I knew how to feel good about myself was if my body was perfect. At the time, I didn't know that I based myself on shape. I had no sense of myself, and I used anorexia as a way of feeling like I was really good at something.

Different stresses made my disorder worse. When my first boyfriend broke up with me, I lost ten pounds in four days and I felt powerful and because I could control what I put in my mouth. I had no idea that losing weight and exercising were symptoms of a much larger problem.

I didn't have much of a voice. I couldn't share my

Silence the Judge, Release the Victim (cont'd from previous page)

ational belief systems centred on illusions of need, judgement and expectations. We are taught as young children to find security and love outside of ourselves, through living up to the expectations of our parents, teachers, religious leaders and the like. From childhood to adulthood, we are reminded of when it is appropriate to laugh, cry, leave the table or tell a joke. As young children, we were taught what was deemed beautiful or ugly, what was deemed fat or thin, and what was appropriate and inappropriate behaviour; and the moment we did not live up to the expectations of others, we were introduced to judgement through reward (love) or punishment (love withheld).

My angel would introduce to me simple methods I could use to re-program myself back to a place of self-love, peace and self-worth, independent of any given situation. Within just a few weeks, the drama of my life diminished and I was experiencing a world filled with nothing but goodness. I saw the world through a compassionate lens. I saw how much the world was yearning, and how much it required healing, love, acceptance, understanding and, above all, peace.

It has now been five years since I met this woman of wisdom, and every day continues to be a day of self-discovery and adventure; whatever the experience happens to be. I continue to grow and evolve with the knowledge that who I am is inspired through my ability to love, nurture and accept myself as I am. I have learned that experiences come in different forms; how I interpret the moment is an expression of how I feel about who I am at a given point in time. Moments are not to be judged: just experienced.

In my book, I wrote about my life journey and the recovery methods I was so graciously given, so that I could help others find alternatives for healing. I know how difficult and lonely life can appear; however, I can reassure you these feelings are illusions.

There are no accidents in this world, only responses to your deepest desires of experience. Making the choice to want to change your life is the first step to healing. Once you have made the choice, listen carefully and bring yourself to the highest state of awareness; your response is on its way. Whether it is in the next song you hear, book you read, person you meet, story you're told, they are all responses to your desire for healing.

thoughts and opinions because I wasn't aware of what they were. I got into destructive relationships where people would say things that made me uncomfortable; because I grew up not knowing how to say, 'That is not okay,' I took the abuse. For me, I really had to discover my sense of self in order to recover. I had to find identity, worth, and things that were important to me.

My journey to recovery started with education in my chosen profession. It got me thinking about myself. Another key that contributed to learning about myself was finally experiencing a real loving, caring, and nurturing relationship with someone. I was able to trust him because he modeled accepting me for who I am. Being with someone who wouldn't change me — or expect that I look a certain way, helped me to feel safe about exploring who I was.

The more in touch that I got with my opinions and values, the more I was able to share them. I learned to set boundaries around what people said to me and started respecting myself. Every time I said "It is not okay for you to say that to me," I reclaimed myself. And as I got my voice back, I was able to experience others accepting me as well."

Her life is a continuous journey of self-understanding but her story ends here. As we end our conversation, she tells me, "I was always being told to improve or change — nobody accepted me for who I am. But when I focused on discovering and accepting who I was, I began to recover." ■

Starving Silence

Eating Disorders in the Lesbian Community

Tania La Salle

As women continue to work towards changing societal standards and expectations of beauty, we often draw upon the acceptance and appreciation of natural shapes and sizes among one another for support and encouragement. Many would reason that the lesbian community would be a place where women could shed their inhibitions about appearance and live confidently, immune to mainstream definitions of beauty. However, like most women in North America, lesbians have also internalized the message that only certain body types are acceptable. The lesbian community has not escaped 'sizeism' and narrow body ideals, and the misconception that it has serves as a barrier for queer women who require services and treatment around disordered eating and related issues. If visibility remains an issue for the DE/ED (disordered eating/eating disorder) community in general, it acts as a double barrier for women who might also experience isolation or rejection based on their sexuality.

There is very little research on the prevalence of eating disorders within the lesbian community, but anecdotal evidence suggests that DE/EDs occur as commonly among lesbian and bisexual women as they do among heterosexual women. Homophobia (irrational fear of and/or aversion to gays and lesbians) and heterosexism (the assumption that everyone is or should be heterosexual) discourage queer women from expressing their sexual identity and can lead to disordered eating behaviours as a means of coping. Women speak of distancing themselves from their lesbianism through bingeing and purging, or through compulsive overeating. The inability to completely express themselves stems from family and social pressure to live a heterosexual lifestyle. Activists believe that homophobia and the subsequent alienation it causes accounts for the high suicide rate among lesbian, gay, bisexual and transgendered youth (LGBT). It should come as no surprise, then, to find a high frequency of disordered eating behaviours in the queer community; the lack of support and acceptance felt by LGBT individuals which can lead to suicide can also lead to usingDE/EDs as a coping strategy

Many queer women have experienced difficulty finding the right kind of support around these issues. Most support groups do not address the issue of homophobia and therefore lesbian and bisexual women feel they are unable to raise the issue and are reluctant to seek out the treatment they need. This reluctance stems from a valid fear of negative reaction or discrimination by health professionals, who are not always comfortable having gay or lesbian patients and who might be unaware of the ways in which homophobic experiences can contribute to DE/EDs. Personal feelings of intolerance can and often do influence how health professionals deal with patients that disclose their sexual orientation. Ironically, this perpetuates the feelings of shame and isolation that bisexual and lesbian women have used DE/EDs to shield themselves against in the first place.

Fortunately, we are no w seeing an increase in awareness around DE/EDs in the queer community. OAmazons is an internet list group for lesbians with eating disorders (at**www.lesbian.org/lesbian-lists/oamazons.html**), and there is an online forum found at **amazingforums.com/forum1/EDIBLEWOME/forum.html.** Here in Vancouver, a support group focusing on issues around body image for queer women is being dev eloped. The groups' facilitators are volunteers with The Centre: A Community Centre Serving and Supporting Lesbian, G ay, Transgendered, Bisexual People and their Allies, who have participated in training workshops offered by ANAD (Awareness and N etworking Around Disordered Eating). This collaboration between these two communities is an important step in breaking down social barriers, connecting women, and creating change in the accessibility of DE/ED support services. ■

Tania has worked with ANAD (Awareness and Networking Around Disordered Eating) and the Centre, A Community Centre Serving and Supporting Lesbian, Gay, Transgendered, Bisexual People and their Allies. She is currently completing her Bachelor of Social Work at the University of Victoria. Portions of this article originally appeared in XtraWest.

A Parent's Battle with the 'Monster'— Anorexia

Jeannie Caldwell

Jeannie is the former Coordinator for ANAD in Kamloops.

The toughest challenge of being a parent faced me in 1997. My daughter — my only child — was dying of anorexia nervosa. I wanted her hospitalized to get the care she so desperately needed if she was to survive. After months, we finally got a response to my many pleas with numerous health care workers at the hospital, and to the rapid decline of my daughter's health.

I felt relieved thinking that the three-week program would now enable her to get her life back. She, too, had a small amount of faith that it could help her deal with this 'monster' (anorexia) controlling her; but as the doctors, nurses, psychiatrists, psychologists, dieticians and other health care workers began their work, my hope began to wane.

The illness was treated as if it were the person, not as a separate entity intending to devour what little remained of my daughter. Patients with heart disease or cancer are treated as a

people invaded by illness, and they are offered support and nurturing. Why was the same not offered to those who are seriously ill with an eating disorder?

During this most trying situation, I was faced with examining all facets of my past, present, and future parenting roles. I was willing however, to do whatever it took to save my daughter's life. Regular visits to the family therapist were prescribed with the understanding that both my daughter and I would receive the support we needed to combat this monster.

Yet, many visits focused on my marriage and my relationship with my husband, one of the few supports I had at the time. On other visits, the therapist's criticism targeted my relationship with my daughter. After an hour of reprimand and condemnation, we were told to "do something together that we both enjoyed," not an easy task considering we left the therapist's office being too angry to even look at each other.

The attack on fundamental relationships did not enhance the health and wellness of the child I loved so dearly; instead, it drove her further into the grips of death. Life was not the least bit enjoyable — many hours, days, weeks, months, and years were spent searching for the elusive reason for all this.

An eating disorder is very complex, and as unique as the person suffering with it. I liken the treatment of an eating disorder to that of someone with a terminal illness — eating disorders can be terminal. There are many types of medical treatment available, and it is up to the patient and loved ones to find it and decide which is best at the time. The difficulty is that a type of treatment works at one point for the individual, may become less effective as the illness progresses.

To find the best possible treatment in the maze of our health care system is challenging, if not impossible. For example, in our situation, we were fortunate enough to find a therapist that truly understood my daughter and the illness; the downside, however, is that the Medical Services Plan (MSP) of BC wouldn't pay for therapy unless it was delivered by a registered psychiatrist or psychologist, even though the fees of our chosen therapist were one-third of those covered by MSP. This further complicated an already volatile situation: eating disorder sufferers don't feel they deserve any help, thus don't see the need to pay for a therapist which would place a further hardship on the family. Where will the money come from?

Looking back, I can say I have learned much from my experience with anorexia. Parents, if you suspect your child has an eating disorder, you are probably right. Find a doctor who has experience dealing with eating disorders, as well as a therapist who understands the disease and how to treat it. Do not delay in getting help. Also, be sure to find supports for yourself, such as support groups, friends, and health care professionals. The battle with the monster can play havoc on *your* health as well as your child's.

I strongly encourage parents to show unconditional love, and be positive in their dealings with their sick child, even though this is not an easy task. Remember too, it is the disease, not your child, that is causing her to act or talk the way she does. This is hard to remember at times, but if you are able let the child know the illness is making them behave this way, it will help them realize they themselves are not the monster.

In closing, do not give up! My daughter graduated with Honours in the Bachelor of Science Program from UVIC a year ago and leads a happy, healthy life. She plans to use her experience to help others fight this horrific illness.

Nourishing a Body with Self-Esteem

Doreen Dunn

Doreen is from Prince George.

Sometimes it's a chore being the baby of the family. Everyone walking before you has "done that." How in the world will you ever do "it"?

We consider ourselves to be a normal family, whatever that is. My husband and I have been married forty years and have four married children. Our daughter Dawnelle was an average girl and above average in her studies, and was always on the honour roll. She was helpful, kind, loving, strong, ambitious, full of fun, wanting to please, and seemingly never needy.

In the late 80s, our family made two moves after living 25 years in one place. We found out later these moves really affected Dawnelle. It was at this time, at age twelve, a strange, mysterious monster entered her young world and remained until she was 20 years old.

She began to do weird things: exercising incessantly, avoiding food, always saying she was fat, developing bizarre eating rituals, and always counting calories. An irritable, depressed mood began to creep in. Sleeplessness and hopelessness were a regular part of her daily routine. She became anxious and extremely fearful of food and eating. Anorexia nervosa was the diagnosis with hospitalization the only alternative available.

For seven years, Dawnelle lived in hospitals, being transferred from one hospital to another hoping to get help. They would get her weight up five pounds, send her home and within days she would have to be re-admitted. In her hometown where she was first hospitalized, her weight plummeted from 72 pounds to 47 pounds. That was scary: very scary!

It seemed the medical profession did not understand anorexia nervosa. Psychiatrists and psychologists tried to change her mind, but her body was so thin, fragile and undernourished, her mind was dysfunctional due to starvation.

