BANA
BE YOURSELF

A publication of the Bulimia Anorexia Nervosa Association

FALL 2021

A Mental Health and Wellness Magazine

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1st Anniversary Issue

Also In This Issue:

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Hosting & production of this publication are thanks in part to the support of the **Paradise Charitable Gaming Association**.

BANA Be Yourself magazine is delivered virtually to community members, businesses and organizations throughout the Windsor-Essex Region, and is also available online at www.bana.ca/magazine. Direct email subscriptions are available by request to info@bana.ca.

Owned and operated by the Bulimia Anorexia Nervosa Association, 1500 Ouellette Ave, Suite 100, Windsor, Ontario, Canada, N8X 1K7.

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Publishers Note:

Hello Readers!

I am honored and delighted to welcome you to BANA BE YOURSELF- A Mental Health and Wellness magazine. This issue marks our one year anniversary! Whether you're reading through these pages with your cup of morning coffee (tea), learning new tips about wellness, or just enjoying the beautiful positive messages, we are here for you.

A big thank you to all of the people who have contributed to this magazine, especially to our editing team of Patrick Kelly and Sara Dalrymple and all of the contributing writers and photographers.

With so much uncertainty, with daily reports on new cases of COVID-19, new measures to protect us, new restrictions, it is frightening- and it is ok to feel that way. However, we must also maintain community and social cohesion in the midst of this physical distancing. We hope this publication helps.

Thank you in advance for the support, we are looking forward to bringing you many more issues in the months to come.

Be kind to yourself, generous with others, and stay healthy during this time.

Sincerely, Luciana Rosu-Sieza, Executive Director

MOVEMBER®

Spotlight on Men's Mental Health:

How the COVID-19 Pandemic Changed the Game.

By Sonya Friesen, Movember Canada

Mental health is experiencing a long-overdue spotlight. While it's never too late to shine a light on the importance of mental health, the idea of promoting mental health resiliency is not new. Global men's health charity Movember has been investing in mental health initiatives for almost 10 years.

In Canada, 75 per cent of suicides completed are by men, and it is the second leading cause of death in men aged 14 to 44. The reality is that men's mental health has been in crisis for many years, however, the rejuvenated conversation around mental health is a welcomed change for organizations like Movember who have been encouraging more vulnerable and open dialogue on the topic.

The COVID-19 pandemic has caused many of us to experience unparalleled levels of isolation, and for men who are already isolated, human connection - even a simple text or phone call - can go a long way. In a survey conducted by Movember in early 2020, 80 per cent of Canadian men surveyed said they found it helpful when people asked if they were having a difficult time, yet 40 per cent still noted that no one had asked how they were coping during the pandemic. In a follow-up survey in early 2021, 66 per cent of men felt men's mental health is worse today than it has ever been, while 55 per cent fear they've missed out on chances they'll never get back.

The COVID-19 pandemic has undoubtedly worsened mental health, but it's not all doom and gloom. The pandemic has showcased just how common these struggles really are, proving to many that they aren't alone. In that same piece of research from 2021, 80 per cent of Canadian men said they now considered mental health a priority, a higher number than those who were prioritizing career or romance. While it's encouraging to see mental health growing in importance for men, the work has only just begun.

The pandemic has encouraged organizations like Movember to think differently about how they support those struggling with their mental health. There are now incredible programs available not only for those experiencing their own mental health struggles, but for those who might be worried about a friend or loved one.

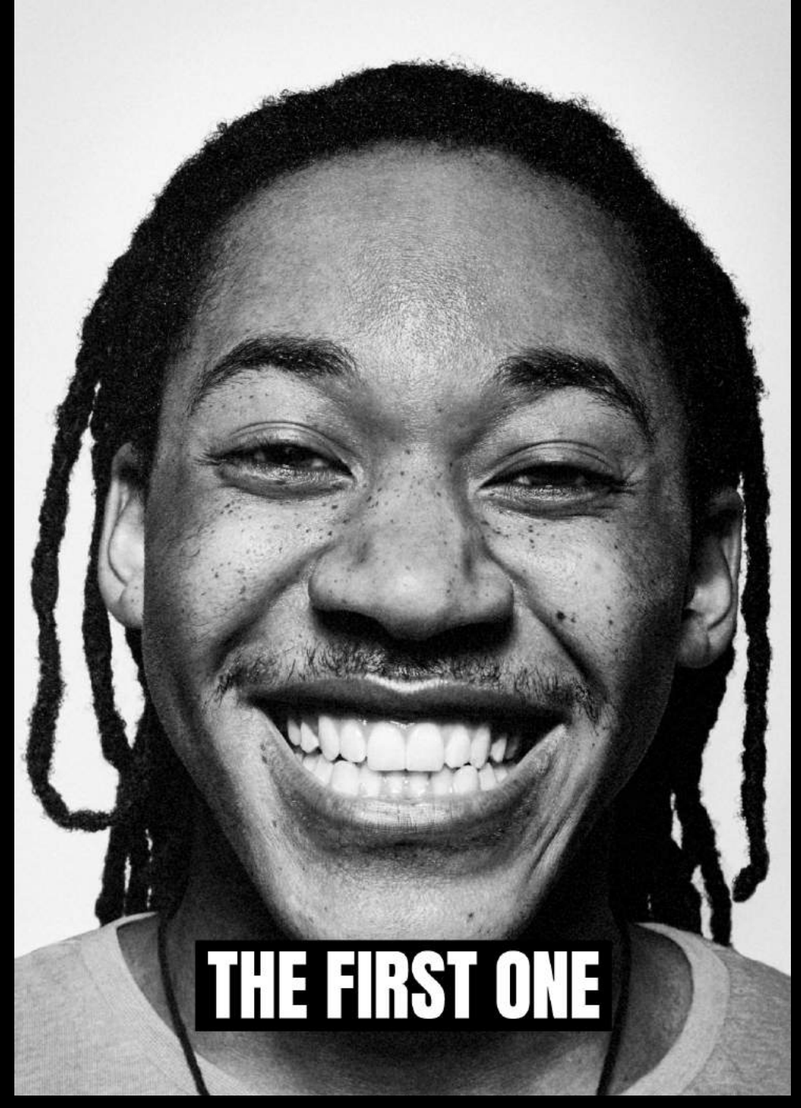
In May 2020, Movember launched Movember Conversations, a free digital tool aimed at helping men better understand how to communicate with a man that they feel might be struggling.

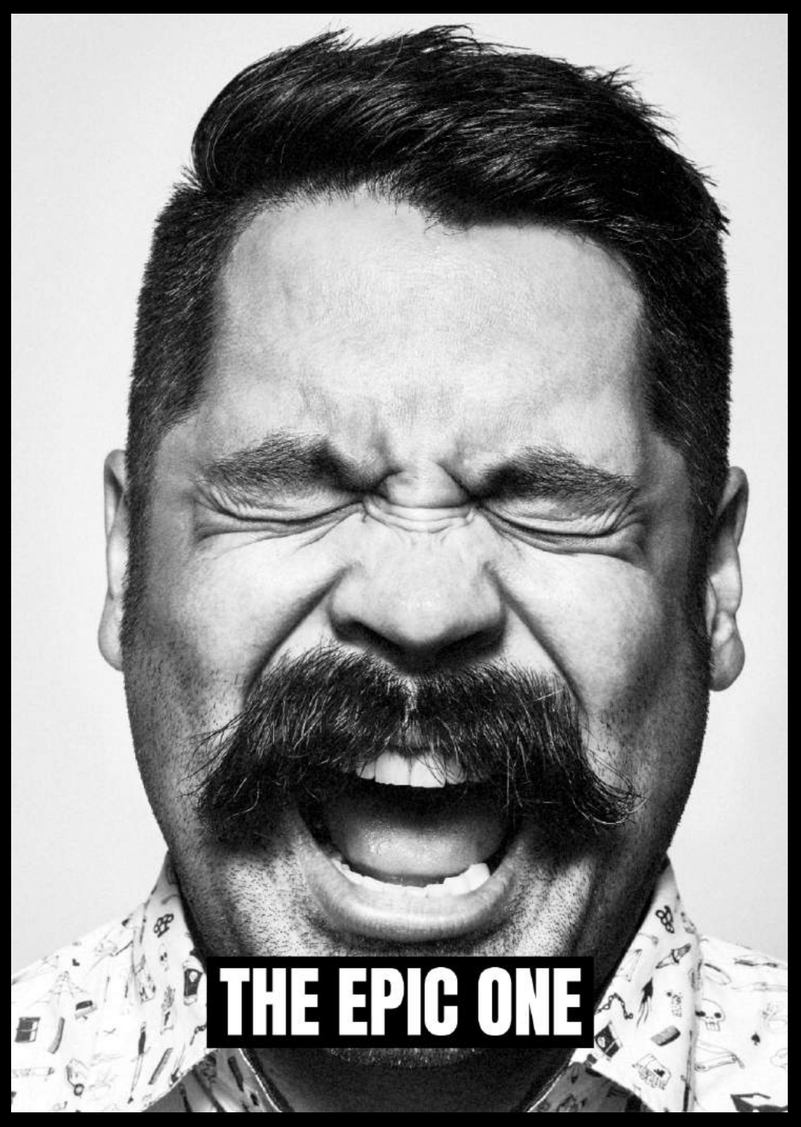
The module-based program provides helpful tools and techniques for communicating with a friend who you suspect may be going through something. In early 2021, Movember introduced Movember Family Man – the first ever parenting program designed for dads. Recognizing that fatherhood is often a catalyst for mental health struggles, Family Man provides men with a chance to feel more confident in their parenting abilities, improving their overall mental health.

Moustaches may be little, but they are powerful. So as the November chill sets in and the annual Movember campaign kicks off, it may seem like 'just a bit of fun' but funds and awareness raised are quite literally changing the face of men's health.

For more information visit:

www.ca.movember.com





The Truth is:
There is Life After an Eating Disorder

By R.S.

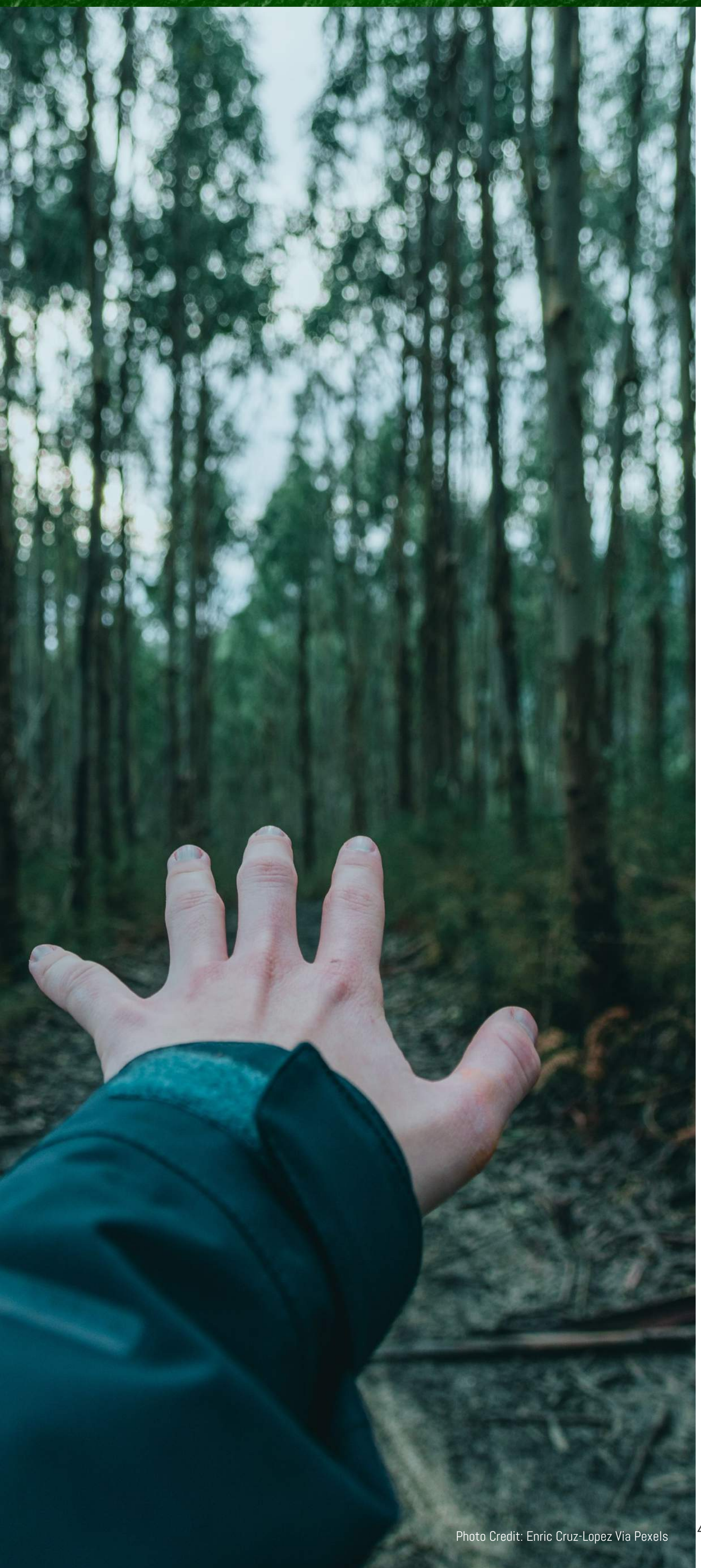


Photo Credit: Enric Cruz-Lopez Via Pexels

This article contains descriptive depictions of an Eating Disorder and content may be triggering. Please use caution when reading.

