BANA
BE YOURSELF

A publication of the Bulimia Anorexia Nervosa Association

WINTER 2023

SPECIAL EDITION

Eating Disorder Awareness Week 2023

Transforming the Narrative from Asks to Action

A Mental Health and Wellness Magazine

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Also In This Issue:

Photo Credit Volodymyr Melnyk Via Flipbooks

TABLE OF CONTENTS

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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. 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 and all of the contributing writers and photographers.

With so much uncertainty when it comes to mental health and wellness in the world today, our goal is to provide an accessible forum for education, discussion and acceptance for both the general public and professionals alike. We hope, that in some small way, this publication can help.

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

As BANA enters our 40th year of service provision, we ask that you take forth the message to be kind to yourself, generous with others, and stay healthy.

Sincerely, Luciana Rosu-Sieza, Executive Director

DISCLAIMER*

Content within this publication may include details from lived experience that can be triggering to some. Reader discretion is advised. Should you find yourself feeling triggered, please seek support.

BANA'S EDAW 2023

Eating Disorders Awareness Week (EDAW) runs annually February 1st- 7th. EDAW has been commemorated across Canada since 1988 by established eating disorder organizations, education and public health institutions, and concerned members of the public. It draws attention to the causes, prevalence, and impact of eating disorders.

What does the Bulimia Anorexia Nervosa Association (BANA) have planned for EDAW 2023?

During the week of #EDAW2023, BANA will be active at various locations within Windsor-Essex to help spread awareness, educate the public and inspire others to act in supporting those impacted by eating disorders. Visit us at various locations on campus at the University of Windsor, at Devonshire Mall and at St. Clair College.

See our EDAW schedule below.

EATING DISORDERS AWARENESS WEEK

FEBRUARY 1-7

WEDNESDAY 1ST

Happy EDAW 2023! Join our IG Live this morning to learn more

EDAW GIVEAWAY ⋆ is running all week on our IG!

Join us at the CAW Student Centre at the University of Windsor (10a-2p)

Visit Windsor City Hall to see it lit up purple!

THURSDAY 2ND

Get involved & visit the BANA Team at the Human Kinetics building (9a-12p) & the Toldo Athletic Centre (12:30-2:30p)

Have you seen our Be Yourself Magazine? Sign up to get your copy!

FRIDAY 3RD

IG LIVE ⋆ with Chloe Grande at 9:30a - Tune in @banawindsor.

BANA will be at the Toldo Health Education Building at the University of Windsor sharing resources. Stop by from 10a-12p.

SATURDAY 4TH

Buy a pop tart at Auntie Aldoo's Kitchen. Proceeds go to BANA!

Don't forget to share a photo wearing something purple to show your support. Tag us! #showusyourpurple

SUNDAY 5TH

BANA will be raising awareness at the Devonshire Mall (10a-2p). Stop by and learn more about how you can take action.

Sign up for a mobility class hosted by Auntie Aldoo's Kitchen. Visit their website to join!

MONDAY 6TH

IG LIVE ⋆ with Ary from NEDIC. Do you know how to reach out for help? Check out our social media today to learn how: @banawindsor

Listen to our special EDAW podcast with guest, Chloe Grande! Find it here: www.bana.ca/podcast

TUESDAY 7TH

Last day to enter: Ditch diet culture & share your resolutions that have nothing to do with changing your body. Visit @banawindsor on Instagram

BANA will be at St.Clair College from 10a-2p challenging you to support ED awareness. Come visit & win some swag!

Tune into NEDIC's panel discussion with other mental health organizations (5-6:30p)

NOTES:

- Visit City Hall Feb. 1st
- #showusyourpurple on Instagram
- Buy a poptart at Auntie Aldoo's Kitchen
- Enter our social media giveaway!

Be Yourself Podcast

Listen to a special episode of BANA's Be Yourself Podcast during EDAW featuring our guest, Chloë Grande. Chloë is a communications specialist turned eating disorder recovery writer, speaker and blogger. After an anorexia relapse at the start of the pandemic, she began blogging about her eating disorder recovery to help create a sense of community for other eating disorder survivors. Learn more about listening to our podcast here: https://bana.ca/podcast/

Treat yourself and support Eating Disorder services

We are so thankful to Auntie Aldoo's Kitchen in Cottam who will be donating the proceeds of their delicious pop tarts sold during the week of EDAW to BANA. Go get yourself a treat and support a good cause!

Auntie Aldoo's is also hosting a mobility class on February 5th and donating the proceeds of this to the National Eating Disorder Information Centre (NEDIC). Sign up and learn more on their website: https://www.auntiealdooskitchen.com/book-online

Our community is Lighting up Purple in support!

We are grateful for the support of the City of Windsor. City Hall will be lighting up in purple all week from February 1-7th to show their support for eating disorders awareness.

Social Media Education and a Special Giveaway!

Ditch diet culture! We are running a special giveaway on BANA's Instagram account for those who share their New Year's resolutions that have nothing to do with changing their body. We will be giving away prizes from five local businesses.
Learn more on Instagram: @banawindsor.

The BANA team will be going live on our Instagram account with special guests:

Ary Maharaj, NEDIC's Outreach & Education Co-ordinator, on February 6th

Chloë Grande, Eating Disorder Advocate & Speaker, on February 3rd

#SHOWUSYOURPURPLE

We also encourage YOU to wear purple during the week of February 1-7th to show your support. Post a photo to social media, tag us and use the hashtag above.

Want to donate? We accept donations!

To help support local services in Windsor-Essex, visit this link: https://bana.ca/get-involved-donate/ to give back to BANA.

CELEBRATING 40 YEARS

THE HISTORY OF BANA

1983

After the loss of their daughter to an ED, BANA founders - Dick & Mary Moriarty - gather 10 community members at the UWindsor HK building to learn more about EDs & identify resources.