Somewhere, somehow, Dawnelle had developed a low self-esteem. She lost her voice! She withdrew from her peers and it seemed she was afraid to grow up. Afraid she would have to suddenly be on her own, she became anxious about life. In her mind, if she avoided food at all cost she would not grow and therefore would not grow up. It backfired on her. Anorexia became such a trap! Life became so small. It consisted of routines, calorie calculations and numbers. That is what her life was. The eating disorder took over and preoccupied her life intensely.

As time progressed, we began to understand a little more about this eating disorder. We realized that curing anorexia was not simply a matter of feeding the body but feeding self-esteem back into her life and helping her find better ways to cope.

However, at different intervals during the years of treatment in hospital, the reality of death was ever-present because of her prolonged starvation. Osteoporosis, liver, kidney and heart failure were already present, as the body had begun to eat its own organs. Treatment included various procedures for feeding her, such as nasal gastrostomy, percutaneous endoscopic gastrostomy and TPN tubes; but none of these were too helpful, as she manipulated them, causing great distress to the treatment team as well as the family. Doctors began to inform us the anorexia was at the serious, chronic, irreversible stage. It was not clamorous then, but black and frightening, stalking us like a big, black bear.

During this time, the family had to travel five hundred miles, often twice each month, to visit her and meet with the care people. We were definitely stressed, worried and sad, but we had hope, hope of Dawnelle wanting to recover, and hope she would recover. We expressed this constantly to our daughter, trying to be positive. Although this went in one ear and out the other, we did not give up. To us, love is a verb, meaning it is something you do, the sacrifice you make, and the giving of self. Love is showing loving actions, and it's not simply a feeling. We showered her with hope and unconditional love. We believed in her and told her so. We supported her without supporting the anorexia. We had a host of friends who had no understanding of the problem, but they stuck with us, heard us out, and showed us love. This kept up our strength.

Finally, after many years and much treatment and caring, Dawnelle made a decision to recover. She finally realized that starvation was not the price of success. She worked very hard at re-feeding herself and getting back into society. Her voice was back. She could have her own feelings and voice them. We were very proud of her! She graduated from grade twelve, completed college and became a pharmacy technician. In 1996, she was married. She indeed has a life and is living it to the fullest.

Dawnelle has so much insight into her years of anorexia which she often shares with us. In anorexia there is:

1. an underlying need to 'numb out'
2. value in getting emotions out of the body and into words
3. difficulty getting rid of your original self and anorexia because both are in your head
4. a necessity to avoid labeling the person as 'anorexic' — they don't own anorexia.

Our faith in God bolstered our lives and our family. We prayed fervently, and we continue to thank God for His work of love on behalf of our daughter. We thank the doctors who helped re-build her self, and those who cared for her during that time. One can completely recover from anorexia nervosa. You have to believe that!

Often when going through a crisis in life, one finds value in helping others walking the same road. We now hold a support group for parents who are struggling with a child who has an eating disorder. We have no pat answers, and no way of 'fixing' another child but we can offer hope, and understanding of what the parents are feeling and going through. We've been there. Done that.

A Well-Balanced Dietary Deprivation

My Dangerously-Poor (Non) Eating Habits

Frank G. Sterle Jr.

Frank lives in White Rock.

"Lunch is for wimps," says Gordon Geco, the multi-billionaire business-tycoon from the 1980s, Hollywood-hit movie *Wall Street*. He said these rather arrogant words in a speech to an auditorium full of admirers.

Well, although I do not agree with Geco's opinion, during the working day, I deprive myself daily of lunch. I do not eat lunch — sometimes not even supper — and never, ever breakfast (though the latter bad habit is mostly due to an absolute absence of any appetite).

Why do I maintain such a potentially devastating dietary lifestyle? For multiple reasons: for one thing, if I do eat lunch, I find that I'm left burnt-out for the remainder of my working day; my working day consists of computer-related labour, which is my reason for going to my local clubhouse (since I'm not that sociable of a guy) during the week, and sometimes even Saturdays, if they're open. My fellows there often ask me if and why I'm not sharing in lunch with them (although I'll often eat whatever leftovers that they're about to throw out). I explain to them that if I do eat, I'll find myself tired afterwards and unable to concentrate on my writing-related chores or projects.

Laziness? It seems that the only 'wimp' is me, because I'm usually willing to have my culinary brother prepare me a dinner (consisting, of course, of a product agreeable to my palate). I believe he fears that I, a Type-2 (i.e., adult-form) diabetic, will basically allow myself to eventually cease to exist if he does not assist me with my diet. Just the thought of shopping for, cleaning and preparing anything near a balanced meal gives me a formidable anxiety attack.

What has absolutely no relation to my poor (non) eating habits is a shortage of funds; people often misperceive such. One morning I found a plastic bag with two large cans of brand-name stew hanging from my door knob; perhaps such misperception is related to my willingness to take home donated food stuffs from the clubhouse.

But I eventually do eat — something — very-late afternoon or very-early evening, although it's a meal too-often consisting solely of fattening carbohydrates. I'm left no real choice but to eventually eat, basically because my body begins to feel as though it has already begun digesting itself; or hypoglycemia begins to set in, which is playing with mortal fire.

I know, I know: I'm diabetic and *need* to eat three to five small, very-balanced meals every day. All of which is the most pressing reason behind my dangerously-poor eating habits: my devaluation of my very existence. Simply put, I do not care much for my life and, thus, am not really motivated by much to coerce myself into eating 3-5 small, balanced meals every day.

I get some sort of dysfunctional sense of satisfaction whenever I deprive my body of proper nourishment. Though consciously, I believe, I do not particularly wish to perish. Otherwise, why do I, for example, continue to drink coffee when it does virtually nothing but harm me and cause me to suffer? The stimulus effect does very little for me but make me excessively stressed, especially when I'm normally very stressed as it is — without any caffeine, and while consuming a plethora of psychiatric medications.

Unfortunately, what I often do not refrain from is fattening junk foods; my taste buds seem to usually be exempt from all of this self-deprivation. This terrible exemption ensures that I maintain an albeit-fluctuating 300 pounds in weight. But I realize that this great weight will only hasten the perhaps-permanent damage done by my one late-afternoon/early-evening, usually-poor-quality meal a day. Perhaps I subconsciously desire such hastened damage.

Smorgasbords? Because of my clinical OCD, I have to totally abstain from such temptation-abundant eating opportunities, or else I'll most-likely end up abusing it, not surprisingly without any regard for my health.

But what does it matter, if according to my psyche, *it's only my life I'm dealing with?*

Perhaps another factor behind my poor eating habits is my OCD-exacerbated guilt-complex troubling me over world hunger. But, nonetheless, it's a dangerously real mentality of mine that must dramatically change if there's to be any real improvement in my well-balanced dietary deprivation.

Approaches to Dealing with Disordered Eating in Schools

One of the goals at the BC Eating Disorders Association is to provide, encourage and facilitate education ranging from school-based prevention programs to broad public education campaigns. While disordered eating is not limited to gender , race, economic status or age, much of the prevention work we do focuses on reaching children and youth. It is our aim to help students develop, at the earliest stage possible, basic building blocks for wellness: self-acceptance, mindfulness, and balance.

Many programs approach disordered eating prevention by *talking* about the group at risk instead of *equipping* those individuals with skills, tools, resources and support to become a part of the change process. This is the type of approach we take in our Outreach Program. To best reach youth, we have developed a program that includes outreach talks to students grades four through university; specialized training sessions for students in educator-supported peer helper programs; and a variety of office resources including support for students, parents and educators. To ensure we are meeting the needs of youth, the program content is developed with the feedback we receive from hundreds of students and their educators each year.

To successfully work with youth, students must be engaged with the material and it must relate to their lives. Students ask for honesty and concrete information. They want to know more than what's wrong, they want to know what they can do about it. Our aim is to do much more than simply offer information but to mentor students and include their voices in the effort to create social change about disordered eating. Our hope is that youth will feel empowered to take action for the promotion of self-acceptance in their lives, and within their peer groups, families and school community.

When BCEDA first began to offer presentations in 1993, the focus was primarily to give students information about clinical eating disorders, anorexia and bulimia. Over the years, the program developed to cover a much broader scope of topics, including our relationship with food, body image, sizeism, media literacy , and others. Outreach talks are not designed to scare students into wellness or to sensationalize the emotional aspect of dealing with disordered eating, but to seriously involve students in discussions about these issues. Talks are put together based on the age and needs of each group, with the students guiding the facilitators who lead the discussion.

Last year, our Outreach Program added training sessions for students volunteering as school-based peer helpers. One strength of peer helper programs is that youth tend to seek out information and support from their peers before they go to a parent or educator. Peer helpers are in a great position to support a student, to direct

how a student can help someone with disordered eating

1. Educate yourself as much as possible. It is easier to be supportive and non-judgmental if you know what signs to look for and try to understand what the person is going through.
2. Get support for yourself. Talk to a counsellor or other adult to discuss the best way to approach a friend.
3. Let the person know you are worried about him or her in an honest and non-threatening way by doing the following:
   - Use "I" statements. Personalize your message. State that it is just your reaction to your friend's behaviour.
   - State your feelings: e.g., "I get really worried when..."
   - Be specific about behaviours. Give concrete examples: e.g., "I got really worried yesterday when I heard you throwing up in the bathroom after lunch" OR "I'm concerned that you haven't been eating anything at school lately."
4. Once you've told the person your observations, don't push. Instead, focus on:
   - letting the person know you care and are there to give support.
   - your friend's inner qualities, and help them realize their worth as a person. The person needs to shift their focus away from their body and build up their self-esteem. This means not even complimenting the person on the way their body looks.
   - giving the person time to talk. Encourage them to verbalize feelings. Listen.
5. Let the person know about available resources, such as school counsellors, support groups or the school nurse. You may also want to leave the person something to read such as a book or brochure.
6. The person may not want to seek help or even admit that she or he has a problem. If they aren't willing to seek help, tell someone who knows about disordered eating and who can provide the needed support (the person may be in physical danger).
7. Be patient. Realize that you can't make your friend get better — she/he has to want to get better. Don't argue about whether there is a problem or not — power struggles are not helpful.
8. Don't let conversations focus on food and weight.
   - Don't tempt her/him with favourite or high calorie foods.
   - Don't make comments like "If you eat you'll look better," OR "You look better since you have gained a few pounds." Disordered eating is not about looks.
9. Don't ignore the problem. If you are concerned, say so, even if it's scary or embarrassing for you to do so. Your friend, even if he or she doesn't act like it, will probably welcome your acknowledgment. People with disordered eating often feel isolated and alone; your attention could save your friend's life.

From the ANAD Resource Kit. Adapted from the BC Eating Disorders Association and Eating Disorders Awareness and Prevention (Dr. Marcia Herrin and Dr. Heidi Fishman)

Denise Hodgins

Denise Hodgins is the Executive Director of the BC Eating Disorders Association in Victoria and brings a combination of personal experience with disordered eating, an academic background in Art History and Early Childhood Education, and a work history in School Aged Child Care and Pre-Kindergarten Education to her current position.

them to services, and to encourage a positive school environment. In recognition of this, we developed a project that builds on the existing peer helper skills, and offers specialized training for disordered eating prevention and intervention. During a total of five training hours, students are given the opportunity to learn more about disordered eating (signs, symptoms, underlying issues, resources) and what they, as peer helpers, can do in terms of prevention and intervention. The students discuss these issues as they relate to their experience as peer helpers as well as act out various role-play scenarios, such as how to support a friend, what to say if you are concerned about someone, and strategies for promoting an accepting school environment.