What comes to your mind when you hear the term "eating disorder"?

For most of you, if you haven't been involved in the eating disorder community for very long, probably thought "female, thin build, doesn't eat". And, although that may be true to some clients, that is not the only criteria for eating disorder clients.

As a male with a slightly larger build who strength trains, I am hoping that some of you will take on a different perspective of this subject. The truth is: eating disorders do not discriminate from gender, race, sex, religion, size or weight. Everybody has a story, and here is a little bit of mine.

For as long as I can remember - and anybody who knows me well will probably agree - one thing I have always loved is food. How ironic that one of the things I enjoyed so much was one of the things that caused me so much distress.

Food has always been a thing that I have had a hard time controlling. I had been binging and overeating food for as long as I can remember. Looking back on my childhood and teenage years, although I was not diagnosed with an eating disorder, I probably displayed symptoms of disordered eating for a long, long time.

I loved food, and I often lost control when eating all of my favourite foods. It gave me a sense of fulfillment that I was missing from something. My overeating and binging behaviours were always justified, because I was a male with a big appetite, who played lots of competitive sports, who did a lot of strength training, etcetera, etcetera.

...The words "eating disorder" never, ever came across my mind.

A few years ago, I was in a dark, dark place. I was not feeling good about myself. I was feeling stressed and anxious. I needed to help myself. One thing I did not like was the fact that I was gaining so much weight. So the first thing I did was: exercise more and watch my diet.

The perfect recipe for a restrict, binge and purge cycle. But I had no idea what I was getting myself into.

I know exercising and eating healthy are extremely important for physical health and mental well-being. But I abused these things to the point where I was unhealthier than I had ever been.

My "banned food list" was probably longer than a Stephen King novel, and everything on my list was all of the good stuff. Every so often, I would once again lose control of my eating while being around one of these "banned foods", and the vicious cycle started all over again.

It came to the point where many people were commenting on my weight loss. But the truth was, despite what the scale read or what anybody said about my appearance, I started to feel worse, and worse, and worse.

It was around this time that I might have realized, "maybe I need to get some help". But I was not sure if I was ready to let go of my habits. I was fearful of what the future would hold. Would I become "fat" again? Am I even "sick enough" to get help? Turns out, I was. And it also turns out that receiving treatment for my eating disorder was undoubtedly the best thing I have ever done for myself. **The truth is: there is life after an eating disorder.**

My experience with BANA was a truly incredible journey that I will never, ever forget. I was diagnosed with my eating disorder in late 2019, just months before the pandemic hit. I was worried when I found out that treatment would not be in the office; rather, it would be done virtually. The team I worked with helped me make the most of every session I attended and did their absolute best to make sure that virtual treatment was effective for me.

Treatment helped me realize so many things about myself that I did not even know. The therapy sessions, the homework I completed, and the challenges I faced were all absolutely critical parts to allow me to heal from my eating disorder. I was trapped for a long, long time. It is hard to truly explain how I felt during the peak point of my eating disorder.

But the team I worked with gave me the tools I needed, and I had to meet them halfway by putting in lots of effort in so many areas; eventually, treatment helped me beat my eating disorder and live the truly fulfilling life that I do today.

Like many clients, I really struggled with my body image. I abused diet and exercise to try to shape my body in a way that I had in my head. But no matter how much weight I lost, no matter how much I worked out, I never seemed to get closer to that standard. One of the exercises I worked on, "Function Over Form", helped me get over what my body looked like, and to celebrate the abilities my body is capable of. This taught me so much about myself.

I actually got to a place in my life where I was ready to make a career switch into the skilled trades, where I use my body everyday to work to provide for my family, to learn new skills, to become stronger and more efficient everyday, and to use my hands to build amazing things.

I found something I love and am passionate about, and have all the room in the world to grow as a tradesman. Sometimes, my job is the "runners high" I need, without the annoyance of calorie counting that had gone on in my head for so long.

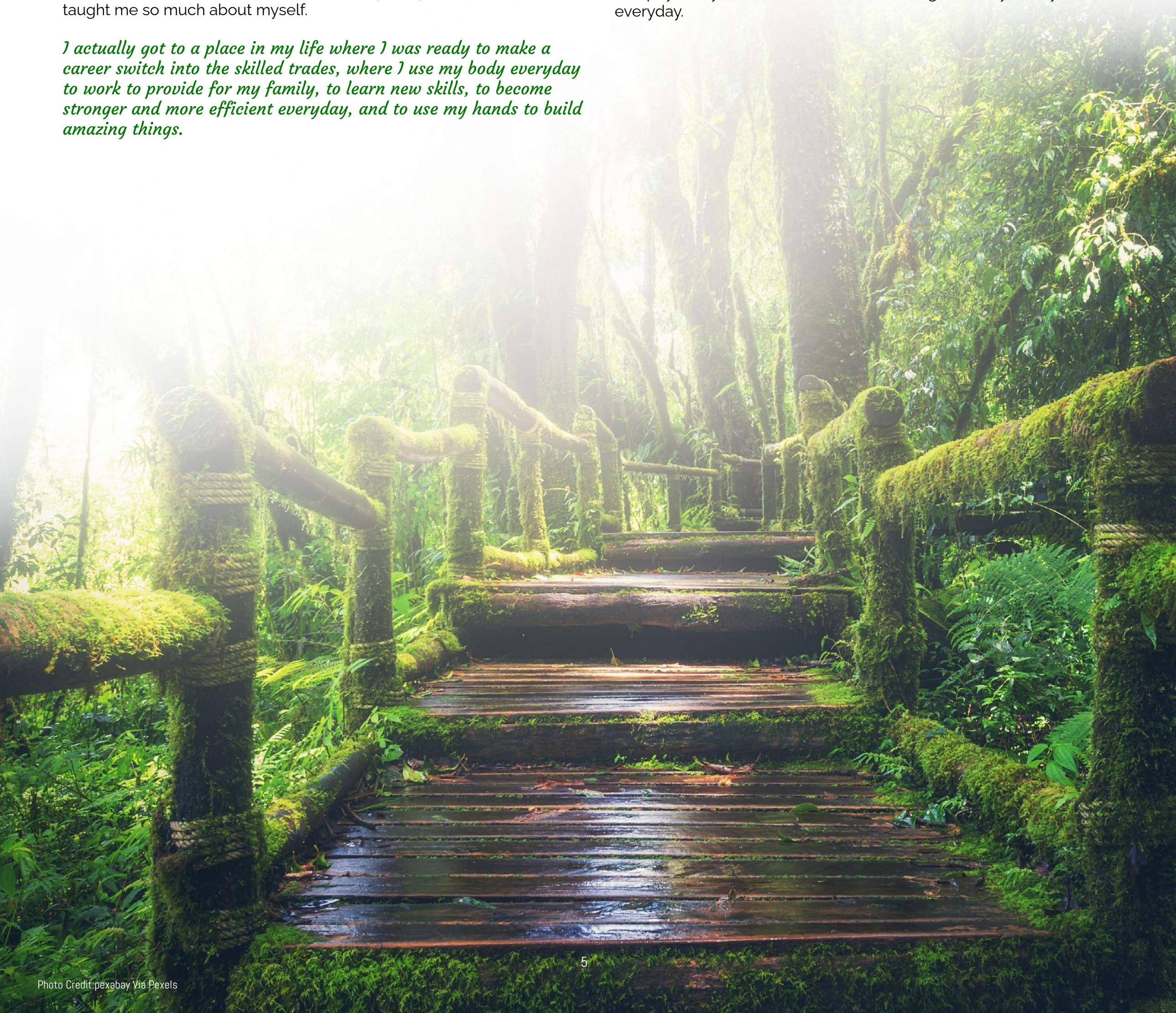
On top of that, I also got to a place where I was ready to put my family before my eating disorder thoughts and behaviours, and I was mentally, emotionally, and financially ready to expand my family. I am now a proud father of 2.

I can confidently say, I would not be the person I am today without eating disorder treatment. Words cannot describe how grateful I am for this organization for all it has done for myself, as well as my family.

So my advice for those who are new to the eating disorder community and think you might be struggling with eating or body image:

It is important to reach out for help. It not only helped me to recover from my eating disorder, but it gave me a whole new outlook on life, and made me feel like my old self again.

I move my body in healthy ways everyday, I enjoy all foods, I cherish my relationships with my loved ones, and I live life to the fullest. I choose to feel good about myself. I am stronger mentally, emotionally and physically than I have ever been, and I get to truly be myself everyday.



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Man Up

Finding Strength in Mental Illness

By Patrick Kelly

Photo Credit Cottonbro via Pexels

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Society has spent centuries pre-disposing gender roles for boys and men and it is quite literally killing them. In this draconic ideology, men are lead to believe that their role is to be stoic and strong in the face of adversity and that nothing short of that, be it physical or mental, is equivalent to failure as a member of your gender. While both women and men share many of the same experiences when it comes to mental health disorders, more often than not, their willingness to talk about their challenges and feelings vary drastically.

So let's be clear from the onset…

Mental – illness - is - not - a - sign - of - weakness!

It's a legitimate, genuine and common medical issue. Everyone, regardless of gender, should be made to feel comfortable asking for help and seeking support without the fear of stigma, diminished image, or being questioned about their competency.

The perception of masculine ideals and inherent stigmas on men when seeking support for mental health disorders present challenges to their overall health and wellness. As a society, stigmas associated with mental health are prevalent and common. Males face the added pressures that 'real men' don't ask for assistance; implying that talking about mental health issues won't help. In fact, the opposite is true. Limiting open conversation surrounding mental health and the related challenges may result in a worsening of underlying conditions and lead to a prolonged state of the presenting symptom(s).

In fact:

Annually, ***men account for more than 75 % of suicides in Canada.***
That's an average of 50 men per week dying by suicide.

Around 10% of Canadian men experience significant mental health challenges in their life

Approximately ***1 million Canadian men suffer from major depression*** each year

28 % of Canadian men said they believed their job could be at risk if they discuss mental health issues at work, and more than ***33 % of men worry they could be overlooked for a promotion*** if they mention a problem.

42 % men surveyed said they are also worried about colleagues making negative comments behind their backs.

Whatever the stigmas, it is paramount that we as a society stop shaming boys and men into thinking that there is something wrong with them when they need to address mental health challenges or concerns. Without fundamental changes on how we perceive masculine roles in mental health circles, men will continue to suffer in silence.

Seeking mental health support is a normal, healthy activity, and can even be life-saving. But you have to start somewhere. So what can boys and men do to help themselves?