- First community meeting is held
- Began attending conferences, interviewing US programs, purchasing books & reviewing literature, engaging in trainings for EDs & ED treatments
- Identified professionals in North America to highlight pathway for referrals
- Application & approval of first grant – used to hire 6 students for educating the public through workshops & conferences
- Beginning of the *Speakers Bureau*

1984

- Development & implementation of quarterly newsletter
- Development of 3 lesson plans to implement in schools through phys-ed, health education, & other ED-relevant classes – over 200 copies sold
- Began accepting Social Work Interns from UWindsor

1985

- BANA became an Incorporated Non-Profit (October 22, 1985)

1986-1987

- Development of ED Resource Directory
- Inception of hotline for connecting people with resources, run by volunteers
- Launch summer camp programs for adolescents and young adults – first of it's kind in North America
- Applebytes & Positive Directions newsletters released (continued for over a decade)

1989

- Received first funding from the Ministry of Health & Long-Term Care to provide clinical services to adolescents & adults
- BANA becomes the first community-based, outpatient program for EDs in the region

1992-1999

- EDAW and International No Diet Day events at St. Clair College and UWindsor
- Dedication of the Moriarty Family Resource Lending Library
- BANA School Poster Design Contest
- BANA Community Needs Assessment conducted by the United Way
- New Mission and Vision statements

1997

- Moved from Cabana location to Market Square (Walker and Ottawa)

2002-2006

- First Trillium Grant (3 year grant, starting in 2002) to fund a Health Educator & puppets for self-esteem and healthy eating community presentations
- Relocation of BANA office from Cabana Road to Ottawa Street (2005)
- Funding from the LHIN begins
- Second Trillium Grant for fundraiser

2008-2013

- Sophie Gregoire Trudeau hosts BANA's 25th Anniversary International ED Conference & Gala; also in attendance was Miss America (2008)
- BANA joins Rotary Club (Windsor-Essex) & Children's Safety Village as hosts of Children's Fest (2012)
- Relocation of BANA office from Ottawa Street to current location on Ouellette Ave. (2013)

2014-2017

- LHIN funding for a second FT therapist & BANA's first FT dietitian
- In collaboration with WeCHC-THC, BANA launches the Centralized Intake line for eating disorders across the region (2014)
- Third Trillium Grant (2 year grant), alongside funding from Greenshield Canada's Community Giving Program, to launch the Dressing Room Project
- Grant from Greater Windsor-Essex Community Foundation for Schoolboard Toolkit, a comprehensive resource package for community-based presentations
- BANA clinical staff trained & implemented Cognitive Behavioural Therapy for Eating Disorders (CBT-E) (2015)
- Launch positive influencer website to educate parents, teachers, youth workers, medical professionals, coaches etc. on various important topics related to youth (2016)
- First submission to & award recipient of the - Gord Smith Healthy Workplace Awards (2017)
- Puppet Program video launch - three videos addressing the topics of self-esteem, societal influences, body based harassment, nutrition & physical activity (2017)

2018-2022

- BANA's 35th Anniversary Gala - Sophie Gregoire Trudeau submits a congratulations video to BANA (2018)
- Implementation of BANA Rocks Initiative (2018)
- BANA participates in the development of the ED-PPEI, lead by OCOPED (now EDO) - the first funded prevention program in Canadian history (development began 2018, launched in 2022)
- First Eating Disorder Prevention Specialist Hired in Ontario, housed at BANA (2021)
- Be-Your-Selfie EDAW Campaign (polaroid pics of self with positive message) - over 300 people participated (2018)
- BANA begins volunteering with Charity Bingo, at Paradise Bingo (2018)
- EveryBODY Has A Voice EDAW Video Campaign (2019)
- BANA launches podcast: Be Yourself - Healthy, Happy, Hopeful (2019)
- BANA launches the Be Yourself Magazine - a free, online mental health & wellness magazine (fall 2020)
- BANA clinical staff trained by Glenn Waller on an abbreviated version of CBT-E; implemented CBT-T (2020)
- BANA develops and implements Skills Training Groups for clients on waitlist (2020)
- BANA moves to fully virtual services temporarily in response to COVID-19 - no shutdown of services took place
- BANA, in partnership with WeCHC-THC & WRH launch the Windsor-Essex Intensive Outpatient Program (WE-IOP) (2022)
- Receive funding for BANA's first nurse practitioner and medical secretary (2022)
- BANA clinical staff begin training on CBT-AR - to launch treatment tract for ARFID in 2023

2023

40th Anniversary

BANA

Est. 1983

Photo Credit: YAnna Shvets

MAiD for Eating Disorders ?

By Dr. Anita Federici

Disclosures/Biases

This has been a difficult article to write and, I imagine, it will be a difficult article to read. I am writing it because avoiding it won't help and we, as a broad and diverse community, need to be talking together about it.

I do not propose to have the answers to this incredibly complex issue.

I am a DBT therapist at heart. My whole career has been spent with people at risk of death, wanting to die, or feeling utterly hopeless that change can happen. I do this work because I witness, time and time again, the incredible changes people can make with comprehensive clinical care.

Most of the people I have worked with don't want to die: rather, they want out of the suffering, out of the exhaustion and fighting and loneliness and given a chance to have a different experience with life, they would choose to live.

I also hold space for those who feel they have exhausted every route and who suffer greatly.

I write this for all of us.

In March of 2023, **Medical Assistance in Dying (MAiD)** will be made available in Canada to anyone for "whom a mental health diagnosis is determined to be causing irremediable suffering, including those with eating disorders." The rationale cited for including those with mental health conditions is one of ethics and not discriminating mental from physical health when determining the right to choose death.

Criteria for establishing eligibility centre around concepts such as *"irreversibility", "incurability", "suicidality",* and *"capacity"*. In reviewing the **Final Report of the Expert Panel on MAiD and Mental Illness** available online through Health Canada , these concepts hinge on the assessment of *"treatment attempts made up to that point, outcomes of those treatments, and severity and duration of illness, disease or disability".*

This article will outline the way in which individuals with eating disorders are in an incredibly vulnerable position with respect to MAiD and, like those with other mental health diagnoses, deserve more advocacy, attention, and system change.

It is of note that, at a time when the demand for ED treatment far outweighs the resources and hopelessness is at an all-time high, the introduction of MAiD for this group must be carefully considered.

This article will look at those criteria as applied to eating disorders. To begin, we must acknowledge that eating disorders are incredibly complex illnesses. Current research demonstrates strong genetic and biological underpinnings that include:

- **Metabolic differences**
- **Sensory and Perceptual disturbances,**
- **Self-regulatory processes**
- **as well as additional Biotemperamental factors**

Eating disorders are associated with high mortality rates and pervasive quality of life impairment. When I teach new clinicians and students about eating disorders, I point out that having an eating disorder is a traumatic experience, similar to other experiences that pose a threat to one's life. There is no doubt that people with eating disorders suffer greatly and that many have had repeated treatment attempts with inadequate responses.

With respect to treatment, it is important to highlight the notable strides in the recognition and treatment of eating disorders over the last thirty years. The development of CBT-E for adults and Family Based Treatment for adolescents have become frontline approaches. Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), specialist supportive clinical management (SSCM), and Interpersonal Psychotherapy are also considered front line approaches.

With respect to innovative treatments for different presentations, the development of CBT for ARFID offers new insights and hope to families. DBT-ED and Radically Open DBT are also well suited for individuals with eating disorders who have not responded to standard approaches and for those struggling with co-occurring problems with emotion regulation and/or personality disorders. Many people receiving these treatments recover, improve their quality of life, experience renewed hope, and do not want to die.