We also provide students with information, support and guidance through our newsletter, drop-in office, phone line, library and web site (www.preventingdisorderedeating.org). The number of students using our office resources has increased dramatically. Often students will have seen a presentation or will have participated in a training session, and will come to the office for more information and/or support. These students look for treatment options, and learn how to support or advocate for their friend/sibling who is struggling. More and more students are taking the initiative to seek out information and to organize their own awareness-raising projects. They are interested in, and are fully capable of, participating in the creation of change.

As we continue to develop our Outreach Program, we are broadening the opportunities for students to become even more involved in the preventing and intervening of disordered eating. In November, we will be facilitating a discussion at a disordered eating conference with two of the students who participated in our peer helper training sessions, and we look forward to further strengthening our connection with youth in the years ahead. For us, working with youth in the prevention of disordered eating is more than a one-time presentation. It means being available throughout the year to provide information, support and on-going opportunities for youth to become a part of the change process ■

related resource

Teaching Students with Mental Health Disorders: Resources for Teachers
Volume 1: Eating Disorders
www.bced.gov.bc.ca/specialed/edi/ed1.pdf
— Plus see sidebar on page 29 of Visions

Learning to Unlearn Nutrition

Finding Your Nutrition Truth

How would you describe your relationship with food?
What is your earliest childhood food memory?
What is your vision of yourself as an eater later in life?

These are just some of the questions I ask people in my desire to engage in meaningful conversations about food, to uncover the rich meaning food brings to our lives. Beautifully woven into these conversations are our nutrition truths: those statements we make about our eating that are truly our own, that define our unique relationship with food. These nutrition truths are like precious little treasures we need to hold close to our heart if we are to strengthen our relationship with food.

These days, food and our consumption of food can represent many things. We eat fast foods because we are so busy and we have little time to choose and prepare the food ourselves. We eat to slow our hectic lives by taking time for food. We eat for comfort after work, during the evening news while we watch in horrified fascination as our world endures such hardship. We eat alone; we eat with others. We eat over the kitchen sink; we eat in the finest restaurants. We eat to celebrate birthdays, festivals, and seasons. We eat to stay connected to our traditions and our families who may live hundreds of miles away. We eat to express our most intimate feelings. We may even refuse to eat. In the most basic sense, we eat to live and to nourish our physical, spiritual, intellectual, and emotional selves. Are you someone who would like to change the way you eat? Where do you begin? Can you find your nutrition truth by acquiring more nutrition knowledge? The answer may surprise you.

If you wander into any bookstore, you will find endless sources of nutrition information. Newscasters and advertisers suggest that we eat more soy, drink more water, buy organic, low-fat, high-fibre, emphasize protein, but not too much, and always choose butter over margarine. No, make that margarine over butter. Actually, just use olive oil. It can get to be overwhelming! Consumers may end up being so suspicious and uncertain of food that they don't want to eat at all! For this reason, I guide you back to the concept of nutrition truth. Scientists, diet gurus, and even our well-intentioned neighbours will eagerly share exciting discoveries about food with us and, at times, those discoveries will contradict each other and perhaps even our nutrition truths. Don't be discouraged. When you stop and think and *feel* what foods work best for you, you won't need to get entangled in the complexity and contradictions of nutrition information. The recipe for a delicious, homemade nutrition truth includes a dash of nutrition knowledge and heaping amounts of trust, permission, and self-acceptance.

To reveal your nutrition truth, ask yourself questions, lots of questions. Be curious, be open, and be prepared to be surprised. What foods give you the most energy? What do you prefer to eat in order to break your overnight fast (breakfast)? When your body signals hunger, for which

foods do you have an appetite? How do you know when you are satisfied? How do you know when you are full (beyond satisfied)? What are the internal, physical signals your body has naturally designed to guide you to your nutrition truth?

If you don't ever feel hungry or satisfied, don't despair; you can reconnect with those signals. The reconnection process is very similar to rebuilding a broken friendship. It requires patience, devotion, compassion, and tender communication: deep listening, attentiveness, and gentle, loving responses. Strengthening or rebuilding your relationship with food is worth the effort. Use your relational gifts to heal or strengthen one of the most important relationships in your life — your relationship with you.

So maybe you already have a beautiful, strong relationship with yourself, but your eating is still difficult. Stay curious. In a non-judging way, begin to explore y our relationship with food more deeply. Become the writer of your nutrition truth memoirs (see sidebar for suggestions).I've invited you to engage in a process of discovering your nutrition truth. Don't feel that you are on this journey alone. Share your stories with others as a tremendous act of courage and healing. Celebrate your discoveries, perhaps over tea and cookies! Support your friends to eat without guilt or anxiety. Take the focus off of weight loss and put it squarely on health and spirit. Let's abandon food rules that do not support our nutrition truths. And finally, in the words of the inspirational writer S ark, "Let's place ourselves squarely in the swirl of life; it will scoop us up and change us somehow. The trick is to come out of hiding, change our routines and allow our actual lives to happen."

writing your nutrition truth memoirs

There is not one best way to do this exercise. Let it inspire new and creative approaches to eating. Remind yourself that regardless of how you do it, you can't do it wrong!

- Consider the qualities of your favourite foods as you eat them. Describe their taste, texture, aroma, appearance, temperature, and the sound they make.
- If you have trouble deciding what to eat, ask yourself: What aroma might appeal to me? Do I want something crunchy, smooth, creamy, soft, or fluid? Do I want something light and airy, heavy and filling, or in between? How do I want my stomach/my head/my body to feel after I finish eating? Describe the specific food that you crave.
- Create a relaxed eating environment. Describe the place where you feel most at peace with eating. Where in the world would you like to experience eating your favourite meal?
- Describe the pleasure you get from the first bites of a favourite food, the middle, and the end. Consider stopping if the food stops tasting good, as your satisfaction diminishes, or as you become full. Permit yourself to wait until you are hungry before eating more.

Jacqui Gingras, MSc, RD

Through her private practice, Deliciosa! Nutrition Counselling, Jacqui offers nutrition therapy to youth, women, and parents of children struggling with food, weight, and body image issues. Visit Jacqui online at www.jacquigingras.com.

Towards Filling the Empty Space

Dance and Drama Therapy for the Treatment of Eating Disorders

Eating disorders — anorexia nervosa, bulimia nervosa and binge eating — are affecting ever-greater numbers of people in North America and are spreading quickly to other parts of the world. Most sufferers are women, though there is an increasing number of men. Many are teenagers. Some are children as young as seven.

There are many theories about why eating disorders exist and how they should be treated. The causes — complex and different for each individual — are usually a combination of stresses experienced in childhood and our cultur e's pressures to be thin. They are also responses to our society's negative attitudes towards the body.

Individuals who develop eating disorder symptoms, whether the self-starvation of anorexia, the bingeing and purging cycles of bulimia, or the compulsive overeating of binge eating, are trying to cope with unmanageable feelings. We are all brainwashed to believe that if we were beautiful and thin, we would be successful and happy. For someone overwhelmed by their life's problems, it is easier to focus on controlling their body.

Because the arena of struggle speaks symptomatically through the body, it is important to address this directly in treatment. Dance and drama

Tannis Hugill, RCC, RDT, ADTR

Originally from Berkeley, California, Tannis is new to Vancouver, where she is now a registered clinical counsellor, as well as a dance and drama therapist in private practice. She provides professional development training and eating disorders prevention workshops. She also teaches workshops in dance therapy, drama therapy and authentic movement.

therapy are both creative, experiential approaches. They engage what is healthy in us and offer activities that give positive experiences in and through the body.

Negative body image is central to these illnesses. Body image is how we see our bodies in our minds, how we feel inside and talk to ourselves about our bodies. Someone with anorexia will see herself as being very fat, in spite of the fact she is extremely thin. Someone with bulimia or binge eating may see herself more realistically but will hate how she looks.

Eating disorders are a way to communicate feelings such as abandonment, rage, fear, grief, and shame. People with eating disorders often speak of an emptiness or void inside. If anything, they fear they are filled with a monster. The symptoms can be seen as a kind of fortress that protects from feeling. They are coping tools that are very hard to give up. In denial, the individual will often refuse treatment; but, they are very serious illnesses — damaging to the mind, body and spirit. There are many suicides as well as deaths from physical complications.

The specific behaviours are the tip of the iceberg. In treatment, it is crucial to attend to the underlying experience. I have used creative, body-oriented treatment in hospital settings and in private practice. Dance therapy is the intentional use of body awareness and movement to bring growth and healing. It teaches us listen to, and trust, what our bodies tell us about ourselves. Because it is non-verbal, movement therapy bypasses the wall of defenses that talking often reinforces. Drama therapy helps us understand the roles and patterns we use to express feelings, by learning to choose ones that are helpful and transform those that are not. Clients are assisted to remain in the present moment, bringing awareness to their experience, thus gaining knowledge about unconscious feelings and beliefs. Thus, they can make more effective choices and create a bridge to their embodied selves.

I often begin sessions with simple stretches and movement patterns, perhaps combined with drawing or storytelling. This allows safe exploration of the body, relieves tension, and teaches healthy self-nurturing. Negative attitudes are transformed. One woman who had abused herself for years began to describe herself as 'graceful' and glided with pleasure across the room.

In role-play, we discover that the illness is both best friend and demon. One client had a breakthrough when she chose her sister for support, instead of the anorexia. In another a girl pushed 'bulimia' away with a forceful "NO!"

Dance and drama therapy both practice setting limits with others. Feeling safe in the body helps relationships by increasing connection with others, instead of the eating disorder. 'Safe-space' dances can bring tears of relief.

The sources of pain blocked by the self-abuse of eating disorders need to be carefully opened and take a long time to heal. There is no magic cure. Dance and drama therapy can thaw these defenses so individuals can find themselves. By joining with their bodies, they are able to accept all aspects of themselves. Thus they gain deep, vital roots to growth. New experiences of self-care create satisfying, fulfilling lives that no longer have need for an eating disorder; the empty space within flowers into a fully embodied, empowered sense of self

Making the Connection

Online Support for Disordered Eating

Heather Lumley, MA, RCC
(see bio, page 6)

With the increase in technology in our modern world and many reductions to services in our communities, many health care providers and consumers are considering alternative modes of treatment for disordered eating. As the internet becomes more available, a question arises pertaining to what could be the best uses of this tool to augment traditional therapies. There are many differing opinions surrounding the use and confidentiality of online support.

What is Online Support?

Online support, also known as e-therapy, uses the power and convenience of the internet to allow simultaneous and time-delayed communication between a client and a professional; or between individuals with common concerns.[1] It's about choices. It's about accessibility. It's about 24/7 availability.

Why Consider Online Support?

Along with the information and educational benefits of online information, there a number of specific situations where internet-assisted therapy is an attractive option.

Rural and Remote Locations

There are many individuals in rural and remote communities that could benefit from the connection of a therapist in another region that has experience with disordered eating. It is apparent that there is often a lack of services in rural and remote communities and the larger centres, too, are witnessing increasing shortages of experienced counsellors in the field of disordered eating[3].

Support for Clients While Therapist is Unavailable

Online information and support can provide continuous support when a clinician is not available, so as to not leave the affected individuals with a gap in services. Although the support online will not match the impact of one-to-one counselling, it can serve to sustain the individual when one-to-one services are not available.[3]

Increase Networking Possibilities

Online support can provide networking and educational support for clinicians and helpers that can work collaboratively to best service their separate communities.