Try talking it out

Give yourself permission to admit to having fears and anxiety. If the global experience of covid has taught us nothing else, it is that life can take its toll on us all. While boys and men may still have a habit of suppressing their emotions, there has never been a time where more people are going to understand.

Relinquish the desire to control everything around you.

Face it...the need to control life for most men goes well beyond not asking for directions or who gets the remote. It's time to start accepting that happiness is not found in our ability to orchestrate every little moment. Try focusing on the end result of your goal, instead of obsessing about every little step along the way; it might make the journey all that more enjoyable.

Change your stars

Sometimes the universe is going to unfold in ways that we could never expect. Zoom meetings. working from home, paternity leave,...life changes everyday and just as we've adapted how we've lived, worked, and played over the last 2 years, so can our roles going forward. While the unknown can certainly evoke hesitancy and trepidation, it can also open doors.

The important thing to remember is that you're not alone.

So how can we help the men our in lives to reach out?

• Recognize the *unique ways in which men experience and express mental illness*, and address the stereotypes that prevent men from seeking help.

• *Become an ally* for those in need and provide a safe, unbiased, and supportive environment.

• Allow boys and men to *speak openly about their feelings without judgement*.

• *Be aware of the signs and symptoms* that a male in your life may be experiencing mental health-related concerns including:

- change in mood, difference in work performance, weight changes.
- sadness, hopelessness, or a loss of pleasure and pulling away from things that used to provide enjoyment.
- physical symptoms, such as headaches and stomach issues.

Although changes in behaviour are common and not cause for immediate concern, if these changes continue for an extended period – typically two to four weeks – it may be a warning sign that there is a more significant mental health issue.

If you have concerns that you or someone you care about may be struggling, the following are great starting points geared towards wellness:

1. ***Become better informed***. Reach out to local men's health organizations.

2. ***Ask what you can do***. Simply asking the question can be a significant step in providing the right support to this individual.

3. ***Be there to listen***. It takes a lot of courage for someone to open up about their mental health. Listening can be one of the most powerful ways to help someone, as it allows the individual to process and share their challenges.

4. ***Don't blame or judge***. The best support you can give is being empathic and compassionate.

5. ***Take care of yourself***. You cannot support anyone with mental health challenges if you are emotionally drained. Protect your physical and emotional health above all.

Perhaps going forward this can be a rallying cry not only for men, but society as a whole. Let's make it less about holding issues in and more about letting them out. When we speak our mind, let's speak about what's on our minds, openly, and listen with understanding and acceptance. Let us do better, by being better.

There is strength in mental illness. In admitting it, in sharing it, in accepting it and in allowing yourself to receive the help we all deserve. ***It's ok...to not be ok.***

...and maybe, together it's time to redefine the term "**Man-up.**"

For a list of article sources please visit: https://bana.ca/magazineresources

Patrick Kelly, is the Communications and Office Administrator at the Bulimia Anorexia Nervosa Association (BANA) and Editor-in-Chief of the BANA Magazine

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Getting to know Avoidant/ Restrictive Food Intake Disorder (ARFID)

By Sara Dalrymple, BA. Psych., MSW, RSW

Photo credit: RODNAE Productions via pexels

Photo Credit: Rodnea Productions Via Pexels

***** Disclaimer: The following article includes information derived from our clinical team's impressions as specialized professionals working directly with Eating Disorders in Windsor/Essex County.**

Avoidant/Restrictive Food Intake Disorder, commonly referred to by its acronym "ARFID", is an eating disorder that few know to exist. ARFID appeared in previous editions of the diagnostic manual as "Selective Eating Disorder", "Feeding Disorder", "Failure to Thrive", or "feeding/eating disturbances", and was typically directed towards children.

Now, ARFID is more clearly outlined as its own diagnosis, and is being recognized in adolescents and adulthood; the diagnostic criteria is no longer age-specific. However, it cannot be denied that ARFID does occur more frequently within child populations.

In the 2018-2019 year, we collected data on our active clients to determine how frequent each eating disorder diagnosis is at BANA. During this year, along with many others, there have been no diagnoses of ARFID within our client population. However, this does not necessarily mean that BANA's intake department has not seen clients with ARFID. Nor does this suggest that BANA does not work with this diagnostic population.

Rather, because ARFID tends to be very unique from other eating disorders and has a very diverse range of presentations, it is likely that these clients are not referred to BANA as often, or the symptoms may be missed/overlooked.

Furthermore, BANA works exclusively with the adult population; as noted above, ARFID tends to be more common with children. Therefore, it is likely that these individuals received treatment before they reached adulthood and could access BANA programming.

The 5th rendition of the Diagnostic Statistical Manual (DSM-5) is the current guideline used in North America to diagnose all mental health disorders. It outlines the requirements that must be met in order to receive any diagnosis within its pages.

It is important to note that because there is such a vast array of presentations in ARFID, many do not fit the criteria exactly but still may require support. It has been speculated that future DSM's may include subtypes to assist in the identification of this disorder.

DSM-5 CRITERIA FOR AVOIDANT/ RESTRICTIVE FOOD INTAKE DISORDER:

A) An eating or feeding disturbance (ex: Apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) – manifested by persistent failure to meet appropriate nutritional/energy needs, associated with one (or more) of the following:

- Significant weight loss (or failure to achieve expected weight gain/faltering growth in children)

- Significant nutritional deficiency

- Dependence on enteral feeding (intake via the G.I. tract, typically seen as a feeding tube) or oral nutritional supplements

- Marked interference with psychosocial functioning.

B) The disturbance is not better explained by lack of available food, or by an associated culturally sanctioned practice

C) The eating disturbance does not occur during the course of Anorexia or Bulimia Nervosa, and there is no evidence of a disturbance in the way in which one's body weight/shape is experienced

D) The eating disturbance is not attributable to a medical condition, or better explained by another mental disorder

PICKINESS VS. ARFID

ARFID is often seen by parents and professionals as "picky eating", which can cause the disorder to be overlooked and left untreated. It is important to distinguish ARFID from picky eating so that these individuals can be connected with appropriate supports.

One key marker that helps to differentiate picky eating from ARFID is persistence; a "picky eater" may have food-preferences that change from time-to-time, and their nutrition and growth will likely remain unaffected. When eating disturbances are persistent and prolonged, and impact the individual's nutritional needs and growth, this speaks more to ARFID. Finally, picky eaters still tend to be interested in food and report an appetite, whereas individuals with ARFID may have no interest in food and often do not report feeling hungry.

When differentiating ARFID from more normative disturbances in feeding/eating, eating disorder professionals recommend taking the following into account:

- **Nutrition and growth (energy/nutrient intake, food variety, developmental growth, weight loss)**

- Feeding/eating factors (feeding skills, appropriate age/developmental stage, ability to self-feed, ability to meet one's own nourishment needs, the "feeding relationship")

- Psycho-social functioning (feeding dynamics within family relationships, stress of the individual and family members, level of social eating, impact on quality of life)

The nature of restriction behind ARFID is quite different than that of other eating disorders. Unlike restriction seen in Anorexia and Bulimia Nervosa, restriction in ARFID is not driven by preoccupations surrounding weight/shape (see discussion of "Body Image & ARFID" below). If restriction is occurring in the individual, it is likely attributable to what can be referred to as "the 3 main influences"; these factors tend to be the driving forces behind feeding/eating disturbances:

1. Low appetite and a disinterest in food, low desire to eat, often report not being hungry

2. Aversive eating experiences and a historical events that may have included food in a negative way, or posed with unpleasant consequences (ex: fear of vomiting or choking)

3. Sensory avoidance and/or sensitivity aversion to certain characteristics of the food (ex: texture, smell, colour)

BODY IMAGE, ANOREXIA NERVOSA & ARFID

ARFID is a unique eating disorder, particularly because it excludes distortions in the way one's weight/shape is experienced. Although individual's with ARFID may have some body image concerns (which is typically normative across the general population), body image is not a driving factor for distress, disruption of functioning, or influenced intake as it would be for other eating disorder diagnoses.

For example: in Anorexia Nervosa, diagnostic criteria requires that the individual not only has fears about weight gain/"fatness", but that the individual also has a distorted view of these concepts. As you can see above, ARFID does not necessitate either of these criteria for a diagnosis.

It is common that ARFID is mistaken for Anorexia Nervosa due to what seems like shared symptoms (weight loss, restriction). However, these are important diagnoses to differentiate because challenging the fear of "fatness" is pertinent to the treatment of Anorexia, but would not typically be addressed in ARFID treatment regimens.

OVERVIEW

ARFID is very often misunderstood, can be excused as "picky eating", or may be incorrectly diagnosed as Anorexia Nervosa. These factors could account for why ARFID appears to be somewhat rare, as professionals or the individual's themselves may struggle to identify and/or correctly classify symptoms. If any of the criteria outlined in this article hit-home, but you're not sure if they meet all the requirements for a diagnosis, do not hesitate to contact us through general intake. We can meet with you to discuss potential symptoms, and can support you through some of your concerns.

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Photo Credit: Nicole Michalou via Pexels

Sara Dalrymple, is a Clinical Therapist at the Bulimia Anorexia Nervosa Association (BANA) and Associate Editor of the BANA Magazine

Thinking Outside the Volunteer Box

This issues featured charity:

Noah's House
Mental Health Foundation Inc.

By Patrick Kelly

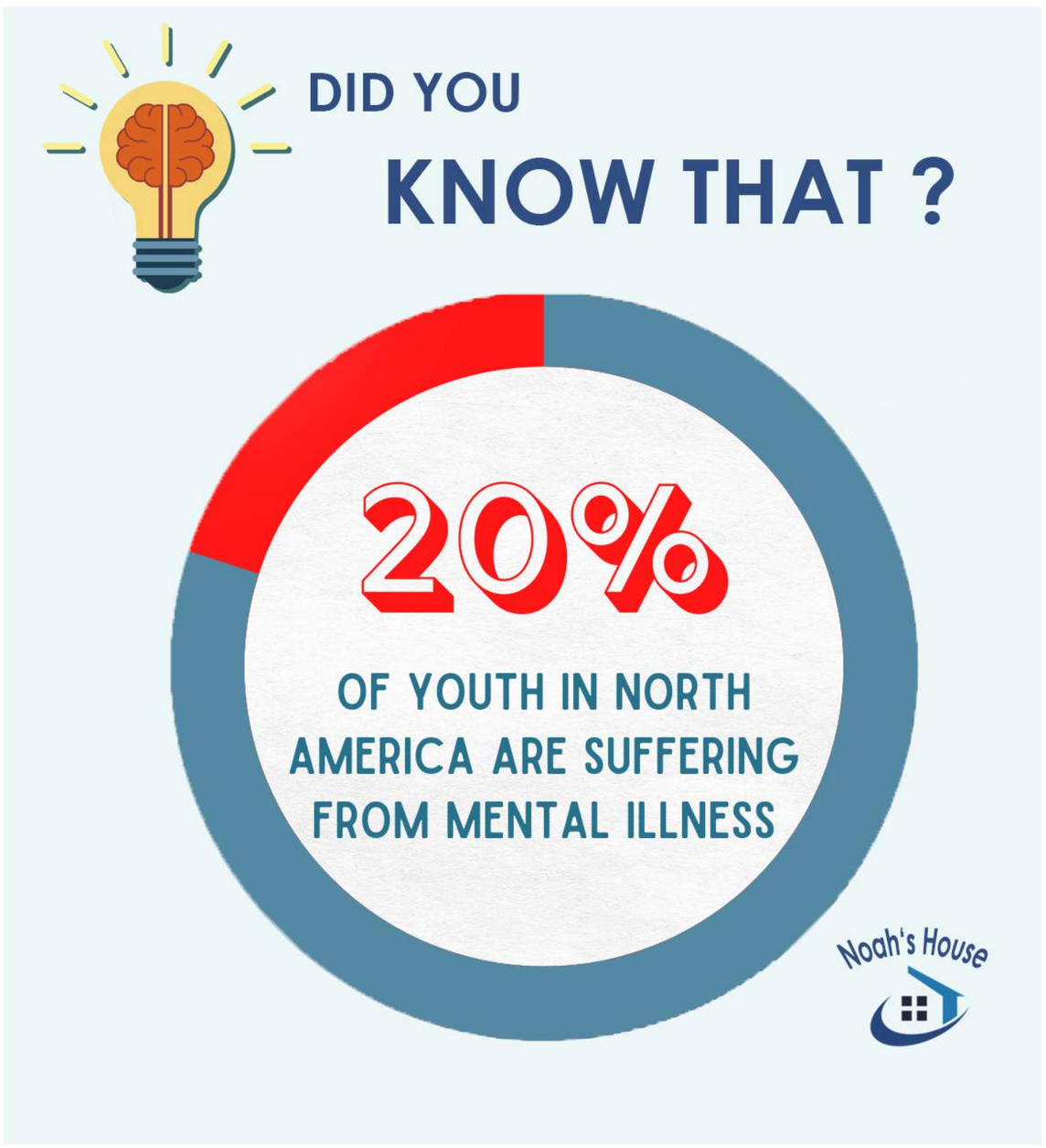
Photo Credit: cottonbro via Pexels

Volunteer work has long been tied to improved mental health. Volunteering has been shown to provide a sense of purpose and life satisfaction, strengthen problem-solving skills, increase health behaviours, improve social interaction, and enhance coping abilities. (Casiday, Kinsman, Fisher & Bambra, 2008).