Yet many people with eating disorders do not have access to these treatments. This is notable given that, in determining whether one is eligible to apply to MAiD, the Health Canada guidelines state the following:

". . . a clinician must carefully consider whether the person's circumstances are a function of systemic inequality.... Where appropriate, interventions focused on suicidality, harm-reduction and recovery should have been attempted." (Health Canada, 2022)

EDITORS POP-UP:

To further illustrate this point Our Editorial team suggests you also read Dr. Federici's previous article: ED Treatment with Indigenous Communities: Challenges and Opportunities found in the Winter 2022 Issue of our Magazine.

There are substantial systemic barriers to care in the field of eating disorders.

Wait times for admission to day treatment and inpatient programs in Ontario is one to three years, with most programs carrying over 300 referrals on their waiting lists. The programs themselves are underfunded and sometimes understaffed. There is tremendous system pressure on programs to fill beds and treat as many patients as possible in order to keep existing funding, which limits how long people can stay in a given program.

These systemic issues impact the type of treatment that is available (e.g. shorter term interventions rather than longer term, comprehensive models) and how treatment is delivered (e.g., length of stay, support for the team to adherently apply a treatment).

Many teams that I consult with talk about rushed days, being overworked, and spending most of their time in crisis management rather than being able to apply CBT or DBT interventions.

The majority of provincially funded programs do not offer evidence-based treatment for suicide and self-injury (e.g., full model DBT) nor emphasize harm reduction approaches.

Most programs do not have ARFID treatment programs or have the ability to treat eating disorders in the context of personality disorders, neurodiversity, or substance use disorders. Evidence-based treatments take time and require ongoing team training, consultation, and enough well-trained staff to operate.

Unfortunately, many of our hospital-based programs were never designed to support the psychotherapy models that are considered first or second line interventions. Hospitals focus on keeping people alive and are based on a medical model of care.

Many of our provincial programs utilize CBT, FBT, and some DBT skills interventions but are unable to provide these treatments in their full and adherent forms.

Thus, the focus for those in day treatment or inpatient is predominately helping the patient with weight and nutritional stabilization and, often times, patients are discharged once they reach these goals.

In an ideal world, the patient would then "step down" to a less intensive, but longer-term treatment. The problem with this is that most hospitals haven't been funded to provide that type of step-down care. While the private system can fill this gap, it is only available to the small percentage who can afford to pay thousands of dollars. The majority of people simply cannot afford this.

"Consideration should be given to whether the requester has received care in a culturally safe setting with access to trauma-informed and culturally-appropriate interventions."

Inequities in access to care are a major issue. BIPOC individuals and those in the LGBTQ2S+ community are far less likely to be assessed for an eating disorder and/or access provincially funded services. There is also a lack of research on eating disorders in these populations as well..

Leading treatments have been criticized for their Eurocentric approach to weight and feeding and not appropriate for many cultures and ethnicities. A lack of attention to the unique experiences and treatment needs of LGBTQ2S+ individuals has further created a gap in services.

Taken together, how does one determine whether an eating disorder is incurable or intractable if most cannot access evidence-based care?

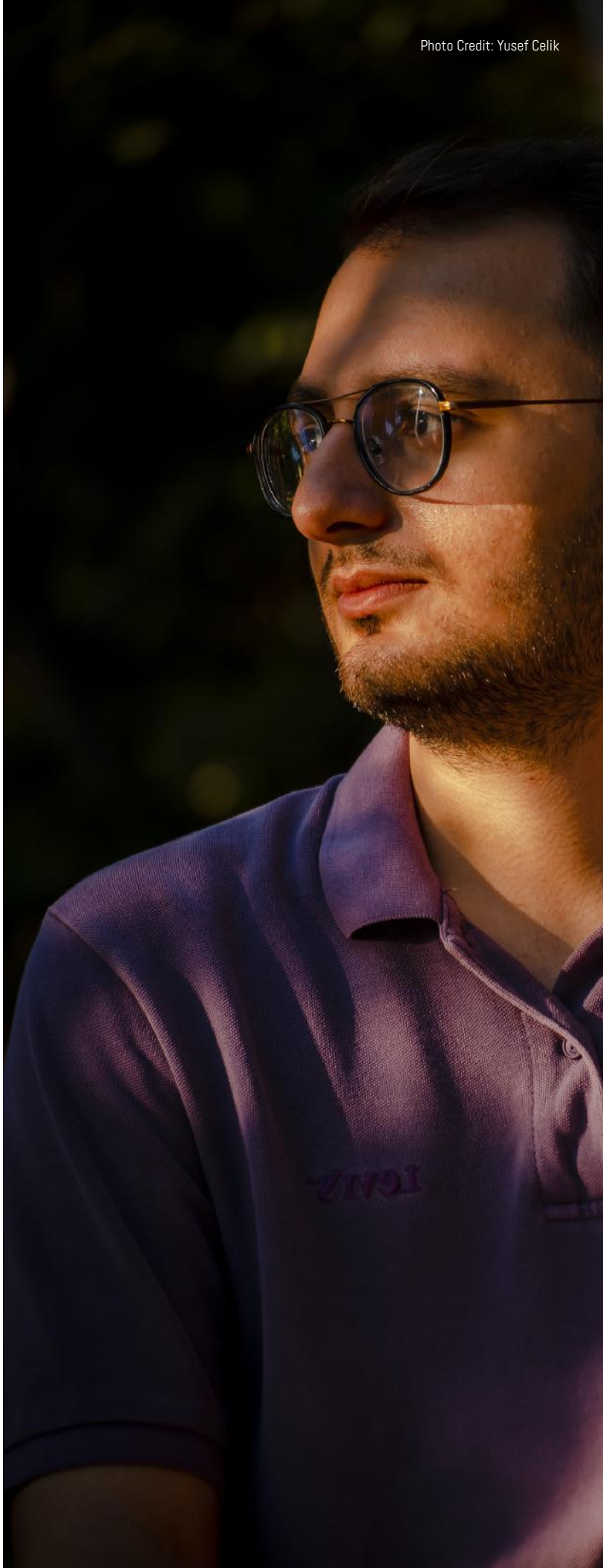

Photo Credit: Yusef Celik

While Health Canada and others argue that people should have tried high quality treatments that are evidence-based, trauma informed, and culturally sensitive, they also state that they cannot "provide fixed rules for how many attempts at interventions, how many types of interventions, and over how much time" because to do so would be discriminatory to those who cannot access care.