Options for Online Support

Email Correspondence

Email correspondence has many different forms. A client could exchange emails with a clinician over a period of time, or could ask a single question that could assist the individual in working through their concerns. This option also allows the therapist to 'touch-base' with a client between sessions, providing additional support without additional costs. In using email correspondence, it is important to note that this represents a vast difference between traditional forms of therapy and connection between individual and professional. Email correspondence is the most popular form of e-therapy and is often viewed as an innovative style of journal-writing.

Discussion Groups/Boards

Many groups provide peer support for individuals that are faced with the same challenges. Individuals can journal and ask questions to other readers, share thoughts and struggles, or support another individual through crisis with the use of discussion boards. It is important, as with all internet information, to ensure that you critically evaluate sites and groups.

Information and Self-Help

In general, these options allow individuals greater access to information and education. Individuals can read how others have coped or are working through recovery and they can read stories, poetry, articles, and research on disordered eating.[4,5,6]

pros and cons[2]

Benefits of Online Support:

- Reaches individuals that may never seek professional help
- Increases accessible resources for individuals in limited/rural areas
- Starting point for more therapy/help in the future
- Decreasing isolation and secrecy of pain individual is experiencing
- Client initiates contact when motivated
- Can be a powerful, quicker change agent
- Anonymity can increase honesty
- Development of inspiration and hope
- Sharing of ideas and resources

Limitations of Online Support:

- Lack of face-to-face interactions and non-verbal cues
- Confidentiality and privacy concerns
- Lack of information regarding outcomes
- Lack of standardized therapy
- Lack of knowledge about the 'therapist' online
- Technological breakdowns

footnotes

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3 Nevala, A.E. (2000*). WSU Program aims to reduce rural suicides: Higher rates away from cities blamed on less access to mental health care*. Seattle Post-Intelligencer.

4 Riemer-Reiss, M.L., (2000). Utilizing distance technology for mental health counseling.*Journal of Mental Health Counseling, 22*(3), 189-203.

5 Robson, D. (2000). Counselling online.*British Journal of Guidance and Counselling, 28*(4), 572-573.

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The Emergence of Pro-Anorexia Web Sites

When I first heard about the existence of pro-anorexia web sites about two years ago, I was quite horrified. Having worked as a therapist and being involved in coalition work and activism around this issue for several years, I felt terrified that all the work that thousands have been doing to end disordered eating might quickly be undone, especially by something existing in a medium as vast and influential as the internet. But as I began to look closer at these web sites, I saw glaring contradictions and paradoxes, and heard voices expressing things that didn't quite mesh with the dominant interpretations and criticisms of what these women were trying to accomplish.

Pro-anorexia (known as "pro-ana") web sites provide girls and women with a forum to discuss and share information about "ana." They make it clear that their purpose is to support those who are struggling with an eating disorder, and to provide a 'space', free from judgment, where they can offer encouragement to those who are not yet ready to recover. The sites tend to have common features such as bulletin boards and chat rooms, diaries, 'tips & tricks,' and 'trigger pics' or 'thinspirations' (pictures of emaciated women to 'inspire' you not to eat).

Upon first contact, the primary purpose seems to be to promote and support anorexia (not just anorexics), including detailed 'how to's.' Ironically, most of the images of thinness and emaciation on the sites are mainstream pictures of celebrities or fashion models. If some of the models and celebrities were not familiar to us, it would be very difficult to discern between the 'abnormal' bodies of the women with anorexia and the so-called 'normal' and 'acceptable' bodies of the models. These images highlight the glaring contradictory messages girls and women receive about appearance and their bodies.

Pro-anorexia web sites have caused a huge uproar in the media, the medical community and among parents and individuals struggling with anorexia. In mainstream media, critiques of pro-ana sites — usually interviews with medical "experts" — the web site owners are blamed for causing and pro -

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moting a deadly disease. These critiques fail to mention the broader and more complex historical, political and social factors contributing to the epidemic of disordered eating in the first place. An examination of the women's own words shows they are quite articulate and aware of their circumstances:

What does pro-ED (pro-ana) mean to me?

People with eating disorders are isolated and surrounded by people who don't understand what we think or feel. Without anyone to talk to and empathize with, we turn more and more inward, which only makes things worse. Eating disorders (EDs) are a coping mechanism. We don't choose to be this way, and we can't simply decide to stop. Some of us need our EDs still and aren't ready to recover.

Eating disorders are dangerous, and ignorance compounds that. We can't go ask for safe advice from non-EDs without a risk of being hospitalized or shunned. Pro-ED to me means understanding that there's no shame in how we are…It means support for us so we don't have to deal with this alone. It means nonjudgmental help so we can survive and remain as safe and healthy as possible while maintaining the behaviors we still need to keep. Pro-ED to me does not mean recruiting, encouraging or teaching others to be anorexic, encouraging excessively dangerous practices, or starving to death.

Unlike the picture that is painted in the media of sinister, pathetic, malicious girls trying to harm themselves and others, many of the narratives on these web sites paint quite a different picture. They illustrate the struggles, pain and searching for acceptance and connection, as well as ambivalence towards recovery that is a realistic part of an eating disorder. We can see that these women are very aware of their own situation, and that they look out for and care for others.

I believe that there is much more depth and meaning to these women's experiences than may be obvious by listening to mainstream interpretations of their messages. Anorexia is certainly not to be taken lightly: its effects can be extremely harmful and potentially fatal. However, considering the high failure rate for biomedical treatment methods,[1] perhaps it is time to re-examine the approach we take as a society to these 'mental disorders.' It is my hope is that the emergence of these web sites might open up areas of discussion and debate, rather than becoming one more reason to pathologize the individual girls and women who struggle with eating disorders. From there, maybe we can begin to better understand what drives women in industrialized societies — and increasingly globally — to need to seek out alternative spaces for safety, understanding and support. ■

offline education tools

The tide of information need not only come from the media and the internet. Teachers and parents have lots of good resources available to them to teach and empower youth about body image issues and self-acceptance. Youth, in turn, will then be in a better position to critically evaluate the whole range of web sites and media messages

- **School outreach program training manual.** (BC Eating Disorders Association, 1998)
- **Girls in the 90s facilitator's manual.** Sandra Friedman (Salal Books, 1994)
- **Am I fat? Helping young children accept differences in body size.** Ikeda & Kaworski (Gurze Books, 1992)
- **A 5-day lesson plan on eating disorders: Grades 7-12.** Levine & Hill (Gurze Books, 1991)
- **Sex-role stereotyping: An awareness kit for parents and teachers.** (Ontario Women's Directorate)
- **Eating concerns support group curriculum: Grades 7-12.** T.J. Shiltz. (Gurze Books)
- **The best you can be nutrition resource package. Body image, healthy eating, and healthy weight.** (Red Deer Regional Health Unit, Health Promotion Department)
- **Teacher's resource kit: A teacher's lesson plan kit for the presentation of eating disorders.** C. Rice (National Eating Disorder Information Centre, 1989)
- **How schools can help combat student eating disorders: Anorexia nervosa and bulimia.** Michael Levine (National Education Association, 1987)

The warning page of a pro-ana web site. The counter reports over 300,000 visits over the past two years.

footnote

1 "Half of anorexia treatments fail," *Globe and Mail*, May 22, 2001.

Addressing Motivational Issues in Eating Disorders

Josie Geller, Krista E. Brown, & Suja Srikameswaran

Josie works with the Eating Disorders Program out of St. Paul's Hospital. Krista and Suja are with the Department of Psychiatry, University of British Columbia.

Individuals with eating disorders are ambivalent about change, and lack of motivation has been associated with high levels of treatment refusal, dropout, and relapse. Recent research has turned to address readiness and motivation in this group. This research has shown that readiness scores are associated with important clinical outcomes, including the decision to enroll in intensive treatment, behavioural change, and dropout.[2] Despite the clinical importance of readiness and motivation, eating disorder clinicians have been shown to be poor at estimating this client characteristic.[1] The discrepancy between client and care provider understanding of readiness may explain the clinical difficulties encountered in treating this group. Motivational Interviewing (MI) has been shown to be an effective approach for populations described as 'treatment resistant'[6] and has recently been applied to eating disorders. This article reviews the motivational interviewing stance, and addresses how it can be used in assessing and treating individuals with eating disorders.

Stance

Communicate Beliefs and Values that Foster Client Self-Acceptance

Many individuals with eating disorders come to treatment feeling shame about having a problem and blaming themselves for their eating difficulties. Given that higher levels of distress are associated with lower levels of readiness for change[2], care providers can help clients prepare for change by letting them know that eating disorders typically develop for a reason, that recovery is difficult, and that change takes time.

Assume Nothing

It is easy to make assumptions about the client's experience, and consequently, for clients to feel misunderstood. Care providers may make assumptions about the client's readiness and motivation for change that are either inaccurate or an oversimplification of the client's experience. For instance, it is possible to assume that the client is distressed by her poor health when she is primarily concerned about her lack of control over her eating.

Be Curious

The best way to avoid making assumptions is to be curious. The therapeutic alliance can be greatly enhanced by care providers using open-ended questions to show interest in the client's experience of the problem, how the problem has been helpful, and how she has coped with pressures to change. Care provider curiosity also helps the client develop a better understanding of herself and her eating disorder.

Be Active

Throughout treatment, motivational work involves actively pursuing a greater understanding of barriers to recovery, and using this information to assist the client in making the best decisions for her care. MI is based upon the premise that failing to address such barriers is likely to lead to treatment failure.

Be on the Same Side

Discrepancies between client wishes and the treatment plan can easily lead to conflicts. When such conflicts arise, it is critical for care providers to take time to understand the client's perspective, and to express a genuine desire to help. This can set the stage for a more productive discussion aimed at assisting the client in determining the best solution for her given her available options.

The Client is Responsible for Change

When clients express ambivalence about making changes or engaging in treatment, it is common for care providers to feel responsible for initiating this change. Unfortunately, overly directive approaches have been shown to be detrimental to the therapeutic alliance, and to decrease the likelihood that the client will follow through on treatment recommendations.[4] In motivational approaches, responsibility for change is the client's.

Assessment

Use the Transtheoretical Model of Change (TMC)[7]

In eating disorders, the Readiness and Motivation Interview (RMI)[2,3] has been used to assess readiness and motivation across eating disorder symptom types. In the RMI, individuals estimate the extent to which they are in precontemplation, contemplation, and action/maintenance for each symptom domain. *Precontemplation* refers to not wanting to change, *contemplation* is seriously thinking about change, and *action/maintenance* is actively working to change or to maintain changes previously made. Internality is the extent to which individuals are making changes for themselves versus for others. Given the research that shows that the degree of readiness for change predicts treatment refusal, symptom change, dropout, and relapse[2,8] it is useful to include questions about readiness in assessment protocols.