For those who have not yet heard about **Noah's House,** it is a mental health charity in Windsor, Ontario, established in 2018 after Noah Butcher-Hagell lost his battle with mental illness. Noah's House is working to fill the gap on mental health support in a non-clinical setting for individuals ages 11-25.

In January 2020, after over a year of searching, they opened their first location just off the corner of Pillette and Tecumseh Road East. In May 2020, they already began to expand into the space next door to what would become the home of the Noah's House Youth Centre.

Here, in a youth-led experience setting, Peer Mentors support adolescents through games, puzzles, or sitting and talking. Noah's House is empowering and inspiring individuals to break free from the chains of mental illness.



Be Yourself Magazine caught up with Noah's House President and CEO, Laura Starling to talk about their programming and how interested parties can get involved.

What kind of programs/activities would volunteers be involved in?

Volunteers help within the youth centre. The youth centre is a youth-led experience where Peer Mentors can support youth through games, puzzles, or sitting and talking. We have computers for homework help, many books, a 3-in-1 games table, a television with PS4 and Xbox One.

What kind of qualities/experience/abilities do you look for in a volunteer? Who's your ideal volunteer?

We prefer someone who is in school for psychology, social work, child and youth care or someone with lived experience. Also, volunteers with a passion for youth mental health.

Do you offer training?

All volunteers go through peer support training, as well as ongoing workshops. Most have training in QPR as well as CPI which are crisis intervention trainings. We ensure that anyone who will be engaging with the youth has the proper training prior to their first shift.

What is the time requirement for volunteering?

We prefer volunteers commit to a minimum of 1 shift per week. This ensures consistency for the youth using the centre and increases their comfort level. The youth centre is open Monday-Friday 4 pm-9 pm and Saturday 5 pm-10 pm

Will you be offering any additional guidance or advice to volunteers in regards to Covid protocols?

We follow safety protocols within the youth centre. Everything is sanitized at night, masks are to be worn at all times and social distancing is encouraged.

Are there other ways people can help Noah's house?

Individuals looking for other ways to get involved can do so through different committees, the board of directors as well as volunteering for our special events and fundraisers.

How do prospective volunteers get in-touch with you?

Anyone interested in volunteering can forward their resume to admin@noahshouse.ca

~ Dieting ~ Don't You Know's

By Sara Dalrymple, BA. Psych., MSW, RSW

Most of the information we have on dieting comes from the diet industry, or platforms and professionals sponsored by the diet industry. We are saturated by the diet mentality, and it becomes more and more difficult to sort through the content at our disposal in order to understand the truths behind dieting.

Often the truth lies within academic journal articles or empirical research – content that isn't always the easiest to read or make sense of. We receive a very one-sided picture of what dieting is, and typically only hear about the success stories or the "pros" of dieting.

Yet, there is a whole other side of this discussion that typically falls "below the radar", and is backed by a huge body of literature that demonstrates how dieting is problematic.

It's important to know what you don't know:

- The diet industry is estimated to earn over 150 billion dollars per year. The industry builds diets to fail and does not aim for permanent results; it won't profit without return customers (ie: those who regain weight after their diet ends).
- Dieting limits the amount of energy the body has to function, which compromises all bodily systems. Repeated "weight cycling" (typical of dieters) increases the risks of numerous health problems, including: cardiovascular disease, nutritional deficiencies, long-term disruption to the metabolism, electrolyte and hormonal imbalances, decreased bone health, impaired cognitive abilities, etc.
- Diets that promise "medical benefits for all" tend to overgeneralize findings from research conducted on specific medical conditions (ie: the keto diet and epilepsy).
- Over 2/3 of those who lost weight on a diet will regain the weight (many studies estimate this number to be much higher).
- Dieting has been shown to increase non-dieting weight overtime (yo-yo dieting has been linked to higher BMI's for decades), can cause the body to gain weight more quickly, and has been seen as one of the causes of obesity.
- Dieting can cause the body to go into "starvation syndrome" – essentially, rather than excreting leftover calories, the body stores the extra in order to guarantee energy for the future.
- Restricting intake has been linked to increased cortisol (the stress hormone).
- Dieting has been linked with higher levels of anxiety, as restrictive eating puts the body into "fight or flight" survival mode.
- Dieting has been associated with lower mood, likely due to cognitive impairment and hormonal imbalances caused by undereating.
- Dieting may be the culprit of many of your day-to-day complaints: low energy, irritability, difficulty concentrating, decreased memory, headaches, general fatigue, thinning hair, dehydration, etc.
- Restrictive eating is the main cause of binge eating, as well as increased food cravings.
- Dieting is considered a common antecedent of eating disorders, preoccupation with thinness, and negative body image.

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The Link between Trauma and Eating Disorders

By Rose Verzosa, MSW, RSW

In popular songs and everyday conversations, we often hear "what doesn't kill you makes you stronger". Though this saying is mostly well intentioned and meant to foster a sense of hope and resiliency, research tells us there is often a lingering emotional response that can result from living or witnessing a distressing experience. We know this as trauma. Trauma is the sum of the event, the experience, and the effect.

Trauma can harm one's sense of self, safety, or ability to regulate emotions or relationships, as well as it can foster shame, helplessness, and powerlessness.

Disordered eating can be a response to these experiences as a means to manage the emotional and psychological effects of trauma. Of course, trauma alone does not cause eating disorders (EDs). However, research shows that many people who experience disordered eating and/or body dissatisfaction have previously or are currently experiencing trauma or abuse. Especially in childhood, exposure to severe adversity can place a person at increased risk of developing psychiatric and medical disorders, including EDs.

How Does Trauma Connect to Eating Disorders?

There is no root cause for eating disorders. The spectrum of trauma associated with EDs includes sexual assault, sexual harassment, physical abuse and assault, emotional abuse, emotional and physical neglect (including food deprivation), teasing, and bullying.

It has been established by research that childhood sexual assault is a significant - although nonspecific - risk factor for EDs; however, it is important to note that it is not necessarily associated with greater severity of the ED. Nonspecificity means that childhood sexual assault is a risk factor for other psychiatric disorders as well. Research shows that essentially any experience that can produce PTSD, partial PTSD, or any form of clinically significant anxiety, and that these comorbidities can increase the probability of developing an ED.

Because of the effect of trauma, it is also important to look at other social and environmental factors, such as colonization, intergenerational trauma, and oppression. EDs can be influenced by the experience of systemic trauma, as well as weight stigma, diet culture and racism.

Consider the saying, "genetics loads the gun and the environment pulls the trigger". There may be factors that will predispose an individual to disordered eating, but there are also various environmental factors that could trigger the ED.

How do ED Symptoms Relate to Trauma Responses?

Types of trauma responses vary by the person and the type of trauma experienced. Some but not all examples of trauma responses include: depression, anxiety, nightmares, shame, dissociation or hyperarousal, seeking control, shame, self-harming behavior or mistrust.

Disordered eating can be viewed as a means to maintain control, self-harm/ punishment, coping with negative emotions, avoiding memories/ feelings, self-soothing or avoiding sexuality.

Disordered eating behaviors can provide short term (but not long-term) relief from trauma.

In looking at the experience of sexual abuse, disordered eating can provide a mechanism to avoid unwanted attention from potential or past perpetrators of trauma.

Research suggests that trauma histories are more commonly associated with Bulimia Nervosa (BN) and Binge Eating Disorder (BED) compared to other eating disorders; however, trauma histories can be seen across the entire ED diagnostic spectrum.

This research also suggests that the symptoms of BN and BED may be a response to abuse and a strategy for coping with the distress caused by trauma. It is important to remember that eating disorders are not always about food or the body.

The DSM-5 criteria for Bulimia Nervosa includes but is not limited to experiencing recurring episodes of binge eating - at least once a week for 3 months; recurrent inappropriate compensatory behaviors that are used to prevent weight gain (ex. self-induced vomiting, misuse of laxatives, fasting/dieting, excessive exercise); and the way the individual evaluates themselves is unduly influenced by body shape and weight.

The criteria for Binge Eating Disorder includes but is not limited to: recurring episodes of binge eating (ex. eating an amount of food that is definitely larger than what most individuals would eat, a sense of lack of control over eating during the episode) and no use of compensatory behaviors.

The symptoms of BN are often used to reestablish autonomy over one's body, through the perception that one can control their weight, shape and eating using compensatory behaviours. Both BN and BED symptoms can be aligned with self-punishment or self-harm.

There are additional factors associated with trauma that can increase the risk for eating disorders. For boys and men, long-lasting adverse familial relationships, particularly in connection with physical abuse and physical neglect, appear to increase the risk for disordered eating.

In women, the risk for disordered eating is more commonly connected to sexual violence. Factors that decrease the risks among men are high parental expectations, maternal presence, and connectedness with friends and other adults.

Factors for decreasing the risk in women may include family connectedness, positive family communication, parental supervision/monitoring, and maternal presence.

Bulimia Anorexia Nervosa Association Statistics:

In Canada, the prevalence rate of eating disorders is between 2% and 3%. In Windsor-Essex, the estimated number of people with an eating disorder is between 7,990 and 11,970. Based on these statistics, approximately 6,012-9,003 individuals in Windsor-Essex would fall within the population served by BANA.

Of a sample of 113 service users at BANA in March 2021:

- 53% were diagnosed with Bulimia Nervosa
- 34% were diagnosed with Binge Eating Disorder
- 6% were diagnosed with Anorexia Nervosa
- 7% were diagnosed with Other Specified Eating or Feeding Disorder/Avoidant Restrictive Food Intake Disorder.

A total of 64% of active BANA clients in March 2021 reported some form of past or current abuse/trauma. The breakdown of the types of trauma goes as follows:

- 21.2% Emotional
- 14.2% Physical, sexual and emotional
- 8% Sexual
- 8% Physical and Emotional
- 8% Sexual and Emotional
- 2.7% Physical and Sexual
- 1.8% Physical

Trauma histories are very relevant in addressing disordered eating and can provide plenty of insight in regards to emotions, behaviors and coping strategies

Conclusion

So, does "what doesn't kill you make you stronger"? The experience of trauma has lasting effects on a person, and can cause serious harm to one's mental, emotional, spiritual, and physical wellbeing.

One may develop disordered eating behaviors as a means to cope with or soothe various trauma responses. This is important to note, as eating disorders have the highest mortality rate of all mental health conditions due to the health risks that involve various parts of the body.

Though the traumatic experience did not "kill" the person, an eating disorder can be deadly. With that said, people are resilient and constantly growing, changing and adapting.

The Merriam-Webster dictionary defines resiliency as:
"an ability to recover from or adjust to misfortune or change".

Resilience is not solely built upon the experience of a traumatic event, but rather the sum of the effect. Survivorship is an ongoing act, even long after the trauma/abuse has occurred. Eating disorder treatment may just be one method to build one's toolbox of coping strategies for their trauma, though, ED treatment is not necessarily a treatment for trauma. Both are separate specialized forms of treatment that can provide a person various levels of support.