The same argument was put forward by Yager et al, 2022 who stated that *"...restricting that definition(of treatment access) only to patients who have the means to endure specific types of extensive treatment is an injustice...the proposed criteria require but do not presuppose the type or duration of high-quality ED care to protect disadvantaged populations from the burden of diminish access to end of life care resources."*

The criteria themselves suggest that limiting access to MAiD would be discriminatory but limiting access to ED treatment is not. Given well established systemic and structural barriers to culturally sensitive and equitable ED interventions, the concern is that the most vulnerable in our communities will have greater access to MAiD than to evidence-based treatments.

This is also important as some have proposed that one of the criteria to determine incurability in anorexia is age. Gaudiani et al (2022) recommend that an individual must be at least the age of 30 to access MAiD (in addition to 4 other criteria that include having the diagnosis, having had access to care as outlined above, and capacity to consent which is discussed below).

The age of 30 criterion is problematic for several reasons, that include but are not limited to:

- Some people don't get diagnosed until they are in the 30s, 40s, 50s.

- Many people recover after long durations of illness.

- Many people have not had access to treatment or do not access treatment until later in life.

Capacity to consent

In order to access MAiD, healthcare providers must determine whether the individual has the capacity to consent.

Capacity to consent refers to an individual's ability to fully understand the nature of their illness and to appreciate the foreseeable consequences of making a decision related to their condition (should we cite PHIPA?).

This is a really difficult criteria to address in those with eating disorders. The very nature of an eating disorder is to lack insight into the severity or seriousness of the illness (this is part of the criteria one must endorse in order to be assigned a diagnosis).

Moreover, starvation causes both acute and long-term effects on the brain. Studies have shown cerebral atrophy in regions of the brain associated with decision-making, logic, and planning.

Additionally, in my experience, there have been many times when a client has said to me that their thinking is much different in a recovered state compared to how they thought when they were unwell.

Renourishment and access to quality treatment changes the brain, helps with emotion regulation, reduces suicidal thinking, and promotes more balanced thought processes.

One person said . . . *"when I look back, it doesn't even seem like me."*

I have had numerous people reach out to me with respect to MAiD stating that they would likely have chosen MAiD in the depth of their illness and are so glad they didn't.

How do we determine capacity in this context? Some argue that people have a right to choose and how do we reconcile that the illness itself affects the process of choosing.

Some argue that people have a right to choose and how do we reconcile that the illness itself affects the process of choosing.

Photo Credit: Fauxels

Without greater discussion, clarity from the field and those with lived experience, and research this could be a very harmful option. Complex presentations often burnout clinicians.

While not unique to eating disorders, it is well established that chronic mental health conditions can exacerbate, frustrate, and burn out mental health practitioners who often feel at a loss for what to do to help.

Given long wait lists and lack of available treatments, many individuals with eating disorders are managed by non-ED specialists who do not have the training or expertise to offer guidance or treatment which further exacerbates hopelessness.

To date, I have had several clients for whom MAiD has been suggested to them by non-ED physicians and psychiatrists. It is very concerning that those with inadequate training and/or those who may feel burnt out at the lack of progress could be responsible for supporting an end-of-life decision. Slow progress or not knowing what more to do clinically is not evidence of incurability.

Marsha Linehan, who suffered greatly for many years and was institutionalized for several years and who went on to develop one of the most highly sought-after treatments in the world wrote that *"life can be worth living even with suffering in it, that all lives are worth living."*

Staying true to my own dialectical nature (that more that one thing can be true at the same time), I cannot speak for all who suffer from an eating disorder. I know some of you have been through many treatments and feel there are no other options.

What I do hope for is the following:

Substantially more government investment for publicly funded services rather than expecting the existing system to absorb the needs

Government funding and insurance coverage for long-term eating disorders treatment offered by specialists in the community

Pausing MAiD for eating disorders until there are agreed upon criteria from researchers and those with lived experience

More research on this topic to inform thinking and decision-making

For article resources visit: https://bana.ca/magazineresources/

Dr. Anita Federici is a Clinical Psychologist and the Owner of The Centre for Psychology and Emotion Regulation. She holds an Adjunct Faculty position at York University and is a distinguished Fellow of the Academy for Eating Disorders.

Dr. Federici also serves as the elected Co-Chair for the Suicide and DBT Special Interest Group for the Academy for Eating Disorders.

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Photo Credit: Cottonbro Productions

An Intersectional Approach to Gender Affirming Care.

How binary approaches fail the 2SLGBTQIA community

by Juliana Simon, BSW, RSW

Photo Credit: Rodnae Production via pexels

As we know, eating disorders do not discriminate based on gender, sexuality, race, or ethnicity. True comprehensive support means caring for the whole person, not just their diagnosis. When supporting 2SLGBTQIA+ individuals it is important to understand the intersections that our community falls under.

At Trans Wellness Ontario, our mission is to enhance and sustain the health and well-being of the 2SLGBTQIA community. We provide gender-affirming individual and community services to queer/trans individuals and their families within Ontario. We also provide support to other Service Providers who may work with members of our community and are looking for consultation on gender-affirming care.

This is an important aspect of the work that we do; through sharing knowledge with service providers we can ensure that other spaces within the community are competent in gender-affirming care. In this article, we will outline key considerations for affirming practices within the scope of eating disorders.

This includes notes for service providers, notes for the community, and some general information on privilege, intersectionality and how they interact with the care we receive and provide.

For Providers

Creating a sense of safety (what does this look like?)

'Safe space' is a term we hear being used often but rarely defined. The tricky part about defining what a safe space is, that safety is subjective. Myself as a queer person, for example, may have a definition of safety that is informed by my various social locations.

This being said, as practitioners, we want to move past competent into comfortable. Creating safety includes the words we use, the examples we give to clients, the resources we provide, and finding resources they can relate to when applicable. Safety can also start with ensuring all of your institutional policies are explicitly inclusive for all identities.

One example of how creating institutional safety can look is changing the language used to describe gender and sexuality to be open-ended. This can give clients full autonomy to represent themselves rather than trying to fit into a box. At Trans Wellness Ontario, during intake we ask clients 'How would you describe your gender identity today?', rather than asking them to check a box of 'male, female, transgender, or other. Not only can this ease the pressure of self-identifying in a way that is affirming, but it allows us to hold space for our clients to embrace all aspects of their identity.

This also allows for our clients' gender identity and sexual orientation to evolve over time; after all, gender and sexuality are fluid. After the intake process, we regularly check in with clients regarding their names and pronouns to ensure we have the most up-to-date information and to reinforce the safe space we have created for them to explore their gender identity.