Ask about all Aspects of the Eating Disorder

Overall, research has shown that individuals with eating disorders are most interested in making changes to binge symptoms, and least interested in making changes to restriction over eating and to the use of compensatory strategies[2]. In order for clinicians to fully capture an individual's readiness for change, all aspects of the eating disorder need to be addressed.

footnotes

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footnotes cont'd ▶

Healthy Attitudes Program

A Community Early Intervention and Prevention Approach to the Problem of Disordered Eating among Vancouver's Youth

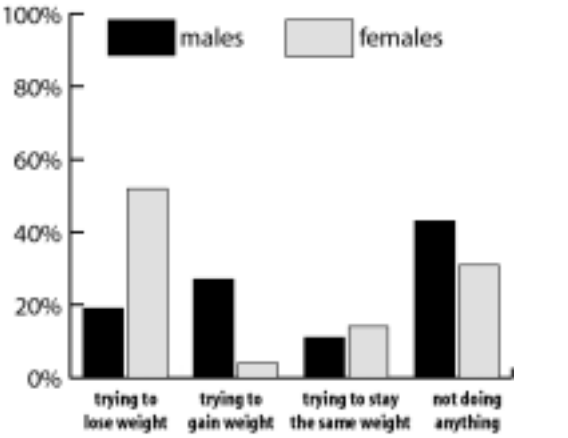

figure 1 – 1998 survey of weight control behaviours among 26,000 BC youth, grades 7 – 12

Janet Mittler

Janet is Community Health Nurse for the South Community Health Office in Vancouver.

The emotional concerns of adolescence are documented and well known. Youth who present themselves to health providers may report physical complaints. However, the underlying problem may be an emotional one and need further assessment and or referral. Six per cent of adolescent males and ten per cent of adolescent females report feeling emotionally upset.

Some of this distress is over unhappiness with body image. Almost half of all female students surveyed are trying to lose weight while one quarter of young men are trying to gain weight (see figure 1).[2]

In the Vancouver area, school counsellors, doctors, and school nurses have seen a growing number of young people who are food-restricting, bingeing, vomiting after eating, using diet pills and laxatives to lose weight, and becoming addicted to exercise. These youth generally do not fit the medical standard for anorexia or bulimia, but their unhealthy eating behaviour and daily struggles with food and weight have a significant impact on their general well-being. Adolescents need a healthy balanced diet for growth and development. Without early intervention, these behaviours can become a pattern leading to more serious illness.[4]

There is a dramatically-increasing prevalence of disordered eating among teens. Estimates for anorexia are as high as one in every hundred girls between the ages of 12 and 18▶

Addressing Motivational Issues in Eating Disorders (cont'd from previous page)

Assure the Client that There are No Negative Consequences to Being Honest

In order to understand the client's genuine feelings about change, care providers need to express interest and curiosity about any ambivalence the client may be feeling.The client is more likely to be honest if she is assured that her truthful responses will not be judged, and will not hinder her access to treatment.

Treatment

Explore What is Helpful About the Eating Disorder

It is helpful for care providers to assist clients in exploring reasons that the eating disorder exists. Determining the role that it plays in her life will help the client feel more accepting of herself, and reduce feelings of shame and guilt.

Validate Client Reasons for *Not* Wanting to Change

In addition to assisting the client develop an understanding of the functions of her eating disorder, it is useful to acknowledge that it makes sense for her to be experiencing ambivalence about making changes. Simply communicating acceptance that the eating disorder may be the client's best method of coping will assist in validating her experience.

Make Treatment Responsive to Client Wishes

The motivational approach involves assisting the client in articulating what she wants to get out of treatment, and ensuring that her agenda is addressed. Care providers can use information about the client's readiness status in assisting her to determine which treatment alternatives are best suited for her

Determine Treatment Non-Negotiables and Communicate These Clearly to the Client

Individuals with eating disorders can be at risk for a variety of severe medical and psychiatric complications. As a result, for both therapeutic and ethical reasons, it is sometimes necessary to implement treatment non-negotiables. Non-negotiables have been described as acceptable to clients when a reasonable rationale was provided prior to their implementation, surprises were eliminated, and client choices were maximized.[5]

Maximize Client Autonomy at All Stages of Treatment

It is common for clinicians to feel that it is their job to 'fix' the problem, and to apply pressure to eating disorder clients to change their behaviours. Unfortunately, this subtle (or not so subtle) influence can be detrimental, as clients may react to what they perceive as a threat to their sense of control. Such client reactions can interfere with both client and care provider ability to understand the client's experience and to determine what is in her best interest. The motivational stance involves informing the client that unless her health is at serious risk, she is in charge of all treatment decisions. ■

footnotes (cont'd)

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6 Miller, W., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. New York: Guilford Press.

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8 Whisenhunt, B., Geller, J. (2002, April). *Internal motivation for recovery in the eating disorders predicts long term outcome.* Short paper presentation at Psychiatry Research Day, Vancouver, 2002.

Bulimia is two to three times more common. Adolescents are at significant risk as most disturbed eating patterns begin during the teen years.[3]

The Healthy Attitude Program is a prevention program directed at youth who are at-risk for developing serious disordered eating habits. The focus of the program is on using the *Vitality* approach of healthy eating, active living, and positive self-esteem and body image.[1] This approach supports youth in developing skill, knowledge and coping ability at a time in their lives when the pressure to engage in at-risk behaviours is high.

The program provides information and support to individual youth who attend the weekly clinic. Youth may meet with a nutritionist, a counsellor, a nurse, or a doctor. This team of professionals is useful because the causes of disordered eating are complicated. It may be the result of many things happening in a person's life and may be different for each person. Eating problems can be related to nutritional choices and habits, physical health, emotional well-being, and social relationships.

Given all of these factors, the Healthy Attitude Program uses several approaches to care. These include education about food/nutrition habits and healthy eating behaviour, the connection between food and optimum health and the normal range of body shapes and sizes. Counselling is aimed at helping youth identify and cope with stress and to help them change unhealthy behaviour.

Youth learn that thoughts and feelings are not the same, and that they can make choices about the actions they take. They also can learn to practice 'thought stopping' to help with negative self-critical thinking, over-focusing on appearance and comparing to others. They are supported to avoid activities or people that don't help them to be healthy and to find resources that can help them to fulfill their goals.

The program is youth-centred, in that it asks youth to think about and make their own decisions about thei r health care. They are asked about what they would like to happen and with whom they would like to make their appointments. The program is free to youth ages 11 to 24 in the Vancouver/Richmond area. They must not be medically at risk and need hospital care. All information is kept confidential.

Those wanting further information about the Healthy Attitude Program may call South Community Health Office and speak with the manager or one of the child and youth community health nurses.

The Healthy Attitudes program operates on Thursday afternoons from 2 – 5pm, and is located at 3405 Knight Street @ 49th St in Vancouver. Call (604) 321-6151 to make an appointment or a referral. ■

footnotes

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South Fraser's Team of 12

Briar Patterson

Briar is the RN Program Coordinator of the South Fraser Eating Disorder Program. The program covers Surrey, Delta, White Rock, Tsawwassen, and Langley.

Twelve passionate, enthusiastic and unbelievably talented team members embrace our eating disorders program. This is the first time the program has had a full complement of staff and we are raring to go! The team consists of a full-time therapist for the adult program, a full-time therapist for the child and youth program, sessional physicians one day per week for both programs, a pediatrician who assesses and admits complicated and acute clients, a part-time dietician one day per week shared between both adult and child and youth, a part-time family therapist two days per week, and a full-time nurse coordinator. There are two managers of the program, one based out of Surrey Memorial Hospital and one with the Ministry for Children and Family Development.

We've started the fall with some fantastic options for our clients and their families. We have a meal support group, a 'Why weight?' group, a family and friends support group, a psychoeducation group, and a surviving-the-Christmas-holiday group. All of our adult clients begin with our Readiness Motivational Interview, which is pioneering research developed by Dr. Josie Geller (see page 29), and has never been done before in the community programs. The results of these interviews provide us with the ability to tailor individual treatment plans through understanding where each client is at in terms of their recovery.

Our intake procedure has changed as we seek to improve our connection and integration with mental health. All referrals, both child and adult, are initially screened and triaged through the mental health centres. This provides the client with greater treatment options, as other possible mental health problems can be detected and treated early, thus assisting in their eating disorder recovery. In addition, the regional eating disorder committee will meet this month along with the eating disorder education network to ensure we are meeting the needs of the community

We hope you didn't miss our first annual fashion sho w, *Bodylicious*, which was held early in November at Clayton Heights Secondary School. This was in celebration of women's natural sizes and features all-sizes-friendly stores such as Changes Boutique, Bodacious, and Reitmans. The evening presents a live band, entertainment, a silent auction, FOOD, and dishy fireman escorting our dashing models. The money raised supports the clients of the South Fraser Eating Disorder Program.

Sadly, our client list continues to grow as eating disorders continue to attack new victims. We try our best to get into local schools to provide positive body education. We wish there were more time for proactive eating disorder prevention, reaching young girls and boys before they have to see us at the clinic. However, here, at the South Fraser Eating Disorder Program, we have a team firmly committed to this fight, excited about the future treatment possibilities, and holding on to the hope and truth that our clients do get better ■

Kamloops Community Eating Disorders Program

Carol Graff

Carol Graff, RDN is employed with the Thompson Cariboo Shuswap Health Service Area and works for Community Mental Health Services out of Kamloops. Carol has worked as a dietitian/nutritionist for mental health since 1995, with specific focus on the development and ongoing operation of the Community Eating Disorder Program. She has worked with clients struggling with disordered eating since 1992.

Kamloops Mental Health offers a community-based Eating Disorders Program utilizing a multidisciplinary approach to promote, preserve and restore health. The program has undergone numerous changes since its humble beginnings in 1995, including a recent move to the Royal Inland Hospital, Alumni Tower.

We believe that a team approach is most effective in facilitating the recovery process, as each team member addresses unique areas of specialty in order to promote and/or restore health. Team counsellors who are trained social workers/therapists provide individual and group work for adults, youth, children and families. The nutritionist provides nutrition education, assistance in designing and implementing a meal plan, and help in interrupting the restricting and/or binge/purge cycle with the aim of normalizing eating habits. The occupational therapist provides functional assessment and assists individuals in areas such as self care, work and leisure to ensure a balanced lifestyle. The therapist can also support the development of tools and strategies in the areas of daily living skills, stress/relaxation, anxiety, and communication. Our team is further supported by the services of a general practitioner for adult clients, a pediatrician for clients under the age of 18, and a psychologist.

A community advisory committee with representatives from both the treatment team and the community serves to respond to the needs of the community and ensures that the program provides services to cover the identified gaps.

The Eating Disorder Program has recently received a number of referrals for childhood obesity, an area requiring the skills of a multidisciplinary team. As research continues to come forward, it is increasingly clear that this is an area of significant need. With the limited resources of the Eating Disorder Team, it must be determined if this becomes the future direction for the team or if the limited resources will need to remain focused on the treatment and prevention of anorexia nervosa and bulimia nervosa.

The Kamloops Community Eating Disorders program accepts referrals from individuals (self-referral), family members or friends, physicians, hospital staff, school counselors, university/college staff and community agencies in the Thompson Cariboo Shuswap Health Service Area. The treatment team in Kamloops has worked hard to establish and maintain strong relationships with all referral sources and with tertiary services at both St. Paul's Hospital and BC Children's Hospital. These links help to enable a seamless transition for treatment, and both liaison and support for those in the community

For more information or to make a referral, please call (250) 851-7450. ■

Kelowna Eating Disorders Program

Mary Lamoureux, RN, MSN

Mary is the Program Coordinator and Nurse Specialist of the Kelowna Eating Disorders Program. She recently completed a thesis study, *Recovery from Anorexia Nervosa: Becoming the Real Me.*

Since the inception of the Kelowna Eating Disorders Program (EDP) in September 1999, approximately 180 referrals have been received for adults in the Central Okanagan and for youth (under 19) in the Central and South Okanagan. The program mandate is to provide outpatient assessment and treatment to clients who have been diagnosed by their physicians with anorexia nervosa, bulimia nervosa, or eating disorders not-otherwise-specified (excluding binge-eating disorders).