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Cognitive Behaviour Therapy for Adolescents with Eating Disorders:
An Effective Alternative to Family-Based Treatment

By Riccardo Dalle Grave, MD,
Director Department of Eating and Weight Disorders, Villa Garda Hospital, Verona Italy

Photo Credit: Anna Shvets via pexels

Eating disorders may have profound negative effects on the psychosocial functioning and physical health of adolescents. Therefore, they must be treated early and effectively to avoid long-lasting and sometimes devastating adverse effects.

A specific form of family therapy, termed family-based treatment (FBT), is the most empirically supported intervention for adolescents with anorexia nervosa. There is also some more limited support for its use in young people with other eating disorders.

However, FBT has certain limitations. All families and patients do not embrace it because it requires parents to participate in sessions and control their child's eating. It is also labour intensive and, most of all, less than 50% of young patients achieve full recovery. These considerations indicate that alternative approaches are needed.

The National Institute for Health and Care Excellence (NICE) has recommended cognitive behaviour therapy (CBT) for eating disorders in children and young people when family therapy is unacceptable, contraindicated, or ineffective. The recommendation was mainly based on reviewing the promising results achieved by the enhanced version of CBT (CBT-E) adapted for adolescents with eating disorders aged 11 to 19 years.

The origin of CBT-E for adolescents

CBT-E was initially developed to treat adults with eating disorders at the Centre for Research on Eating Disorders at Oxford (CREDO). CBT-E has been defined as "enhanced" because it uses a variety of innovative strategies and procedures to enhance the effectiveness of the original CBT for bulimia nervosa and address the psychopathology of eating disorders rather than a specific diagnosis of eating disorders. CBT-E has been evaluated in several clinical trials and is recommended by international guidelines for the treatment of all clinical forms of eating disorders in adults.

The idea of adapting CBT-E for the treatment of adolescents was raised ten years ago at the Department of Eating and Weight Disorders of Villa Garda Hospital, Italy, during a periodic supervision visit by Professor Fairburn, the undisputed 'father' of CBT for eating disorders. Two main clinical observations made us undertake this project. First, since young patients with eating disorders show the same specific psychopathology (i.e., over-evaluation of shape and weight, strict dieting, excessive exercise, binge eating, and purging) as adults, they could benefit from CBT-E, a treatment specifically designed to address the psychopathology of eating disorders. Second, although young patients are often in an egosyntonic phase of their disorder, they can be actively engaged in individual psychological treatment, as my colleagues and I have observed in many years of clinical practice.

Main adaptations of CBT-E for adolescents

CBT-E for adolescents was adapted considering three distinctive characteristics of young patients with eating disorders. First, some medical complications associated with eating disorders (e.g., osteopenia and osteoporosis) are particularly severe in this age range, and periodic medical assessments and a lower threshold for hospital admission are integral parts of CBT-E for adolescents. Second, a particular effort is made to engage the young patient in treatment and change, as they are often unaware of having a problem to address. Third, in most cases, parents need to be involved in treatment, given the age and circumstances of these patients.

CBT-E for adolescents with eating disorders: An overview Structure

CBT-E for adolescents involves two assessment/preparatory sessions followed by three main steps, one or more review sessions, and three post-review sessions (see Figure 1).

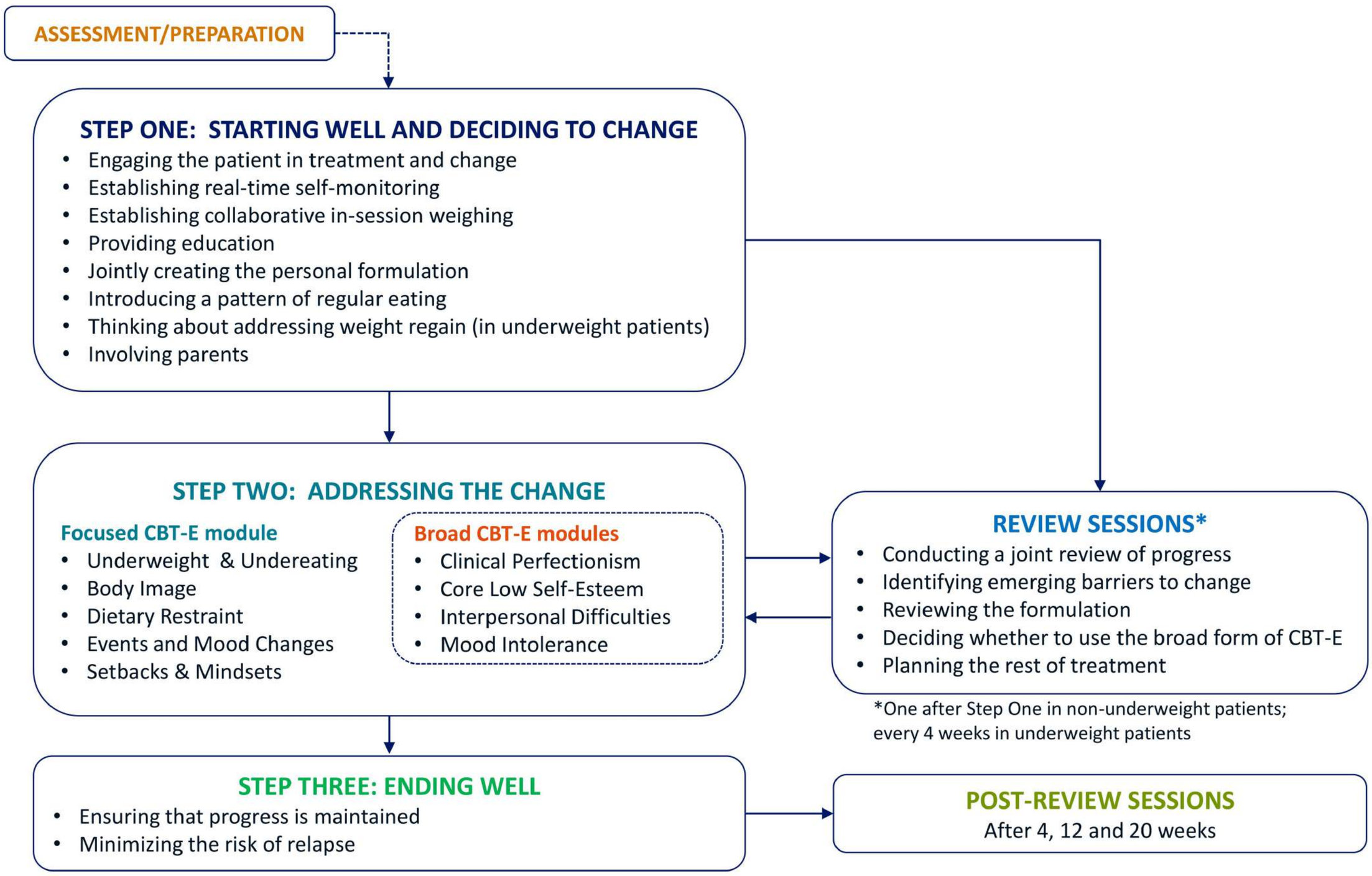

FIGURE 1. The CBT-E map for adolescents with eating disorders.

Treatment lasts 20 weeks in not underweight patients, while in underweight patients, the standard 40 weeks of adult CBT-E may be shortened to about 30 weeks, as adolescents tend to restore a normal body weight faster than adults.

Parents are asked to participate alone in an interview lasting approximately 90 minutes during the first week of treatment. Subsequently, the patient and parents are seen together in six to eight joint sessions of 15 to 20 minutes immediately after a patient session.

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General treatment strategy

After the assessment, the patients are taught about the two main ways of understanding eating disorders, namely the so-called "disease" and "psychological" models, and the treatment approaches based upon them. Specifically:

1. The disease model postulates that the characteristics of the eating disorder are the result of a specific disease (i.e., anorexia nervosa, bulimia nervosa, or other eating disorders).

   The patients are considered not to be in control of their illness because they are not aware of it.

   Therefore, they need the external control of parents, as in FBT, and/or health professionals. In this model, the patients adopt a passive role in the treatment.

2. The psychological model adopted by CBT-E is based on a psychological explanation of the patient's eating disorder; specifically, the young person has difficulties seeing dieting and low weight as a problem because their self-evaluation scheme is predominantly based on shape, weight, eating and their control.

   This explains why being able to diet and achieving a low weight is often associated with a sense of realization, despite its negative consequences.

   However, according to this stance, patients can be helped to understand the psychological mechanisms maintaining their eating disorder and that their self-evaluation system is dysfunctional. They can 'actively' decide to find other, more functional solutions for reaching a stable and balanced self-evaluation scheme and, therefore, recover from their eating disorder.

The psychological model adopted by CBT-E explains that the treatment never asks the patient to do things they do not agree to do because this may increase their resistance to change. For example, in the two assessment/preparation sessions, patients are asked to think about the pros and cons of starting Step One (not to change) for having the opportunity to improve the understanding of the psychological function and maintenance mechanisms of their eating problem and to reach a better position to evaluate the implication to change.

Furthermore, the goal of Step One of CBT-E for low-weight patients is not weight regain but to help them understand the psychological nature of their eating problem and actively decide to address weight regain.

This strategy is also used to address other egosyntonic features of eating-disorder psychopathology (e.g., dietary restraint, excessive exercising). To this end, a key strategy of CBT-E is to collaboratively create with patients a personalized formulation of the main processes that maintain their eating problem, which will become the target of treatment.

***The patients are educated about the processes reported on the formulation and are actively involved in addressing each of them. If they do not conclude that they have a problem to address, treatment cannot start or must be postponed for a time, but this is not a common occurrence*.**

Once the patient is engaged, they are encouraged to observe how the processes in their formulation operate in real life. For this purpose, they are asked to monitor in real-time their eating, and events, thoughts, and feelings that have influenced eating. Then, they are asked if they agree to make gradual behavioural changes and analyse the associated effects and implications on their way of thinking.

This approach usually produces a gradual reduction in their shape, weight, and eating concerns. In the later stages of the treatment, when the main maintenance processes have been disrupted and the patient reports experiencing periods free from shape, weight and eating concerns; the treatment focuses on helping them to recognize the early warning signs of eating-disorder mindset reactivation, and to de-centre from it quickly, thereby averting relapse.

Parents of adolescent patients are actively involved in creating an optimal family environment to facilitate the patient's change and, in agreement with the young person, support them in implementing some procedures of CBT-E.

How effective is CBT-E for adolescents?

To date, five different cohort studies in patients between 11 and 19 years of age evaluated the effectiveness of CBT-E for adolescents. About 72% of patients with anorexia nervosa completed outpatient CBT-E, and among completers, about 62% displayed a full response at follow-up. A recent not randomized effectiveness trial found that the CBT-E outcome was similar to FBT at 6 and 12 months of follow-up. Comparably encouraging results have also been achieved when delivering treatment in real-world clinical settings. Finally, approximately 70% of non-underweight patients displayed minimal residual eating disorder psychopathology, and half of those with previous episodes of binge eating or purging reported no longer having them.

Conclusions

CBT-E is a promising treatment for adolescents with eating disorders. It has several clinical advantages. It is acceptable to young people and their parents. Its collaborative nature is well suited to ambivalent young patients who may be particularly concerned about control issues and for parents who cannot participate in all treatment sessions. The transdiagnostic scope of treatment is an advantage as it allows to treat the full range of disorders that occur in adolescent patients. In conclusion, CBT-E provides a strong effective alternative to FBT.