Utilize gender-neutral language when you are unsure; it is easier to change the language later than have to apologize for misgendering someone. An example of this is using terms like partner, spouse, significant other, parent, guardian, and caregiver, instead of gendered terms, until you know the words people use to describe themselves.

So what happens if you misgender someone?

Apologize, correct yourself, and move on. Later, reflect on the mistake. What can sometimes happen in these situations is the more you dwell on the mistake, that individual is forced to provide you with reassurance, when they were the ones hurt by your mistake.

This is a situation where the individual should not be taking on this emotional labor to make you feel better for your wrong. The bottom line is that if you do not feel comfortable or confident about the information you are talking about, your clients can tell and that can affect how safe they feel with you.

Allyship is an action word. It means a continual process of learning and unlearning in order to maximize care.

As practitioners, we want to move past competent into comfortable. The most valuable thing you can do is educate yourself, on your own time. Minoritized people are often expected to be the educators - to educate people about racism, sexism, queerphobia, and transphobia - to educate other people about how to be allies. This is exhausting and emotionally laborious for people to constantly share their personal stories, their trauma, and to advocate for themselves and their communities' rights and dignity.

Two simple ways providers can educate themselves is by following trans and queer activists/creators/pages on social media, and reading books written by trans/queer folks. This is a great way to learn about some of the nuances of the experiences of trans/queer folks.

Remember that it is not the personal responsibility of minoritized people to educate you - it is the responsibility of people with privilege to relieve the pressure from minoritized people by educating themselves Being an ally means you will often find that you need to challenge any biases, stereotypes, and assumptions you didn't realize you had.

Each of us have different social locations and experiences that shape how we think, feel, and act. Through reflection we can confront our biases and avoid making assumptions. Regardless of personal beliefs, practitioners must provide respectful and non-judgemental care to sexually and gender diverse clients, family members and carers which affirms their identity.

If you hold privilege within society, you do not need to feel guilty for this: it is not something you choose. What you can choose to do is to push back against your privilege and use it in a way that challenges oppressive systems instead of perpetuating them.

Recognizing your privilege and areas of intersectionality is important but it has to be the beginning, not the end. In this way, examining privilege and intersectionality can be seen as areas of opportunity and responsibility. "If privilege guilt prevents me from acting against oppression, then it is simply another tool of oppression." - Jamie Utt.

To the Community

As members of the 2SLGBTQIA+ community, seeking any type of care where we have to disclose personal information that deviates from traditional norms can be scary and difficult. This means that some folks might avoid those services due to fear of homophobic or transphobic violence.

This is a very serious reality for 2SLGBTQIA+ individuals. As a member of the community and a service provider, I have noticed that some of the reasons our service providers are so hesitant are due to the fear of making a mistake when it comes to our identities.

As we know, we are humans and we all make mistakes. However, this does not mean our service providers are given a free pass to do and say whatever they want.

Some important considerations and things I wish I knew before stepping into the first appointment for my eating disorder treatment were:

One, a lot of information is about to be thrown at you. Some of the examples given to you in articles, homework, and scenarios will not be affirming to your experience as a queer/trans individual. This is a great talking point with your therapist once you become comfortable. Being able to share resources with them is a powerful experience that can have a positive impact on the next queer/trans individual that they work with.

Two, look for affirming visual representations such as pride flags, safe space stickers…etc. Not only do these symbols signal to us as members of the community that the space has considered our safety, it can also be a way to hold our service providers accountable to sustaining a safe space. Your service provider calling themself an ally is one thing, but a true ally can take feedback and grow from it.

Three, making this investment into yourself will be one of the best decisions you make in your life.

There is very limited knowledge (ex. Research, empirical data) within the field of Eating Disorders on what competent care looks like for the 2SLGBTQIA+ community. This is especially true within the intersections of Body Image and Gender Dysphoria. It is not that your care provider does not want to provide affirming care, but the evidence based practice simply does not exist at this time.

What we do know is that representation matters, feeling like your care provider sees you as whole is important in trusting them in guiding you down the path of recovery.

Your care provider is there to ensure you gain what you need to gain from treatment, being open to share your knowledge of your lived experience with them helps gain insight into your wholeness.

Photo Credit: Rodnae Production via pexels

As members of the 2SLGBTQIA+ community, it is seldom that we see positive representations of our community in the media. Often times 2SLGBTQIA+ representation is centered around white, cisgender, gay men. This can make relating to the images in media extremely difficult.

Now, with the app Tiktok rising in popularity, we have seen space carved out for the 2SLGBTQIA+ community that is comprehensive in body size, race, ethnicity, gender expression, sexual orientation..etc. There are always considerations to take for online safety but one thing we have seen with Tiktok is the ability for anyone to reach a wide audience. This means that individuals who may have been suppressed by other social media platforms are able to have their voices heard by people who can relate to them.

When looking for representation, look in spaces that are not mainstream. Every individual is unique and finding someone in mainstream media who embodies your life experience is not always possible. When we look for representation in spaces like TikTok, Instagram and other social media platforms we can find individuals who may look similar to us, have similar gender identities and sexual orientations, and may have similar life experiences (ie: experience of transphobia; the coming out process; etc.). Representation in media is crucial to our confidence and for individuals with unique identities - we may have to become creative to feel seen.

Considerations for 2SLGBTQIA individuals in recovery or on their way to recovery;

- Find a member of your chosen family you can trust to talk about how you feel.
- Find individuals who represent aspects of your identity that you can relate to in the Media (ex. Similar body type, gender identity, sexual orientation..etc).
- Know that recovery is not a one size fits all, you have every right to a positive relationship with your body and food.
- Speak on your experience when and if you have the ability to do so, but also know you do not owe anyone your story. This can be done in many ways from participating in research, writing about your own experiences or simply talking to your chosen family.
- You are more than what society tells you what your body should look like.
- Reach out to organizations such as Trans Wellness Ontario for advocacy/service navigation if needed.

Gender Affirming Care

A key consideration for gender-affirming practice is understanding that although individuals may identify differently than the sex they were assigned at birth, this does not exempt these individuals from things like patriarchy and toxic masculinity. In the same ways as their cisgender counterparts, Trans* individuals are told that their bodies need to look, act, sound certain ways to be perceived as desirable. This can cause individuals to take extreme measures to avoid assumptions about their gender journey.

Gender Dysphoria is described as, "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)" (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Thus, transgender, and gender-nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the greater concern that might be diagnosable and for which various treatment options are available. "

The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments." (The World Professional Association for Transgender Health, 20).

This being said, Gender Dysphoria is not a determining factor in a Trans* individuals' gender journey; rather, it is a factor that can enhance their feelings of body dysmorphia and falls into the intersection of body image and gender identity. Intersectionally, we know that these two challenges compounded can enhance the distress an individual may experience.