The Program has undergone a number of exciting changes in the last three years. Most recently, we were fortunate to have Dr. Mike Ocana join our team, two mornings per week. Dr. Ocana comes to us from Ontario and specializes in child and adolescent psychiatry. Prior to entering medical school, he had a nutritional science background, and has a special interest in eating disorders. He will see clients of all ages within our program.

In terms of service delivery, for the first two years we offered mainly individual therapy, family therapy, nutritional counselling and nutritional psychoeducational groups. Earlier this year, our waitlist for all services had escalated to unmanageable proportions. So, with the assistance of our senior management, consultations with the Provincial Eating Disorders Advisory Committee, and some creativity, we were able to re-design our program to offer more timely service.

Background to Waitlist Problems

The process of recovery for eating disorders tends to be lengthy and variable. For bulimia nervosa, recovery averages 3 to 5 years. With anorexia nervosa, recovery averages 7.5 to 10 years[2,5] or as long as 10-15 years.[3] Because of the protracted nature of recovery, clients who are newly diagnosed and/or seeking treatment tend to engage in our outpatient program for at least 1 to 2 years, sometimes longer. Thus, our time for individual and family therapy became scarce, with new clients having difficulties accessing those services.

The life-threatening nature of eating disorders demanded creativity in reducing our program's waitlist while function-

ing within a fixed operational budget of having very part-time staff (1.7 FTE) that serves a geographical population of almost 300,000. We continue to be reminded that anorexia nervosa has the highest suicide rate,[4] and mortality rate [1] of any other psychiatric illnesses. Therefore, it is potentially dangerous to have clients on waitlists unless various safety measures are in place.

Increasing Accessibility via Use of Groups

Because some clients had been waiting for a year without being able to access therapy, in May 2002, we initiated group therapy for adults to replace individual therapy. Approximately 12 of the 21 women who were on our waitlist for individual therapy agreed to participate in this group. Of that group, approximately six women attend on a regular, weekly basis. Since it's designed to be an open, ongoing group, newly-referred clients are able to access group therapy services immediately after assessment (if appropriate). Although a significant percentage of clients were reluctant to join the group, taking time to understand and help them process their fears, and using a trial approach seemed to help. As well, monthly individual check-in sessions are offered to those engaged in group therapy. Having a core group of women attending regularly for the past four months has offered strength and stability to this ever-evolving group.

The waitlist for family therapy in our program was just as dismal. Families often need education prior to starting family therapy. So, recently, the 'Why Weight?' parent and teen psychoeducation group was initiated as a pre-requisite to family therapy, and five families agreed to this process. This bridges the gap between the time spent waiting for family therapy while offering support in an educational forum. Family therapy has also been reduced to a biweekly format in order to accommodate more families.

Individual nutritional therapy with Linda Trepanier is also a resource with great unmet need, given the one day per week funding. Linda has been running a "Why Eat?" nutritional psychoeducation group for clients and their families. This group has played a pivotal role in our program's ability to offer "some" service during the time when our waitlist for individual and family therapy had been so lengthy. This five-week group series also reduces the amount of time Linda spends in education and frees up more time for counselling in the individual sessions.

'Continuing Connections' is another group for adults with eating disorders, specially designed to address quality of life issues. Motivational enhancement is the key approach within this group. Individual therapy continues to be offered to teens on a more intensive basis, i.e., once per week, while adults attending groups are seen once a month.

Conclusion

The waitlist for the Kelowna Eating Disorders Program has been dramatically reduced to the point where clients wishing to access services are waiting a maximum of four weeks for assessment and treatment. Although there was much resistance from our clients (and sometimes ourselves) toward the idea of 'group,' it has proven to be effective in offering a more timely and diverse menu of services. Although there may be approximately 20-30% of clients who refuse group services, the majority of clients are reaping the benefit. Other service challenges remain related to lack of funding for meal support, day programming, and case management workload. Thanks to all those who supported us in this process. ■

footnotes

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Rural Reflections

Ellen Dearden, RN, BN

Ellen is the clinical nurse coordinator/therapist of the East Kootenay Eating Disorder Clinic located in Cranbrook, BC. She works with a very part-time team of a doctor, nutritionist and group therapist. She lives on a Christmas tree farm with a mountain-loving husband, three active teenage daughters, two German Shepard dogs and Oreo the Cat.

I stare at the empty pad of paper in front of me as I reflect on the challenges and joys of the past fourteen years working as the Eating Disorder Nurse/Therapist in rural 'Small Town, BC'. I am in my parent's empty home, sitting in my dad's kitchen chair, my dad who passed away last June. I just finished watching the News Channel's lead-up to the tributes planned in memory of the tragedies of September 11th, 2001, the same day my family buried my grandmother. These were all events I could not control, yet 'control' is the most commonly-used word in eating disorder treatment literature to describe the psychological/physical needs of eating disorder sufferers.

As the deaths of the last year demonstrate, none of us have total control over ourselves or of events around us. We need to learn to adapt to the challenges life brings us unbidden. Working as a small town eating disorder nurse has taught me to be adaptable. I learned and am still learning to deal with administrative isolation, lack of specialist services, especially psychiatric, public misconception (e.g., "Are eating disorders really a problem here?"), and of course the "Tyranny of the Urgent!" What should I focus my energies on, in my one-day-a-week job, within the context of what our regional funding allows. Do I see clients or a family, teach a prevention program at the local school or tackle administrative funding issues?

People appreciate my efforts and care, complain that funding is inadequate, and wonder about a referral to the 'Big City' eating disorder specialists. Going through periods of burnout for rural practitioners is not uncommon, as we deal with our own sense of inadequacy, of possibly not knowing or doing as good a job as our colleagues in the 'Big City'; where seeing your client at church, at the gym, your daughter's dance class or at the grocery store does not allow you the anonymity/privacy a larger community affords. Where you or your team (if you have one) are the only resource treating eating disorder clients, and there-

Tertiary Services in BC

The following excerpts are part of interviews conducted with the tertiary eating disorders clinics in Vancouver. At St. Paul's Hospital Eating Disorder Clinic, I interviewed Dr. Laird Birmingham and Linda Lauritzen; at Vista, a program developed in collaboration with St. Paul's, I talked to Tracey Dobney. Ron Manley met with me at BC Children's Hospital Eating Disorders Program.

Alexis Beveridge

Alexis is a social work student from the University of Victoria who is completing her fourth year practicum at ANAD (Awareness and Networking Around Disordered Eating) in Vancouver, BC.

What services do you offer?

St. Paul's: We are the provincial adult eating disorder program so if there are tertiary type problems [more serious] throughout the province, they are referred to us. Clinical services consist of assessment (psychosocial and medical), the Community Outreach Partnership Program (COPP), the Patient/Family/Friends Psychoeducational Group, Outpatient follow-up, the Short Stay Program (Extra Care Program), the Day Treatment and Residential Program (Vista), Quest and the Long Stay Program. So we have both inpatient and outpatient services; as well, we are active in research and education for the whole province.

Vista: We are a three to four month intensive residential program for men and women with eating disorders. We have a total of 10 beds in our program — eight of those beds are allocated for people who are going into the Discovery Program at St. Paul's (i.e., the Day Treatment program). Two of our beds are support beds available for people prior to going into the day program at the hospital, and following treatment as a transitional space.

BC Children's: This program has been in existence for approximately 20 years and the programs have several different components: there is an inpatient program for people that are medically unstable, there is quite a large outpatient program, a day treatment program, and a residential component.

What is the underlying philosophy of the program?

St. Paul's: Our primary responsibility as far as the government is concerned is to make sure that those people that are the sickest receive good treatment. The other part of our philosophy is to try to help develop those treatment facilities or treatment modalities throughout the province; this includes looking into treatments and giving advice about what treatments might be of use throughout BC.

Vista: We come from a psychosocial rehab perspective, so what we are looking at in this part of the program is all aspects of the client's life in terms of their psychological and interpersonal skills. We really look at an eating disorder as a coping mechanism; what we see is that you cannot take away that coping mechanism without replacing it with other things that are not going to be so destructive, and therefore take away from quality of life for people.

BC Children's: Our philosophy is certainly multidisciplinary, so there is a very strong emphasis on the team approach and an understanding of the eating disorder in a much larger context, a biopsychosociospiritual model of care.

Have you seen any shift in your demographics or diagnostic trends?

St. Paul's: We are seeing more and more very ill (people); we used to years ago be able to see people from throughout the province sometimes with mild eating disorders. A very important change, which is a very positive one, is that we now can treat people that need long-term inpatient care here at St. Paul's instead of sending them out of province, which costs more money. We have noticed that one of the biggest shifts over the last 10-15 years is that there is quite a different approach in offering treatment to people with eating disorders. In the past, people were often brought into hospitals and treated against their will and treated for longer periods of time under certification. Now there is a much more healthier respect for the patient, where they are at, so what we have found and what the literature supports is that it is not helpful to offer aggressive treatment to someone who is not ready or willing to look at making changes. Now there is more of an emphasis on helping people to get to a place of wanting to make changes.

Vista: The people we are seeing are actually at a higher body weight than when we started 7 or 8 years ago . They were more undernourished in prior years, we used to take people at 10% body fat and now the minimum is 16%, because for them to do the intense work they need to do, they need to be able to think and at a lower body fat percentage they are starving and just can't function.

BC Children's: I would say that our demographics are pretty much the same; because of our mandate here we have always seen people who are pretty ill. One thing that has shifted is that our census used to go down in the summertime to some degree, but in the last few years the number of referrals has really increased.

What do you see as the most pressing issue in the area of treatment for disordered eating? What would you like to see change?

St. Paul's: We need a larger population of family doctors throughout the province that would help us treat eating disorder patients. Because not all

Rural Reflections (cont'd from previous page)

fore if you get sick or quit, there is no one to replace you or even anyone administratively who would oversee the responsibility of replacing you.

Despite these difficulties, many rural practitioners have stayed in their small communities, fighting to maintain their eating disorder programs. Why? Because there is a sense of satisfaction that one is contributing in some small way to groundbreaking work in rural eating disorder treatment. There is independence and yet a sense of professional community with the support and encouragement of other rural eating disorder practitioners in the province who are faced with the same challenges. Last, but not least, there are the women and girls I work with, who are bright, sensitive and unique. I am encouraged when I see them make improvements in their quality of life and when years later they return to thank me. Through helping them in their struggles, they teach me about myself, that I can't control everything and that death may come unbidden, but I can learn to adapt and help make a difference by my presence, caring, support and prayer. ■

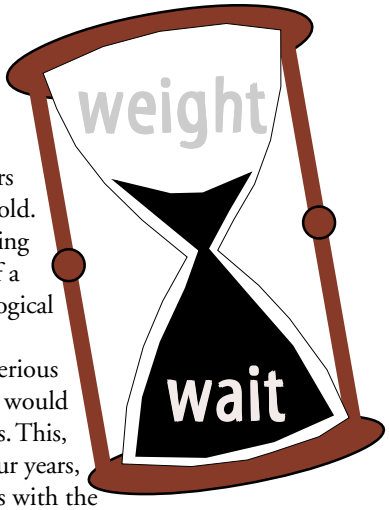
doctors are familiar or even comfortable with eating disorders, they perhaps do not receive enough time or backup to help people with eating disorders where they live. The next thing that is needed is a much larger group of psychiatrists throughout the province. At the moment there are very few psychiatrists that would say that they are experts in treating eating disorder patients. Finally, in the logical sense, we need to have hospitals commit to admit patients with eating disorders, because even hospitals throughout the province are quite often confused or uneducated or not aware or perhaps not motivated — for whatever reason they will not accept patients with eating disorders.