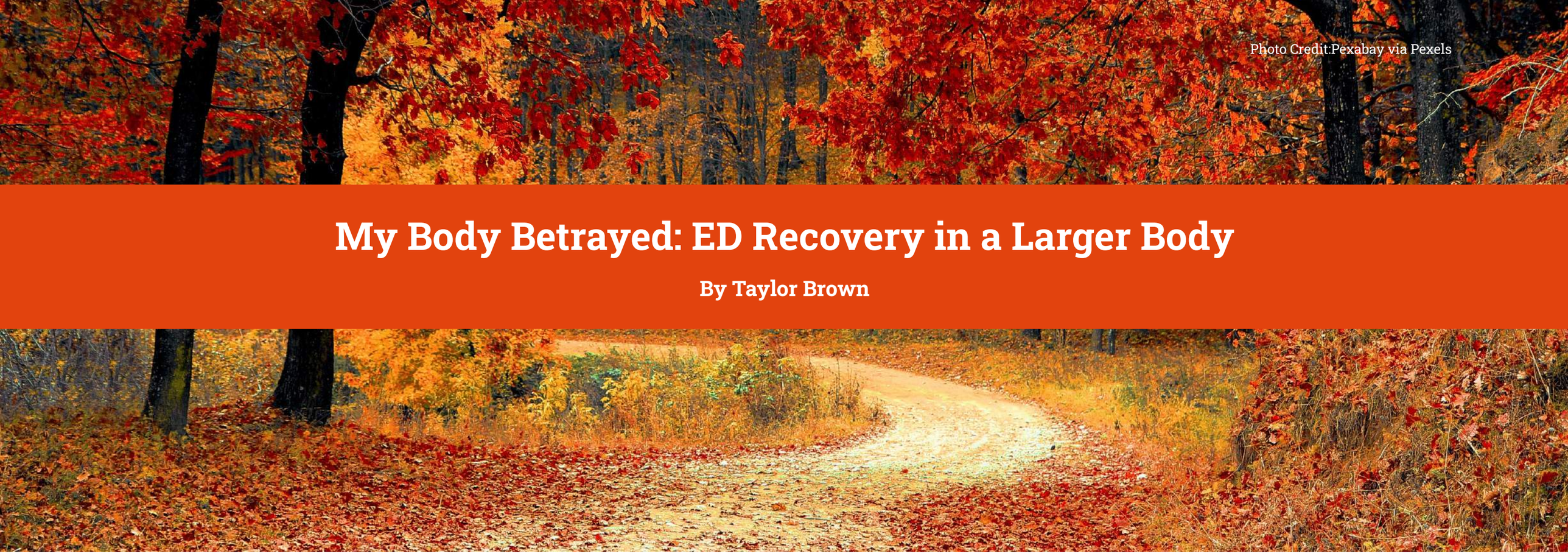
Further readings
Dalle Grave, R., & Calugi, S. (2020). Cognitive behavior therapy for adolescents with eating disorders. New York: Guilford Press.
Dalle Grave, R., & el Khazen, C. (2022). Cognitive behaviour therapy for eating disorders in young people: a parent's guide. London: Routledge.

Riccardo Dalle Grave, MD, is Director of the Department of Eating and Weight Disorders at Villa Garda Hospital, Verona (Italy), where he has developed the CBT-E for adolescents with eating disorders recommended by many international guidelines.

He is the editor of the CBT-E website, fellow of the Academy of Eating Disorders and a member of the editorial boards of several journals on eating disorders

The Staff at BANA and BANA Be Yourself Magazine would like to wish the best of luck to Dr. Christopher Fairburn, on his reitrement as Director of the Centre for Research on Eating Disorders at Oxford (CREDO)

Your outstanding contributions and leadership in the the field of Eating Disorder treatment has been immeasureable and is deeply appreciated.



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My Body Betrayed: ED Recovery in a Larger Body

By Taylor Brown

This article contains descriptive depictions of an Eating Disorder and content may be triggering. Please use caution when reading.

When I arrived at BANA as a client for the first time in my early twenties, I had already been to other eating disorder treatments twice. The first time, I was reluctantly dragged into family-based outpatient treatment when I was 15. And the second time - when I decided in grade 12 that I didn't want to start university struggling the way I was - I voluntarily went into inpatient treatment for 13 weeks. Both times, I was either underweight or at the low end of an "average" weight.

Entering treatment at BANA looked a little different from my previous treatment experiences because I existed in a larger body - one deemed as "unattractive", "too large", and "undeserving of support" in both my eyes and the eyes of society.

Going to inpatient treatment at the age of 18 really did save my life. It took me out of the comfort of my eating disorder and taught me skills that I could use to stay on track with recovery. The treatment was based on Dialectical Behavioural Therapy (DBT), and to this day I use what I've learned to manage my mental health diagnoses.

Leaving treatment and going directly into my undergraduate degree was extremely difficult, and the first couple of years of university were exceptionally challenging for me. The last few years of my undergrad were a lot better in terms of my overall mental health, but the pesky eating disorder voice was still there. It would decrease and increase in intensity, but it was still molded into my brain and was always there if I felt I "needed" it.

As I started eating more normally during and after inpatient treatment, I did gain weight. A part of me -the part of me that is passionate about feminism and social justice, and tries to advocate for eating disorder awareness - knew that this weight gain didn't define me or make me a "bad person" or "unlovable" in any way. However, the eating disorder part of me ended up winning that fight, as I convinced myself that I desperately needed to lose weight and get back to the weight I was before I got "fat".

And so I slowly slipped back into my eating disordered ways; before, my symptoms were more aligned with restriction, and I felt validated and praised for my weight loss. This time around, despite all my eating disorder's efforts, I continued to gain and then maintain my weight. This only strengthened my efforts to control my food intake, and I quickly spiraled into an extreme form bulimia. One of the reasons I was hesitant to reach out for help (despite some part of me knowing that the behaviours that I was engaging in were neither sustainable or healthy) was my weight.

"Even though I knew that eating disorders do not have a universal "size", and despite me telling other people with EDs that their weight doesn't dictate their worth, I absolutely thought that I was the exception to this."

I didn't want to take the spot of someone in worse condition, that may have needed help more than I did. I also thought I was functioning well under the circumstances. No one in my life really knew I was struggling – most people thought that I was past my eating disorder, and that it was something I only struggled with in adolescence. Perhaps this assumption factored into the shame I felt reaching out to BANA for the first time.

When I started working with my BANA clinician, it became really apparent to me just how much my eating disorder had infiltrated my life. A huge part of treatment was recording my food intake, symptoms and behaviours, and whatever thoughts and feelings were coming up.

I began to see patterns in my eating that were keeping me stuck in my ED, and in trying to reduce my symptoms through normalized eating, I noticed just how much thought, time, and effort I had been putting into my eating disorder without realizing. I also became aware of all the body-checking behaviours that I was engaging in, which kept me hyper-focused on my body.

"One of the hardest things that I faced during my treatment was feeling betrayed by my eating disorder."

For so long, I had this part of me that was so focused on weight and how much space I was taking up. This voice that was indistinguishable from my own told me that engaging in purging behaviours would keep me from gaining weight. That I can't eat and not compensate. That certain foods are only to be enjoyed under certain conditions.

But now, by doing some psychoeducation with my clinician, which involved looking at an energy graph and considering how my disordered eating pattern could increase my symptoms and negatively impact my body, I had an "ah-ha" moment that I'll never forget. I became aware that the exact behaviours that I thought were helping me maintain a sense of control over my weight and body were actually doing the opposite.

I was putting my body through a lot of distress, which was affecting my metabolism, hunger cues, and more. This was a really transformational part of my treatment, as I feel like the eating disorder lost a lot of its power. I also felt silly to have thought I was "in control" when, in fact, my body was actively trying to correct the damage I was doing.

It was a surreal feeling, to know that this illness – which had been a part of my life since I was 15, sometimes a bit quieter but always there –wasn't helping me lose weight, nor was it making me more enjoyable to be around. The ED just kept me in a spiral, not allowing me to fully be my authentic self.

This “ah-ha” moment that I described above really lead me to invest all the time, energy, and effort I could into my treatment at BANA. After that moment, which had occurred early in treatment, I truly felt like it was me and my clinician against the eating disorder.

"Though I had to mourn the part of myself that was so attached to my ED, just having the knowledge that it was harming me a lot more than it ever helped me was significant."

Eating disorders ultimately serve a purpose in someone’s life. For me, it was an outlet, a coping mechanism, an aspect of my identity, and a close confidant.

Before entering treatment at BANA, the eating disorder held more power than I did - making decisions, and planning symptoms and behaviours on my behalf. After putting in a significant amount of work, this is no longer the case. I’ve continued to challenge my unhealthy thought patterns, analyse any urges to engage in symptoms, and problem solve around those triggers.

For the most part, I now have a neutral stance toward my body. I understand that it may not look how I want it to look (based on societal standards of beauty), but it has kept going despite all that I’ve put it through.

My body is now my home, and I commit to treating it with kindness and love.

Photo Credit: Taryn Elliott via pexels

We Are All In This Together:

Tying Together Research & Grassroots Community Advocacy in Eating Disorder Prevention

By: Amanda Raffoul, PhD, CIHR Postdoctoral Fellow

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The COVID-19 pandemic has emphasized a simple truth: people need each other to thrive. This focus on community and collaboration through times of isolation has been known among people who work in the field of eating disorders for some time.

Often, we are the only people in our hospital, university department, or office who specialize in or even dare to mention eating disorders, but we take comfort in knowing that we have national networks to support us in feeling heard. Some of us stumble into the field, but most dive in with a passion to prevent the harmful and toxic effects that disordered eating and body image concerns have on the lives of many people of all ages.

I found work in the field of eating disorders around the same time that issues surrounding body image and weight control found me. This phenomenon is, unfortunately, not uncommon – few people speak about eating disorders in the general public, they are often left out of conversations about mental health and disability, and our societal idea of what an eating disorder looks like is astonishingly narrow.

And yet diet culture is pervasive in all of our lives, from calorie labels on menus to social media posts selling products that promise a thin body to gyms telling you that you need to "work off" your meal... and on and on. pressures surrounding food and weight are ever-present and yet invisible at the same time.

When I began my undergraduate degree at the University of Windsor in 2009, I was set on pursuing a career in clinical psychology. I inhaled psychology textbooks covering a range of psychiatric conditions, pursued elective courses in the humanities that could round out my graduate school applications, and even wrote the Graduate Record Examinations that are required for clinical programs (twice)!

By chance, I stumbled upon the university's Volunteer Internship Program, which paired students with local non-profit organizations seeking skilled volunteers for short-term projects. I was paired with BANA in 2010 as a data entry clerk, which seemed like a perfect pairing for my research-oriented brain (and for a Windsor-Essex local!).

At the end of my internship, I continued as a volunteer occasionally, but struggled with my own patterns of disordered eating as I adjusted to university life. It was only a few months before I was invited to re-join the organization as a volunteer with the Health Promotion department, that I "found my calling".

Through BANA, I co-facilitated school workshops on body image and healthy relationships with food, organized booths at local events to promote the organization, and collaborated with groups that served youth in the Windsor-Essex County community.

My relationship with my own body image began to heal as I found community in the hundreds of young people who told me they were tired with narrow depictions of beauty on social media and pressures to twist and contort their bodies to look a certain way.

As a community advocate, I was energized by a sense that I was contributing to something bigger than myself. But as a researcher, I knew that the field of clinical psychology felt too narrow and reactive for my newfound perspective.

My work in the community directly inspired my decision to shift gears to pursuing a career in public health research, with a focus on preventing eating disorders and the variety of eating- and weight-related concerns that so many Canadians experience. I moved to Waterloo, ON to pursue a Masters degree and then a PhD in Public Health and Health Systems at the University of Waterloo, but kept my connections to community alive throughout the research process.

Many people assume that research is conducted by independent scientists and then simply handed over to grassroots, community organizations to use.

Although this (unfortunately) happens sometimes, in more recent eating disorders prevention work, the relationship is often a more cyclical process – grassroots community work drives the political will to explore an issue, researchers listen and collaborate to address the issue, and community organizations use the science to continue advocating for people with eating disorders and their loved ones.

My Masters and PhD both focused on the unintended consequences of the "war on obesity", and how an emphasis on dieting and weight loss could instead increase the risk of eating disorders and harmful disordered eating attitudes and behaviours among youth and young adults in Canada. This was directly influenced from my time at BANA, where as a Health Promotion Educator, I witnessed schoolteachers instruct students to run a lap to "earn" a cookie, or overheard youth point to classmates and say that they would "have a heart attack" if they ate a burger.