Much like recovery itself, supporting 2SLGBTQIA+ individuals with eating disorders is an active process that requires compassion, competence, care and a deeper understanding of intersectionality.

To be competent is to be inclusive, to be non-judgmental, and to be able to find comfort in the uncomfortable. Care must be tailored to the needs of each person, reflecting an understanding of and respect for each individuals' social location(s).

Heteronormativity and cissexism can find its way into recovery spaces; messaging such as "Men love women with curves" assumes sexual orientation, and "love the body you're in, the way it is" can be invalidating to individuals with gender dysphoria.

These binary approaches to care fail individuals if their lives do not fall into the binary. When utilizing approaches outlined above, we hope to see more inclusive spaces for our community.

For article resources visit: https://bana.ca/magazineresources/

Juliana Simon BSW, RSW (she/her) is a Registered Social Worker at Trans Wellness Ontario. As someone who has sat on the 'other side of the couch' and began my journey to recovery from an Eating Disorder in 2020 she has always advocated for 2SLGBTQIA+ inclusive care, but now I am spending time advocating for this care within Eating Disorder support.

Featured Recipe:

One Pan Chicken Fajita Pasta

Recipe adapted from: https://www.kevinandamanda.com/chicken-fajita-pasta/

Ingredients:

- 2 tablespoons olive oil
- 1 pound boneless, skinless chicken breasts
- 1 white onion, diced
- 1 green pepper, diced
- 1 red pepper, diced
- 1 orange pepper, diced
- 3–4 cloves garlic, minced
- 2 cups low-sodium chicken broth
- 1/2 cup milk
- 1 can diced Tomatoes and Green Chiles
- 8 oz (about 3 cups) penne pasta
- 1/2 teaspoon salt

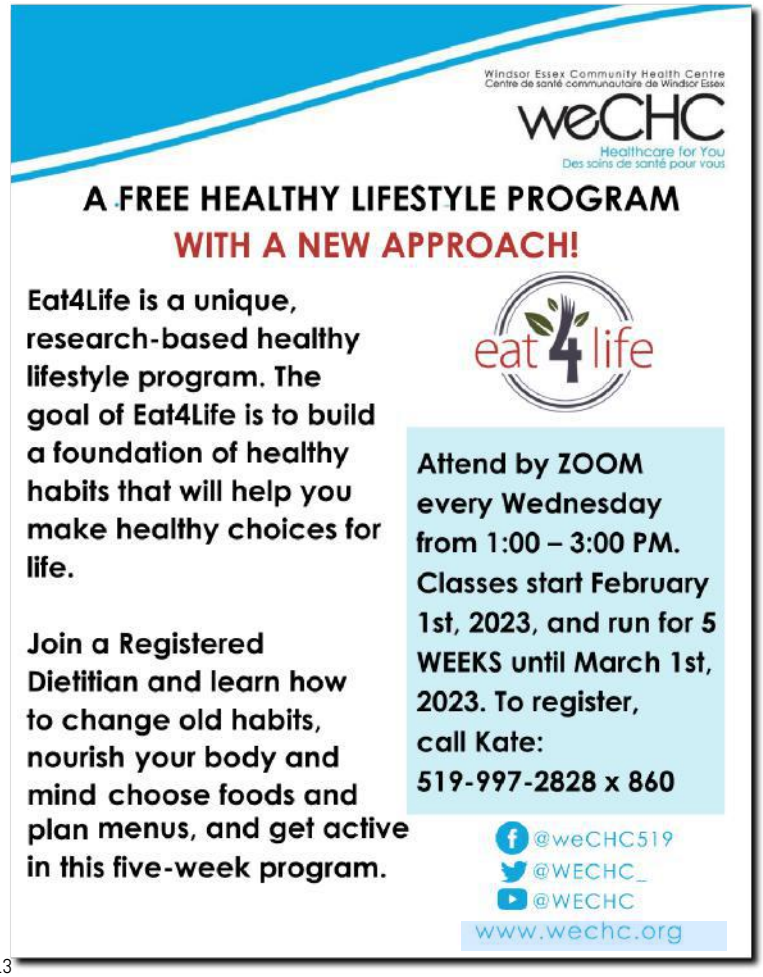
Homemade Tex-Mex Seasoning:

- 1 tsp Chili Powder
- 1 tsp Ground Cumin
- 1 tsp Paprika
- ½ tsp Garlic Powder
- ½ tsp Onion Powder
- ½ tsp Dried Oregano
- Pinch of cinnamon
- 1/8-1/2 tsp Cayenne Powder (based on spice level

Kia Peters is a Registered Dietitian with the Bulimia Anorexia Nervosa Association in Windsor, Ontario, Canada

Instructions:

1. Mix Tex-Mex seasoning in a small bowl and set aside. Cut chicken into bite-sized pieces. Season chicken with half of the tex-mex seasoning.
2. In a large skillet, heat 1 tbsp oil over high heat. Sear chicken 2-3 mins per side or until browned and cooked. Remove chicken to a plate and set aside.
3. Add remaining oil and turn heat to medium. When oil is very hot, add the onions, bell peppers, and remaining taco seasoning. Cook, stirring occasionally, until the veggies are slightly blackened. Turn heat to low, add minced garlic, and stir until fragrant and well combined, about 30 seconds. Move veggies to the plate with the chicken.
4. In the same skillet, add the broth, milk, diced tomatoes, uncooked pasta, and salt. Stir to combine and bring to a boil, then cover. Turn heat to med-low and cook for 15 mins or until pasta is tender and liquid is mostly absorbed.
5. Add the chicken and veggies back into the skillet and stir to combine until heated through, about 2 minutes.



EATING DISORDERS AND RESPONSIBLE MEDIA

Over the past few decades, the media and popular culture has had a constant interest in the topic of eating disorders. As we represent those who are actively engaged in the education, prevention and treatment of disordered eating and related body image issues across Canada; we ask you to join us in acknowledging the severity of this topic.

After all, outside of opioid addiction, ED's have the highest mortality rate amongst all mental health disorders.

February 1st-7th every year in Canada is
Eating Disorders Awareness Week.
This annual event gives us the opportunity to share our experiences and expertise with you, the storytellers.

While we have seen an increase in accurate portrayals of ED's in media in recent years, a change we openly welcome; there are still too many occurrences that continue to represent the issue in ways that are trivializing and triggering to many vulnerable people of all ages, genders and races

We hope to offer this wealth of knowledge and resources to you, so that we can work together toward a more responsible and healthy media environment for all Canadians.

HOW CAN MEDIA RESPONSIBLY REPRESENT EATING DISORDERS ?