Vista: I see the need for there to be more work done around the issues of eating disorders and alcohol and drug addiction, specifically the catch 22 that people are in. Generally they cannot get service for the alcohol and drug issues if they have an eating disorder and cannot get treatment for the eating disorder unless they are first treated for the alcohol and drug issues.

BC Children's: There are so many that it is hard to put your finger on just a few. Given that we can't do everything, how best can we meet our mandate in the best way possible? I think that there needs to be more education and research done across the province about eating disorders, especially with children and adolescents, because we need the developmental aspects met. There are different considerations with this population and there is not much written on it — instead they scale down what is written for adults. ■

Navigating the System

An Insider's Look



Anonymous

Across North America, and indeed, the Westernized world, eating disorders and disordered eating are almost as common as, well, the common cold. Research, and a quick scan of your local city street or TV programming show that this illness is on the rise. Pressure to fit into the mold of a narrowly-defined picture of perfection drives women to deny biological need and risk both health and happiness.

Given this rise in the population dealing with eating disorders (EDs) and the serious risk to health to those affected, one would imagine that the helping community would respond quickly with a range of services which would assist women dealing with EDs. This, however, is not the case. As one who has been a consumer of services for the past four years, I believe there is much ground to be covered if we are to provide holistic services with the flexibility to meet the needs of the women whose lives are affected.

I am a single, working woman, living in the Lower Mainland, who has had an ED for nearly six years. Since seeking help with my struggle to overcome my ED, I have accessed many of the services available in this community. Though the helping professionals in the field are caring, well-trained and compassionate, they lack the resources to provide the level of care necessary. The services available in BC are inadequate, incomplete, and lacking the flexibility to respond to women with different needs.

St. Paul's Hospital has four beds available for acute care and three beds available for extended care. The waiting list for the acute beds, which serve women whose physical health is in jeopardy, is commonly three to four months long. The Vista/Discovery Program, which is a 12-week residential recovery program, has eight beds. A space in this program can take six to eight months to come available. The COPP Program is a community-based program which can offer support outside the hospital and treatment programs. Finally, St. Paul's offers various support programs and services, but the wait to be assessed can be long.

The most obvious shortcoming in services is access. Women from Cranbrook to Fort St. John to Port Hardy must come to Vancouver to receive the specialized care of St. Paul's. Though other communities may offer some services, they do not offer the range that Vancouver has. Women must incur the expense, inconvenience of travel, and due to these barriers, may be unable to access the necessary care.

Secondly, there is no ability to respond to the barriers that affect women's lives. The services — that were once primarily accessed by younger women — are now needed by women who have commitments such as rent, children and elder care. Women with children often do not have the flexibility to spend three months in a treatment program. They may lack the supportive connections in the community to provide care for their children. Women who are working may not be able to afford time off; they may be unable to regularly access nutritionists, physicians and other professionals during working hours. The restrictions of the programs available make them inaccessible to those whose life commitments are not flexible.

Lack of service continues to be one of the most frustrating issues affecting access to care. The whole province depends on St. Paul's for the provision of specialized services. The waiting lists are long and often devastating for those waiting. It is unacceptable, long before cuts to other medical services in BC, that women with EDs have been forced to wait months for basic service.

We have a long way to go in this province to support individuals suffering from EDs. Much must be done to educate ourselves and our communities to stop the continued rise of this disorder. The Association for Awareness and Networking Around Disordered Eating (ANAD), a province-wide organization dedicated to creating more understanding is chronically underfunded. Services must be broadened and increased and made available in local communities. Disordered eating and the illness it can give rise to are serious and often fatal conditions and must be attended to in our communities, both at the individual and community level. ■

Eating Disorder Resource Centre of BC

Patricia O'Hagen, PhD

Patricia is the Director of the Eating Disorder Resource Centre of BC.

Mission

The Eating Disorder Resource Centre of BC (EDRCBC) is a non-profit organization with the goal of prevention and education of anorexia and bulimia nervosa, compulsive eating, chronic restrained eating, weight and body consciousness, and unhealthy body weight. Youth, women and men are welcome to join us. The mission of EDRCBC is to provide services, resources, education programs and skills training for our clients by staff and volunteers. Our clients can be categorized into three groups:

- those struggling with disordered eating, their family and friends
- professionals working in disordered eating and related issues, and
- community groups, students, and those interested in the area.

The Centre's long-term goal is to become the National/International Prevention Research Centre in Disordered Eating.

Philosophy

Our philosophy is that disordered eating is understood from a multi-determined model that includes genetic, biological, individual, sociocultural factors. Those disordered eating behaviours are expressed by youth, men and women in a range of ways, from obesity and compulsive eating, to anorexia and bulimia nervosa. We emphasize social change and social action based on prevention and educational awareness. These actions focus on our attitudes, beliefs, and behaviours that affect our health and social relationships in society, school, workplace, family, and peer groups, including:

- body consciousness (body image, shape and size),
- weight consciousness (obesity, calorie counting, overexercising, weight scales, dieting, and fat phobia)
- the pursuit of thinness (associated with autonomy, achievement and self-control).

Our Services

1. The Provincial Directory of professionals working in the area of disordered eating. Call us to find a support group, program, workshop or professional (e.g., a psychologist, doctor, and counsellor) in your community.
2. Resource counselling is provided at our library, and by fax, email or phone. Receive personal support and short-term assistance for referrals and information.
3. Provincial media campaigns to increase awareness of disordered eating.
4. Provincial community outreach and educational programs for all school levels and ages from elementary through university.
   - We are implementing *Preventing Disordered Eating: A Manual to Promote Best Practices for Working with Children, Youth, Families and Communities*. This manual is a two-year collaborative project with the BC Ministry of Health Services and the Ministry of Children and Family Development, and the Prevention Advisory Committee of the BC Provincial Eating Disorders Program.
   - The prevention manual includes the most current research and best practice strategies in prevention. The manual is going to be adopted by the Australian Medical Director for Eating Disorders.
   - Our program is based on implementation of the prevention manual and is provided by Dr. Patricia O'Hagan, staff, community professionals and volunteers.
   - The programs are developed based on availability and our clients' needs.

Other Initiatives

- **A pilot study**, being carried out this fall on the prevention play *Insectable Delectables*, to be presented by selected grade 6 classes to students in grades 1 through 4.
- **A joint education project** with the province of Alberta on prevention and body image to be piloted throughout the elementary and secondary schools of BC and Alberta.
- **Eating Disorder Awareness Week.** Development and delivery of educational events during the awareness-raising week in February of each year.
- **Library services** including information packages, videos, books, and professional journals on topics specific to a client's needs.
- **EDRCBC Volunteer Training Program.** Create projects or help us with ongoing programs.
- **Practicum student placement** for those in their final year of a counselling degree.
- **Newsletter** led by volunteers, community members, and staff who provide the content by submitting articles, events and services.
- **Co-morbidity Provincial Advisory Committee**, including practitioners from Addictions and Eating Disorders. This committee is conducting a pilot study of an eight-week support group for clients struggling with alcohol/drug addictions and disordered eating. The support group is a joint study between Addictions Services of Ministry of Health Services and the Eating Disorder Resource Centre of BC. The group will meet at the Addictions Services Facilities and begins mid-October. Contact EDRCBC for more information at (604) 806-9000 or toll-free at 1-800-665-1822, via email at edrcbc@direct.ca or on the web at www.disordered eating.ca.

The House of Mirrors Project

Raine Mackay

Raine is the Executive Director of the organization Awareness and Networking around Disordered Eating.

Over the last four years, the House of Mirrors (HOM) Project has created an increased awareness around disordered eating/eating disorders in a unique way

The underlying assumptions of Awareness and Networking around Disordered Eating (ANAD) are that disordered eating/eating disorders are more than medical conditions, self-esteem issues or simply products of the fashion/diet/cosmetic surgery industries, and that disordered eating/eating disorders are woven into the very fabric of our society's belief system. Therefore, in order to address this issue effectively we need to challenge the inherent assumptions our society makes based on these beliefs, and challenge them in *all sectors* of our community: a tall order for sure, but we believe that by using the House of Mirrors Project as a tool we can bring together the various sectors of the community to start the process.

Art is one of the most powerful means to encourage an examination of the attitudes, values and beliefs that underlie disordered eating/eating disorders. In order to develop a better understanding of the issue, we must look at where these attitudes, values, and beliefs come from. As individuals living in Western culture, we have all learned and absorbed societal stereotypes and prejudices. However, when we step back and look at the bigger picture, we can begin discussions that examine the context surrounding disordered eating rather than simply viewing disordered eating as an isolated 'personal problem.'

The House of Mirrors is a visual arts installation of 26 full-length mirrors. Over the past four years, women, girls and artists of various cultures, ages, and body types have portrayed the numerous ways fat phobia and violence have impacted their lives.

For those of you who have never been in one, a typical house of mirrors at an amusement park contains mirrors that have flaws in the glass causing the reflections they cast to be distorted. The artistic director felt this to be the perfect metaphor for the distorted images reflected back to women and girls every day. It is very common for us to look in a mirror and not see ourselves as we are, but in a negative relationship to what we 'should' be.

The women and girls who participated in the project were provided with the opportunity to exorcize these distortions from their minds and get them out on to the mirrors. Through work with the artists, the participants developed ways to visually express their experiences, stories, and journeys and give them form through symbols, shapes, textures and colours. The hope is that the viewer will act as witness to them.

The installation, then, reflects how the participants have challenged the distorted images of the female body and the discrimination against people of size. The show's themes reveal myths about fat, explore how we participate and perpetuate these prejudicial beliefs and look at how we can reclaim our bodies and change societal beliefs. The show is divided into three themes: *The Lies We Are Fed, Swallowing the Lies,* and *Telling Our Truths.*

The Lies We Are Fed

(such as *"You can never be too thin or too rich"*)

Through research, discussion and exploratory exercises, the participants examined what they had been told all their lives about how they should look. The women and girls looked at the media, fashion, diet and medical industries in order to examine societal belief systems and to uncover the subtle and obvious messages that shape and impact their self-confidence.

Swallowing the Lies

In this theme, participants explored the impact that fat-phobic messages have had on their lives, how these messages were internalized and how these internalized thoughts manifested in their behaviours, belief systems, eating habits, relationships and feelings about their bodies. As one participant stated "I literally purged the lies I swallowed through my bulimia."

Telling Our Truths

Here, women and girls portrayed what is true for them about their bodies and the diversity and richness of who they are. As one participant said "Women are so much more than the images that we see reflected to us through the media."

The House of Mirrors Project is designed to provide a tool for communities to use to increase awareness around this issue. So what does this look like in practice? Each community has varying needs, levels of public awareness and access to the full continuum of health, educational and social services needed to deal with this issue. In some communities, the emphasis will be on getting the local or regional health authority to recognize the need for health care services; in others, it will be to get the school boards to incorporate appropriate curriculum; or to get local youth-serving organizations to provide environments that are supportive around addressing these issues; or to get the local merchants to take some responsibility, and so on. The community decides the need and we provide the focus: the House of Mirrors Project.

The impact it has had on previous communities has been assessed through participant evaluations. Viewers reported an increase in knowledge and awareness around the impact of media on girls and women, the unattainable physical ideals found

two of the panels in the HOM project, one depicting a toilet bowl lid and bathroom tiles as seen too often through the eyes of someone with bulimia; the other an antiseptic fridge with meals portioned out for the week, each with a comment attached. For more images, see page 8.

in the fashion industry, problems with diet/weight-loss programs and finally, fat prejudice. Participants considered the use of this type of venue to be a very creative and engaging way to get these messages across, and the project was consistently considered to be a thought-provoking means to create self-awareness.