Eating disorders prevention is often seen at odds with public health efforts to improve population health, but this could not be further from the truth. The promotion of healthy body image, enjoyment of meaningful physical activity, reduction of harmful weight biases and stigma, and granting of safe and affordable access to a variety of foods free of shame can improve a wide range of health outcomes for all.

As the field continues to grow and shift, researcher-advocates around the world are informing their scientific endeavours with the voices of people in their communities affected by eating disorders.

In the United States, the Strategic Training Initiative for the Prevention of Eating Disorders (STRIPED), where I currently work as a research fellow, enrolls the expertise of youth to engage in research-informed advocacy and to join meetings with lawmakers who aim to introduce legislation that can help to reduce disordered eating behaviours.

In the United Kingdom, the Centre for Appearance Research (CAR) produces a podcast that highlights the voices of lived experience and ties it in to their ongoing research projects. And closer to home, the Ontario Community Outreach Program for Eating Disorders (OCOPED) has recently launched one of the first ever government-funded programs comprised of regional organizations and researchers aiming to prevent eating disorders among the province's youth.

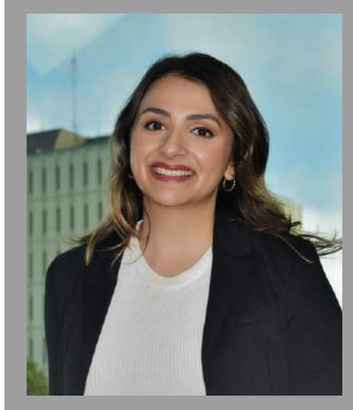
This is only a sample of the many, many ongoing international initiatives to tie together research and grassroots community advocacy for the prevention of eating disorders.

I recently had the privilege of serving on a committee of Canadian researchers, clinicians, and advocates from organizations across the country that organized the 2021 Eating Disorders Awareness Week (EDAW). As a member of the Waterloo-Wellington Eating Disorders Coalition, I represented our organization in this working group aiming to raise awareness of eating disorders in the midst of the COVID-19 pandemic.

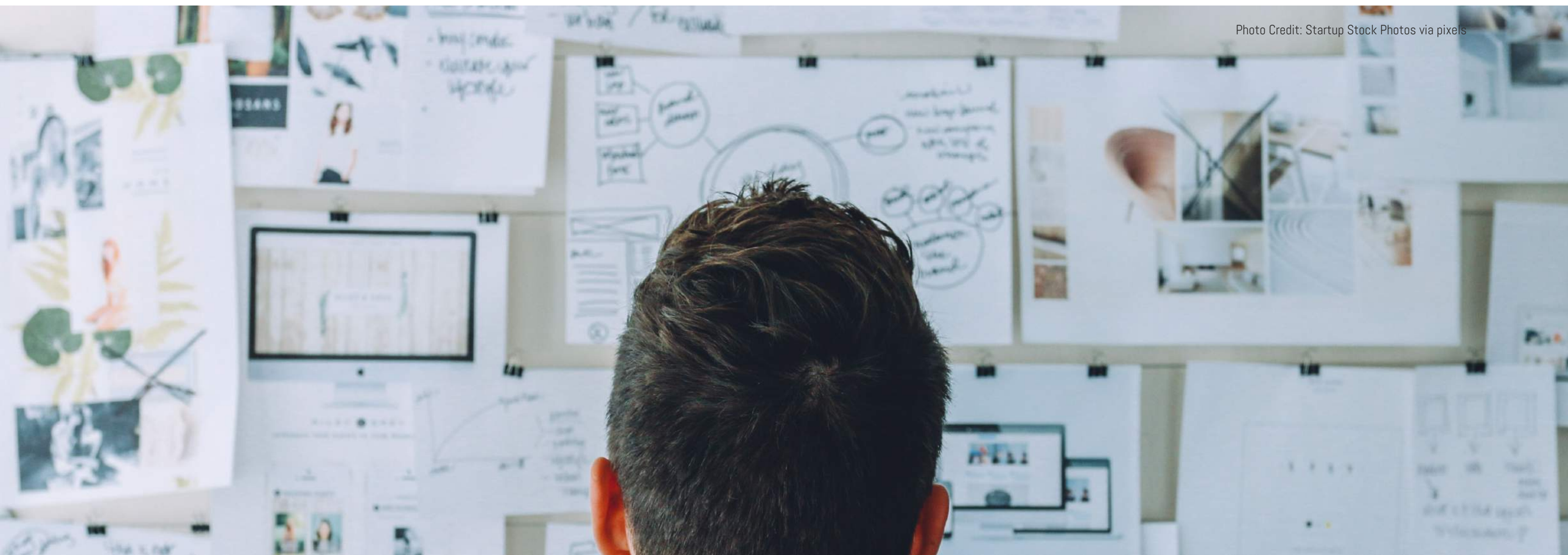
The committee had no leaders or hierarchy, and the voices of people with lived experience in British Columbia mattered as much as the voices of scientists in Quebec. We used evidence-informed strategies to develop a social media campaign and launch a letter-writing campaign to elected representatives that generated responses nationwide, all while connecting individuals to resources within their own communities.

As a relatively new researcher in the field of eating disorders prevention and a seasoned advocate (thanks to BANA), all of the progress being made in the realms of research and grassroots community advocacy excites me! Building on the decades-long work of the prevention advocates who have come before us, a whole generation of researchers whose lived experience and community volunteering fuelled their passion is producing meaningful change for public health and eating disorders prevention.

There are encouraging pathways being built within and across communities, which serves as a reminder that none of us works alone in the mission to prevent eating disorders and build towards a healthier and a safer world for future generations.



Amanda Raffoul, PhD, is a Canadian Institutes of Health Research postdoctoral fellow with STRIPED, the Strategic Training Initiative for the Prevention of Eating Disorders, based at Boston Children's Hospital and the Harvard T.H. Chan School of Public Health. Amanda received her MSc and PhD from the School of Public Health and Health Systems at the University of Waterloo, where her PhD dissertation focused on the unintended consequences of weight and nutrition policies (such as calorie labelling) on disordered eating. She became interested in eating disorder prevention while completing her BA in Psychology at the University of Windsor and has since been actively engaged in community-based, national, and international advocacy related to eating disorders and public health policy.



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Tis' Almost the Season - De-stressing the Holidays

By: Shelby Colarossi

For most people, the holiday season is a wonderful time of year. It is often a time of family reunion, socializing, and celebration – a time when families, friends, and coworkers come together to share good will and good food. The season is meant to be bright, happy, and full of the best of relationships. Yet, for many who suffer with eating disorders, this is often the worst time of the year. For those who are suffering with an eating disorder, the holidays often magnify their personal struggles, causing them great internal pain and turmoil.

Whether you are currently suffering from an eating disorder, or you are in recovery, social events of any kind can cause stress and can be triggering, especially around the holidays.

Here are some things you can do to help reduce stress and avoid situations that may be triggers.

1. **It's okay to have a plan.** A plan to sneak away for a break in a quiet place should you feel stressed or anxious. Tell yourself: being scared is normal, but fear does not have to control your actions. Remember, all foods fit. There is no such thing as a good food or bad food. Being more flexible with food allows you to have a full life.

2. **Your support system is there for you.** Before your holiday event season kicks off, talk to your therapist and your dietitian about your hesitations. They can help you with healthy coping strategies to manage or alleviate some of your stress. Additionally, connect with a friend or family member who is familiar with your current struggles and can support you through your holiday events. Having a partner during this time can help you stay accountable to your plan, or even help you exit situations that become stressful.

3. **Don't Be Afraid to Say "No."** There is a natural tendency to try to be everywhere during the holidays. Shopping, family parties, company parties, meeting up with friends - it is easy to over-extend yourself. Trying to attend every function can quickly lead to anxiety and stress, and the feeling that there isn't enough time for yourself. Before the holidays come, plan ahead by making a list of events you must attend or truly want to attend. You can preserve your mental health by keeping your schedule as stress-free as possible by not overextending yourself.

4. **Set Boundaries.** The holidays mean you may see people who may not understand your eating disorder and may engage in weight-related talk. If the conversation becomes uncomfortable, you can change it to something less threatening. You may respond with, "Can we talk about something more meaningful?", "I'm just really thankful that I am here spending time with you today", or "Tell me about your new job or future school plans." Use this as an opportunity to be positive and talk about positive things.

Give yourself the freedom to have fun and enjoy your friends and family. All too often, we allow our eating disorder to control us, and our mood, leaving us feeling defeated and overwhelmed. All food is fuel for your body and what you eat does not define who you are.

Ensuring that you have a balanced diet that provides enjoyment, convenience, and supports your optimal physical and emotional health and wellbeing is one factor that can help anyone struggling with an eating disorder find long-lasting recovery. Balance and acceptance of all foods should be a recovery goal.

It's important to include and enjoy both the carrots and the carrot cake because both have their place in a healthy diet, and you deserve to eat foods that you actually enjoy! All foods really do fit, including carbohydrates, fats and sugar.

Did you know...

Carbohydrates

Carbohydrates are the body's main energy source. It is recommended that carbohydrates supply more than half of our total daily energy needs. Carbs also make serotonin, the hormone that helps us feel calm and relaxed. They add satisfaction and pleasure to the eating experience, not only are they the primary source of energy for the body, they are in most foods and they taste great! Meals without carbs tend to be less satisfying. Having a source of carbs with your meal helps keep you full and happy longer. Who doesn't want that?

Fat

Fat plays an important and beneficial role in the body. Fats boost your brainpower and help absorb vitamins we need, such as A, D, E and K. In addition, they can lower feelings of anxiety and depression. When you get enough fat in a meal it signals your gut to tell your brain to relax and that you're satisfied. This helps you to think about food less so you can pay attention to other things.

Sugar

Instead of quitting sugar, try working on establishing a healthy relationship with it. All foods can be part of a healthy diet. Food is fuel for our bodies; however, it is also supposed to be pleasurable. Restricting certain foods can take away pleasure and satisfaction from the eating experience. Additionally, mental health is an important part of your overall health; feeling guilt and anxiety about eating a dessert is not mentally healthy. For someone who is breaking free from the diet mentality or an eating disorder, the healthiest thing may be to eat a brownie!

It is natural to want to isolate yourself from the festivities, but don't let your eating disorder stop you from enjoying your holidays. Isolation can lead to negative behavior patterns - remember how vital it is to have a support system in place. If you are concerned about an upcoming holiday event, share those feelings with your family or friends. Coping with an eating disorder is much easier if you have people helping to stack the odds in your favor.

Loved ones can be instrumental in helping to ease concerns and reduce anxiety this holiday season. If you're a loved one and are wondering how exactly you can help, here are some tips that have proven beneficial for the loved ones of someone struggling with an eating disorder.

HOLIDAY TIPS:

- Try not to make a big issue about what your loved one is eating. A little bit of encouragement is okay.

- Do not focus too much on food, it may only fuel the eating disorder.

- Don't get mad. Provide positive reinforcement and support.

- Stress and anxiety are huge. See if you can find out what may be creating anxiety and try and understand. Being understanding, kind, and supportive is key.

- Spend quality time with your loved one outside of situations that involve food. Make sure that the primary focus of the holiday is not on the food but rather on the family and the valued time you will share together.

- Before the Holiday itself, and before family gatherings, make agreements about how you can best help your loved one with food. Honour the agreements you make.

- Do not give loud and attention drawing praise when they do eat.

- Do not talk about diets, weight loss, or weight gain. It causes great anxiety and may increase a felt need to engage in eating disorder behaviour.

- Do not stare.

- Learn what the triggers are. Help your loved one develop skills as well as strategies to defy eating disorder thoughts and urges.

- Focus on how your loved one is feeling inside, what issues are of worry, what are the fears and needs, rather than just how much they are eating or not eating.

- Be patient and nurturing.

- Let them know that they are loved.

- Don't allow them to excessively isolate.

...and lastly...

There may be times throughout this season that your loved one's eating disorder may create conflict within the family/friend system. Remember this is not them, it's their eating disorder.