INCLUDE PEOPLE WITH DIVERSE AND INTERSECTING IDENTITIES AND AVOID PERPETUATING STEREOTYPES.

Stereotyping can be triggering or actively prevent folks from seeking/receiving support

FOCUS ON EMPOWERMENT

Avoid using blaming or shaming language. For example, instead of "Why weren't you eating?... try "What made recovery challenging?"

CONSIDER THE IMPACT OF YOUR LANGUAGE

Be mindful of the language your subject uses.

Avoid language that moralizes food.

Avoid triggering details like calories or weight goals.

SUPPORT RESPONSIBLE AND POSITIVE MENTAL HEALTH ENGAGEMENT

Have a care plan in place for both interviewees and interviewers.

Have an accessible, crediable and culturally relevant list of trauma and informed resources available at the end of your story

EMPHASIZE AND CELEBRATE THE POSSIBILITY OF RECOVERY

Don't glorify or sensationalize Eating Disorders. Avoid focusing on celebrity stories, this can erase the severity and seriousness of the issue.

ENCOURAGE EDUCATION

Ensure that writers, interviewers and hosts educate themselves prior to engagement.

For additional resources visit:
www.nedic.ca/edaw

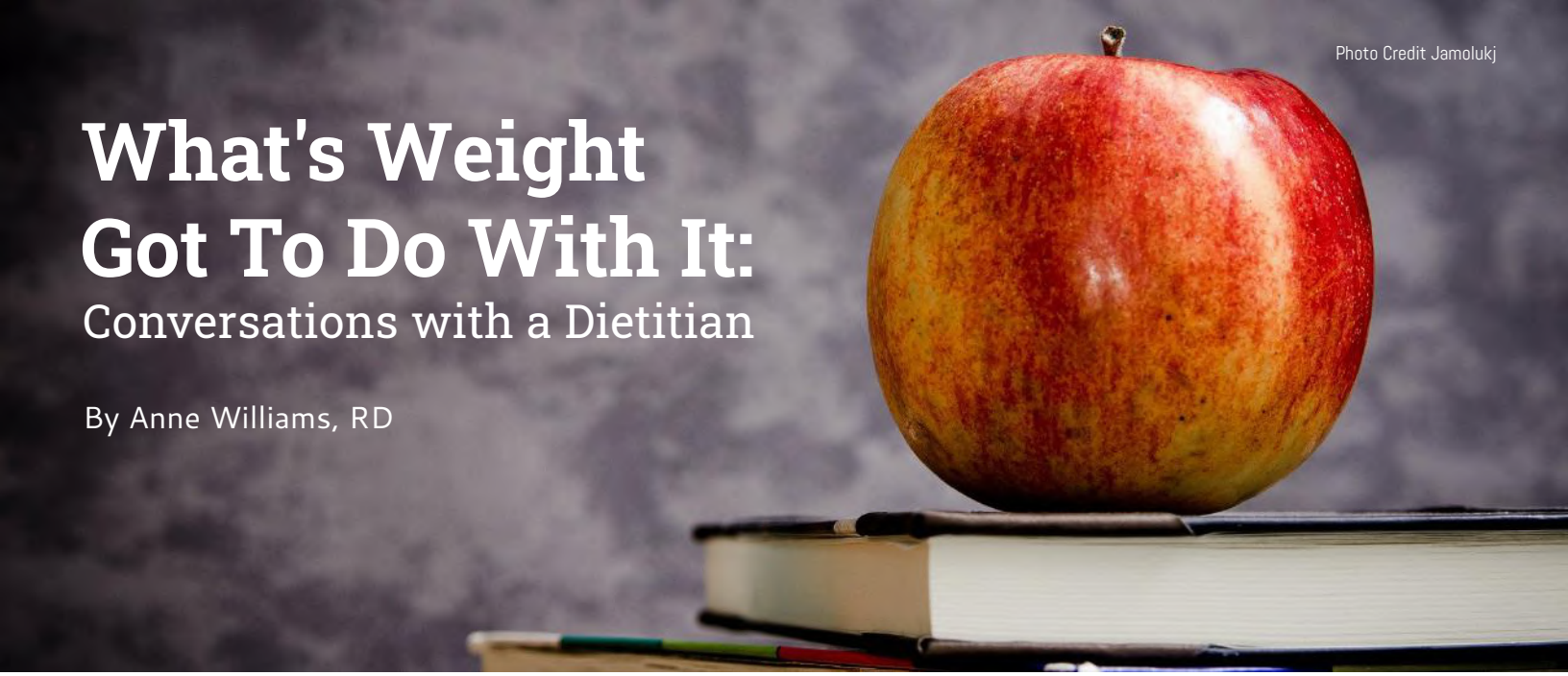


Photo Credit Jamolukj

What's Weight Got To Do With It:

Conversations with a Dietitian

By Anne Williams, RD

The following article will, with the best of intentions, challenge common beliefs and practices around weight. In doing so, it will point to research findings; the reference list (in a separate link) will include studies from obesity scientific literature.

There could be many reasons why reading this article might not feel comfortable for you at this time. We live in a world that sends highly negative messages about those of us not meeting a very narrow weight, appearance, health and ability ideal.

The author has chosen to use neutral language about body size, to not use the term obesity, and to refer to BMI (a problematic metric) only once in the article. However please proceed with self-awareness and compassion, and give yourself permission to skip reading further if it doesn't feel comfortable..

If you have read other issues of Be Yourself Magazine, you may have noticed there has never been an article about losing weight to improve physical or mental health. You may have also noticed neutral or positive terms being used to describe bodies and food; the last issue even had a great article discouraging weight loss challenges in the workplace. If you have struggled with disordered eating or an eating disorder, you will hopefully have received the same kind of weight-neutral messaging from your care providers.

Lots of us have been exposed to body positivity and more gentle messaging about bodies like this in recent years. Many of us agree that crash diets don't work in the long term. And many of us may even understand why being careful with our messaging about weight could protect youth and others at risk of poor self-esteem and eating disorders.

While we may accept all of these reasons for not discussing weight or weight loss, many of us wonder whether there is likely some weight or BMI over which a person should consider sensible methods to lose weight. And why wouldn't we?

Not a day goes by when we aren't exposed to multiple posts and headlines about the link between higher weights and health conditions or even the risk of death. These messages are reinforced by conversations in our lives, and by many of the healthcare practitioners, we see. And if we live in a larger body, the world treats us differently. It makes complete sense that we would believe that sensible weight loss would benefit people once they reach a high enough weight.

As a dietitian who has worked with countless individuals with all kinds of health concerns, I do not recommend intentional weight loss for the management of any condition (although I will always respect and understand an individual's choice to lose weight).