The HOM was created in 1998, through the Canada Council's "Artists in Community Project," which initiated five-community art projects in British Columbia. The project used the arts to develop existing relationships between artists and their communities. In Vancouver, collaborative work between community organizations, artists, and 150 women and girls created a 26-piece art installation entitled the House of Mirrors. ANAD co-sponsored the creation of the House of Mirrors with Kiwassa Neighbourhood House, Pacific Immigrant Resources Society and the Roundhouse Community Centre. The art project was fist exhibited at the Roundhouse Community Centre from July 23 to August 2, 1998. It has been shown in Prince George, 100 Mile House, Smithers, Campbell River and earlier this year in Victoria.

Regional Contacts around BC

city	program	contact	phone	email
Chilliwack	Chilliwack Mental Health	Marion Fallding	702-4860	marion.fallding@fvhr.org
Comox	Eating Disorder Outreach Program – St. Joseph General Hospital	Shelly Park	339-1576	spark@mars.ark.com
Courtenay	Eating Disorders Outreach Program	Shirley Wade-Linton	339-1576	swl@mars.ark.com
Cranbrook	East Kootenay Eating Disorders Clinic	Ellen Dearden	489-6416	edearden@telus.net
Delta	South Fraser Adult Eating Disorders Program	Briar Patterson	592-3701 ext. 3788	freedbc@yahoo.ca
Kamloops	Kamloops Mental Health	Picku Multani	851-7472	harmandir.multani@thr.ca
Kamloops	Royal Inland Hospital	Libby O'Donnell	314-2740	libby.odonnell@thr.ca
Kelowna	Kelowna ED Program	Mary Lamourex	868-7763	lamm@oshr.org
Kitimat		Cheryl Brown	632-3181	tcbrown@kermode.net
Mission		Gurmeet Singh	820-4300	Gurmeet.Singh@gems4.gov.bc.ca
Nanaimo	Child & Youth Mental Health Consultant	Dolores Escudero	390-5454	Dolores.Escudero@gems8.gov.bc.ca
Nanaimo	Nanaimo Family Life Association	Nina Evans-Locke	754-3331	nelocke@shaw.ca
Nelson	Nelson Mental Health	Anona Zmur	354-6322	anona.zmur@kbchss.hnet.bc.ca
Penticton	OSHR Nutrition Program	Cathy Richards	770-3526	kestergaard@oshr.org
Prince George	Prince George Eating Disorder Program	Sarah Hanson	565-7413	shanson@nirhb.bc.ca
Quesnel	Quesnel Mental Health Centre	Doris Hocevar	992-4288	doris.hocevar@caribooheath.com
Rossland	Trail Eating Disorders Program	Hilary Wehle	362-7344 ext. 224	
Vernon	Vernon Eating Disorders Program	Christina Camilleri	542-7111	edp303@hotmail.com

resources

Organizations

- **The Association for Awareness and Networking Around Disordered Eating (ANAD)**
  Tel: (604) 739-2070 Toll-Free: 1-877-288-0877
  www.anad.bc.ca
- **The Eating Disorder Resource Centre of BC**
  Tel: (604) 806-9000 Toll-Free: 1-800-665-1822
  www.disorderedeating.ca
- **BC's Children's Hospital Eating Disorders Program**
  Tel: (604) 875-2200
  www.cw.bc.ca/mentalhealth/srved1.asp
- **BC Eating Disorders Association**
  Tel: (250) 383-2755
  www.preventingdisorderedeating.org
- **National Eating Disorder Information Centre**
  Toll-Free 1-866-NEDIC-20 (1-866-633-4220)
  www.nedic.ca
- **National Association to Advance Fat Acceptance**
  www.naafa.org
- **Anorexia Nervosa and Related Eating Disorders Inc. (ANRED):** www.anred.com
- **The Center for Eating Disorders: St. Joseph's Medical Center, Maryland:** www.eating-disorders.com
- **Eating Disorder Referral and Information Center**
  www.edreferral.com
- **Eating Disorders Awareness and Prevention**
  www.edap.org

More Web Sites

- www.something-fishy.org
- www.edrecovery.com
- recovery.hiwaay.net
- www.open-mind.org/ED.htm
- www.eating-disorder.org
- www.angelfire.com/ms/anorexianervosa/index.html
- www.mirror-mirror.org
- www.about-face.org
- www.caringonline.com

Videos

- *Becoming Barbie* (SHE TV, 1993)
- *Dying to Be Thin* (WVIA-TV, 1986)
- *The Famine Within* (Kendor Productions, 1990)
- *Slim Hopes: Advertising and the Obsession with Thinness* (Jean Kilbourne, 1995)
- *Still Killing Us Softly* (Cambridge Documentary Films, 1987)
- *Take Another Look* (Desperate Measures, Coaching Association of Canada)
- *Dual Diagnosis: Chemical Dependence and Eating Disorders* (Magic Lantern, 1990)
- *Food For Thought* [Degrassi Junior High series, 26 min. episode] (Image Media Services, 1988)
- *In Our Own Words: Personal Accounts of Eating Disorders* (Gurze Books)
- *Kids of Today* (Saskatchewan Valley School Division, 1998)
- *Skin Deep: A Story About Disorder Prevention* (Magic Lantern, 1994)
- *The Psychology of Weight Loss: Resolving Emotional Eating for a Lighter, Healthier You* (Magic Lantern, 1991)

Books

Fiction

- *The Best Little Girl in the World.* S. Levenkron (Contemporary Books, 1978)

Memoirs

- *Wasted: A Memoir of Anorexia and Bulimia.* Marya Hornbacher (Harper Flamingo, 1998)
- *Inner Hunger: A Young Woman's Struggle Through Anorexia and Bulimia.* M. Apostilides (Norton, 1998)

Non-fiction

- *No Fat Chicks: How Women are Brainwashed to Hate Their Bodies and Spend Their Money.* Terry Poulton (Key Porter, 1996)
- *Males with Eating Disorders.* A.E. Andersen (Brunner/Mazel, 1990)
- *Breaking the Diet Habit.* Janet Polivy & C. Peter Herman (Basic, 1983)
- *The Dieter's Dilemma: Eating Less and Weighing More.* William Bennett & Joel Gurin (Basic, 1982)

Sociocultural Context

- *Anorexic Bodies: A Feminist and Sociological Perspective on Anorexia Nervosa.* Morag MacSween (Routledge, 1993)
- *Fat is a Feminist Issue.* Susie Orbach (Paddington, 1978)
- *Unbearable Weight: Feminism, Western Culture, and the Body* Susan Bordo (University of California Press, 1993)
- *The Beauty Myth.* Naomi Wolf. (Vintage, 1990)

Therapy and Self-Help

- *Overcoming Binge Eating.* Christopher Fairburn (Guilford Press, 1995)
- *Clinician's Guide to Getting Better Bit(E) by Bit(E): A Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders.* Ulrike Schmidt & Janet Treasure (Taylor & Francis, 1997)
- *Eating Problems: A Feminist Psychoanalytic Treatment Model.* Carol Bloom et al. (Harper Collins, 1994)
- *Anorexia Nervosa: A Survival Guide for Families, Friends and Sufferers.* Janet Treasure (Taylor & Francis, 1997)
- *Like Mother, Like Daughter: How Women are Influenced by Their Mothers' Relationship with Food — and How to Break*

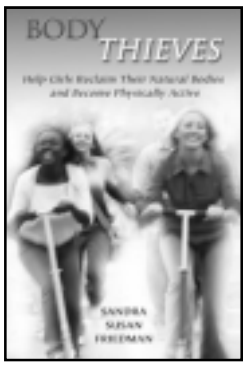
This list is meant as a guide only and not meant to be exhaustive. While we have attempted to include helpful references, inclusion in this resource list does not necessarily reflect content endorsement by CMHA BC Division

the Pattern. Debra Waterhouse (Hyperion, 1997)

- *Every BODY is a Somebody: An Active Learning Program to Promote Healthy Body Image, Positive Self-Esteem, Healthy Eating and an Active Lifestyle for Female Adolescents.* (Body Image Coalition of Peel, 1997)
- *Real Gorgeous: The Truth About Body and Beauty* Kaz Cooke (Norton, 1996)
- *When Girls Feel Fat: Helping Girls Through Adolescence.* Sandra Friedman (Harper Collins, 1997)
- *Preventing Childhood Eating Problems: A Practical, Positive Approach to Raising Children Free of Food and Weight Conflicts.* Jane Hirschmann & Lela Zaphiropoulos (Gurze Books, 1993)
- *Little Girls in Pretty Boxes: The Making and Breaking of Elite Gymnasts and Figure Skaters.* Joan Ryan. (Warner Books, 1995)
- *All Shapes and Sizes: Promoting Fitness and Self-Esteem in Your Overweight Child.* Teresa Pitman & Miriam Kaufman (Harper Collins, 1994)

Teaching Kits see sidebar, page 28

book review



Salal Books, 2002; 244 pp.; $19.95 Cdn

Review by Nicki Breuer, Odin Books (www.odinbooks.ca)

Body Thieves:

Help Girls Reclaim Their Natural Bodies and Become Physically Active

BY Sandra S. Friedman, BA, BSW, MA

When I first read *Body Thieves*, I was struck by the aptness of its title. Anyone female recognizes the struggle we've all have had for ownership of our bodies; it's disappointing, but no real surprise that the effort continues. This book begins by defining the enemy — a list of body thieves which hold girls hostage to bathroom scales, limit their vision to pounds and kilos and narrow their focus to a slim definition of worth based on size or lack thereof.

Therapist, educator, and consultant, Sandra Friedman is no stranger to these topics.The author of three other books on girls, eating disorders, and body image (*Just for Girls*, *When Girls Feel Fat: Helping Girls through Adolescence* and *Nurturing Girl-Power*), she's also conducted training workshops, spoken at major conferences, and been active in the media in getting this message out.

My curiosity about what new ground she could cover was soon replaced with surprise and admiration for the sheer volume of information she has compacted into the pages of this volume. From web sites that support and enhance her considerable research efforts, to a crash course in media literacy Friedman provides a thoughtful, intelligent guide to interacting with teenage girls on several of the most important topics of their lives.

This book is well-written and informative. It follows a natural progression from gender and development through socialization, relationships with girls, and takes readers through a plain-spoken and eye-opening journey of the perils facing teenage girls today. Yes, I've long been aware of the media's role in bombarding us all with messages about body image and the unacceptability of living in a fat body . What I haven't really given much thought to (and it's high time that I did), is how simple it is to actually take some positive action to be part of the solution.

Friedman doesn't offer pat answers, nor does she pretend that this is an issue that can be easily 'fixed.' What the book does offer is the clear message that there are concrete things that family, friends, educators and support people can do, and that these things will add up to social changes that will profoundly affect us all. I' m reminded of the old adage "It's simple, but it ain't easy." With a book that actually offers sample letters to write to the editor of your local newspaper, self-tests to help girls figure out what issues they need to address, and lists entitled WHAT YOU CAN DO, it becomes a lot easier, and a lot more possible than any of us would think. Inasmuch as I liked Mary Pipher's book *Reviving Ophelia* for identifying the difficulties facing adolescent girls, I think this is the book that will teach us all how to be proactive in empowering all the teen girls we know to have richer, more physically active, and happier lives.

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