Validate that the holidays and food-focused activities are difficult to navigate and that you are in this together. Most importantly, validate yourself. As a family member or friend who is helping someone struggling with an eating disorder, you have the right to notice that the recovery process is not just hard for your loved one; it's hard for you too.

Have some compassion for yourself and realize all of the things in your life that you are doing well, and getting through the holidays is absolutely one of those.

Remember the meaning of the holidays and have fun! This time of the year can provide an opportunity to learn to trust your body around all foods.

There needs to be balance throughout one's life. As individuals think about creating meal patterns, they should allow themselves to choose a variety of foods that meet the needs of hunger and enjoyment.

For sources please visit: https://bana.ca/magazineresources

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Photo Credit Anna Shvets via Pexels

Major Depressive Disorder

with Seasonal Pattern

We all have bad days..., sometimes we have several, and in the case of this past year maybe even more than that. But what if it's more than that? The point of concern comes in when those "blahs" start to cause interruptions in your daily life.

Major Depressive Disorder with a Seasonal Pattern (formerly known as seasonal affective disorder, or SAD) is characterized by recurrent episodes of depression in late fall and winter, alternating with periods of normal mood the rest of the year.

However, if you have been feeling this way for longer than a few days and it is causing interruptions in your daily life, you may need to talk to someone.

Prevalence increases among people living in higher/northern latitudes.

Symptoms:
Commonly, symptoms present as an atypical depression. Although not everyone experiences the same symptoms, the classic characteristics of Major Depressive Disorder with a Seasonal Pattern include:

- Hypersomnia (or oversleeping)
- Daytime fatigue
- Overeating
- Weight gain
- Craving carbohydrates
-

Other symptoms could include:

- Decreased sexual interest
- Lethargy
- Hopelessness
- Suicidal thoughts
- Lack of interest in usual activities and decreased socialization

The most import factor in recognizing this condition is establishing the pattern. Commonly symptoms present in the fall (October/November) and subside in the spring (March/April).
As part of the criteria for an onset and remission must have occurred during at least a two-year period.

Plan the work and Work the plan
Since this disorder has a pattern, you can prepare and help mitigate the symptoms.
For instance:

- Plan to be more active during these periods
- If you use seasonal therapy, start before your symptoms do
- Sunlight can help, go outside more our start using a lightbox
- Plan a vacation to a sunny spot during this time

For a list of article sources please visit: https://bana.ca/magazineresources

Photo Credit:Tobias Bjørkli via Pexels

Cooking *is about* Caring

Photo Credit: Pixabay via pexels

Creating snacks and meals can have a positive effect on one's mental health. A healthy relationship with food preparation can be used as an act of patience, mindfulness, creative expression, and can help to raise one's self esteem.

It can be a wonderful expression of care towards yourself and loved ones. Sometimes the simplest of dishes can still be a celebrated success. Check out this twist on a classic chicken finger favourite.

Pecan Parmesan Chicken Bites

Preparation Time: 15 minutes Cooking Time: 15 minutes Makes: 6 servings

Ingredients:

Boneless skinless chicken breasts	3 (about 1 ¼ lb/600 g)
Maple syrup	2 Tbsp (30 mL)
Canola oil	1 Tbsp (15 mL)
Whole wheat panko breadcrumbs	½ cup (125 mL)
Finely chopped pecans	1/3 cup (75 mL)
Parmesan cheese, grated	1/3 cup (75 mL)
Flax seeds, ground	¼ cup (60 mL)
Garlic powder	2 tsp (10 mL)
Dried oregano leaves	1 tsp (5 mL)
Each salt and fresh ground pepper	¼ tsp (1 mL)

Directions:

1. Cut chicken into cubes or strips and place in a large bowl. Drizzle with maple syrup and oil and coat evenly; set aside.

2. In a large resealable bag, combine breadcrumbs, pecans, cheese, flax seeds, garlic powder, oregano, salt and pepper.

3. Add a few chicken pieces at a time to bag and shake to coat.

4. Place onto parchment paper lined baking sheet and repeat with remaining chicken and coating.

5. Bake in preheated 475°F (246°C) oven for about 15 minutes or until golden and chicken is no longer pink inside.

Source: https://www.unlockfood.ca

The Wise Mind Worksheet

Your mind has **three states:** the **Reasonable Mind** **(rational thoughts)**, the **Emotional Mind** **(thoughts based on distressed feelings)**, and the **Wise Mind** **(the merging of minds).** We all have these states of mind but it's that wise inner part of us that just 'knows' what is true or valid.

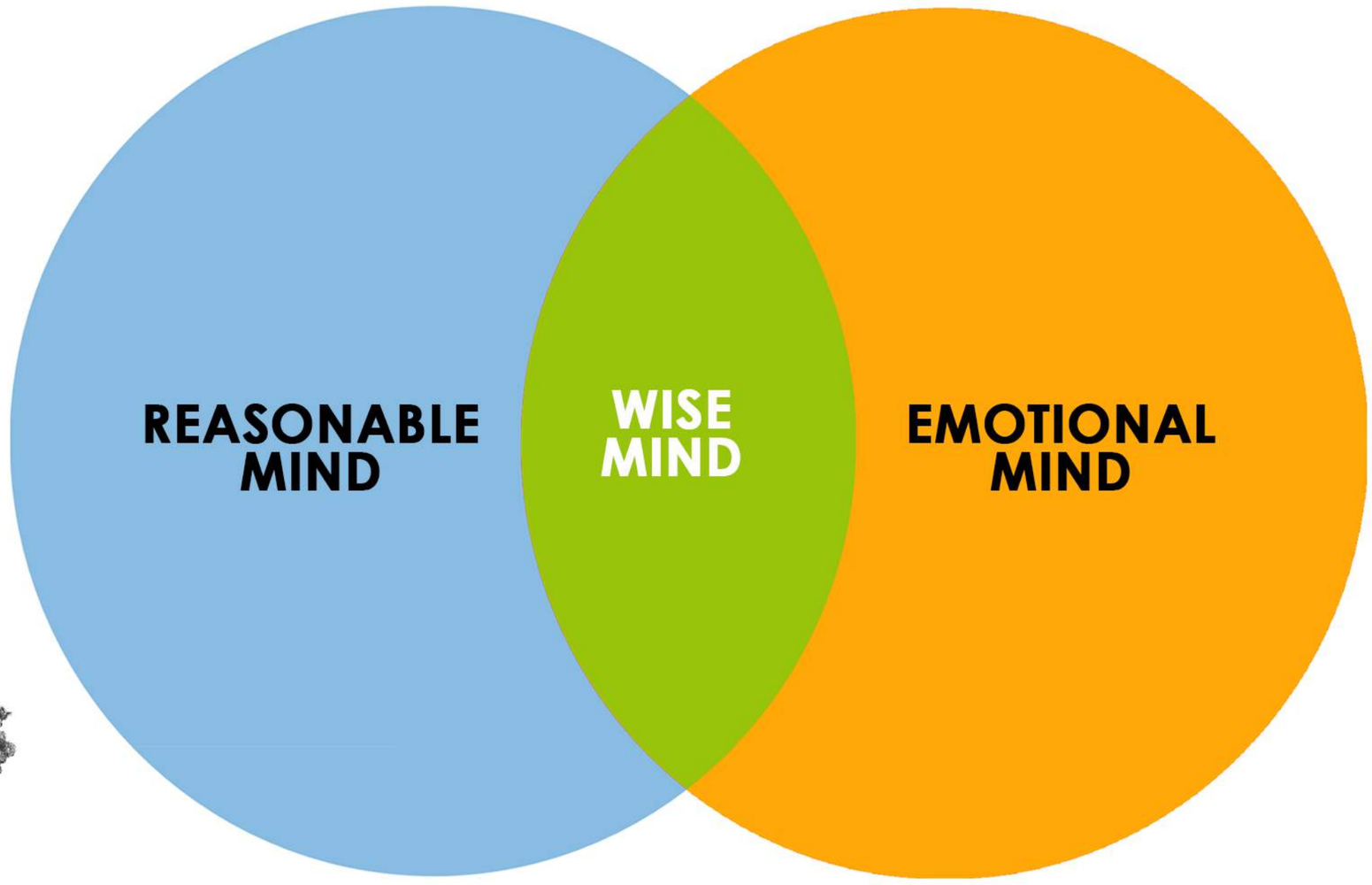

photo credit: eric w via pexels

Take a few minutes and think about a time where you have a difficult decision to make. Got it? Now complete the following and walk through your states of mind.

REASONABLE MIND - based on factual evidence and objectivity.
What is the reasonable course of action? What would I tell a friend if they had this problem? Is this really as important as it seems? What are the facts? Have I felt this way before and gotten through it?

EMOTIONAL MIND - based on our opinions, interpretations, assumptions and emotions.
What went through my mind? What disturbed me? What is it that is making me feel this way? What am I reacting to? What's the worst case scenario? How is this making me feel? How do I want to feel?

WISE MIND - based the combination of reasonable and emotional minds.
STOP! Take a breath. What will the consequences of my reaction be? (short and long term) What's going to be the best response to this situation – best for me, for others, for the situation. What will be most helpful and effective, all things considered?

Source: DBT Skills Training Manual, Second Edition, Marsha M. Linehan

BANA-QUIRIES

As mental health educators and clinical service providers, we get a lot of inquires about treatment, prevention and overall wellness. In each issue we'll try to address a few of these **"BANA-QUIRES"** for you, our readers.

Men don't really have Eating Disorders....do they ?

Yes...yes they do!

20% of people living with an eating disorder are boys and men.
33% of all adolescent males use unhealthy weight control behaviours
37% of men who binge eat experience depression
43% of men are dissatisfied with their bodies

The misconception that eating disorders almost exclusively affect girls and women is likely one of the larger obstacles for boys and men in seeking and accessing help. The stigma felt by those with eating disorders for male sufferers is amplified as a result of not wanting to have a 'girl's illness'. Societal misconceptions have led us to believe that it is not masculine to talk about feelings and that seeking help is a sign of weakness.

Photo Credit: Rodolfo Magalhaes via Pexels

WARNING SIGNS AND SYMPTOMS

Physical, behavioural, and emotional warning signs of someone experiencing or at risk of an eating disorder include:

- **Excessive concern about one's weight, size, or shape.**
- **Preoccupation, guilt or shame with food and nutrition.**
- **Depression or irritability.**
- **Rigid and ritualistic eating behaviours.**
- **Feeling fat despite being at a low or "average" weight.**
- **Exercising through fatigue, illness, or injury.**
- **Noticeable weight loss or weight fluctuations.**
- **Inappropriate use of substances, e.g. sports supplements, steroids.**

HOW CAN I HELP MYSELF?

- **Talk honestly with someone you trust**
- **See a qualified health practitioner.**
- **Be gentle with yourself.**
- **Recognize that it is possible to recover.**

HOW CAN I HELP SOMEONE ELSE?

- **Seek credible information about eating disorders – the more you know, the more you can help.**
- **Make sure the individual knows your are willing to provide non-judgemental support.**
- **Help and encourage the individual to find qualified supports.**
- **Be patient. This is going to take time.**
- **Modify your language to avoid topics of appearance. Instead, talk about concerning behaviours you have observed.**
- **Stick within your limits and take care of yourself.**
- **Role-model healthy attitudes and behaviours.**

*BANA Clinical services are limited to residents of Windsor and Essex County, Ontario, Canada

Photo Credit: Shvets Production via Pexels

Are you struggling with mental health issues and don't know who to call ?

HÔTEL-DIEU GRACE
ESTD HEALTHCARE 1888

- 24/hr
- 7 days a week, 365 days a year
- Crisis support; resource recommendations; connected to the crisis center at Windsor Regional Ouellette Campus

DISTRESS CENTRE
WINDSOR-ESSEX COUNTY

- 12 pm (noon) – 12 am (midnight)
- 7 days a week, 365 days a year
- Support for distress; resource recommendations; if you just need someone to talk to; crisis support

Be a Positive Influencer

bana.ca/bekind

A publication of the Bulimia Anorexia Nervosa Association
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