This is not only because I have seen the effects of the pursuit of weight loss on those vulnerable to disordered eating, or because it takes the joy out of life. I practice in this way because of my understanding of the scientific literature around nutrition, health, and weight.

The rest of this article will briefly review what I wish everyone, including fellow healthcare workers, more fully understood about the science around weight:

Our bodies are hard-wired to fight against weight loss and calorie deficits in the long term. Even if we start out at a higher, "unhealthy" weight.

This is one of the most replicated findings in science and is agreed upon by weight researchers. There is no diet or activity intervention that is superior (sorry, keto!).

Weight regain starts within the first year after weight loss, most weight is regained by 2 years, and by 5 years, the vast majority of people have returned to their original weight or have exceeded it.

This is not seen by weight research experts as a lack of willpower, but rather due to a complex set of body and brain mechanisms that have evolved to fight energy deficits and weight loss over human history. It is not at all easy to hear for those of us who live in larger bodies. But it is not disputed among those who research weight.

This fact is why weight loss surgery and the newer weight loss medications are considered by researchers to be the only effective ways to sustain weight loss. It is in fact why researchers acknowledge that the newer weight loss medications will need to be taken permanently.

And while effective, both surgery and medication come with significant lifetime side-effect considerations.

As my young adult son said to me recently when he overheard me teaching this online, "Mom, nobody knows this". He is right. Not even in front-line medicine. Weight loss is recommended in healthcare routinely as a first-line approach for many conditions (diabetes, reflux, sleep apnea, arthritis, etc).

Fully informed consent about the low likelihood of long-term weight loss maintenance could make such a difference for clients. And if we understood this in "the real world", many of us might abandon the treadmill of repeated dieting and focus on more sustainable and joyful self-care.

Weight cycling, or "yo-yo dieting" is a very possible longer-term outcome of trying to lose weight through diet and exercise. Weight cycling can negatively affect our health.

Often, healthcare practitioners may recommend weight loss with some understanding of the low success rates, possibly because they believe there could be some short-term benefit. Or perhaps to "help motivate" a client.

However, there is a risk of harm in recommending weight loss: weight cycling is one of those potential harms. When weight regain occurs, most people, especially those in larger bodies, - will attempt weight loss again with the assumption that they didn't try hard enough or that they need a new approach.

We have strong evidence that repeated weight cycling can worsen insulin resistance and glucose tolerance (avoiding weight cycling is a recommendation of the Canadian Diabetes Association Guidelines).

There is more limited research to suggest it can increase the risk of some cancers, heart disease and stroke, cholesterol levels, gallstones, blood pressure, and inflammation. Note that ironically, these are many of the health conditions that lead a person to consider weight loss in the first place.

Weight cycling can drive weight higher over a lifetime since exceeding baseline weight is a risk each time we engage in weight loss.

And finally, weight cycling is discouraging. It can affect self-esteem and self-care. People often abandon health-promoting behaviours when weight regain begins. Behaviours such as consistent joyful movement, more fruits and vegetables, more plant protein, fish, and adding more whole grains can improve health outcomes even if weight loss is not sustained.

Bias and discrimination against those living in larger bodies is prevalent in our world, and research has shown it to be consistently high among healthcare workers. Weight bias is an independent risk factor for illness and mortality.

This second sentence is summarized from the second of 5 key summary points in the Canadian Clinical Practice Guidelines for Obesity in Adults published in 2020. The evidence for the harm of weight bias is that strong.

My experience in working with clients in average and larger bodies is that weight-based discrimination and bias in healthcare are the norm and not the exception.

Research shows that it affects physical and psychological outcomes both directly (eg: delayed treatments, declined care, missed diagnoses) and indirectly (eg: abandoning medical care, lower self-esteem, depression, weight cycling, reduced health behaviours, disordered eating)

It's important to consider that prevalent weight bias also affects how research is funded, designed, interpreted, and reported. My suspicion is that cultural and healthcare weight bias often informs frontline healthcare advice about weight as much as the weight science literature does.

One could argue that fighting weight bias in culture and in healthcare is a more sustainable way to improve health than recommending weight loss. To be fair, those who still recommend weight loss (even if through medication or surgery) would argue that both can be done.

Based on my experience over 29 years as an RD, I am not convinced.

Photo Credit Thirdman

Weight is not the most important predictor of health. And yet, it is emphasized so strongly in healthcare that many of us believe it to be so. This entire article could be devoted to the above point.

It's important to know that the link between weight and health outcomes is mostly based on population-level observational research.

Surprisingly, it would be uncommon for more than 3 or 4 other factors affecting health to be controlled for in these studies (such as age, gender, smoking, and socio-economic status).

Factors such as: substance use, weight cycling, the effects of weight discrimination in healthcare, quality of food intake, physical activity, as well as broader social determinants of health (safety, education, access to healthcare, experiences of trauma and discrimination, etc) are not usually controlled for.

We know that these other factors can all have significant effects on health over a lifetime.

Dieting and/or energy deficits lead to out-of-control eating for most people if given enough time. Dieting also affects our physical, emotional, cognitive and psychological functioning.

The first sentence of this point relates back to the lack of sustainability of weight loss. Out-of-control eating is part of how the body eventually fights back against an energy deficit and weight loss.

It is a predictable biological response that has allowed humans to survive throughout our history and even now in many parts of the world where food insecurity exists.

Because we live in such a weight-biased world, we blame ourselves when this happens. For some of us, it may lead us to "double down" and work even harder to lose weight or keep it off.

This can lead to disordered eating and eating disorders for some. The risk of developing an eating disorder or disordered eating is another significant risk of harm from the pursuit of weight loss.

Finally, even if someone starts a diet and eventually abandons it without developing an eating disorder, the time spent in an "energy deficit" affects how they function. Many of us have experienced this: fatigue, lowered concentration, poor digestion, food preoccupation, irritability and perhaps even worsened anxiety or mood while dieting.

I have seen the irony of clients being advised to lose weight to improve their mental health; weight bias has led the practitioner to discount the foundational importance of adequate fuel for optimal brain functioning.

All of the omega-3 intake in the world will not make up for a lack of food energy for the brain. And all of the green and orange veggies in the world won't make up for calories needed for the body.

These concepts about weight and health are the ones I wish were "mainstream" for all of us, including health and mental health practitioners.

I am aware that even though weight researchers agree that the body fights against weight loss in the long-term, many come to different conclusions than I have in this article (they may attribute more importance to weight's effect on health, would recommend medication or surgery, and often downplay the risk of disordered eating or weight cycling from weight loss attempts).

Photo Credit: Cottonbro

I acknowledge that my weight-neutral approach is informed by the literature, but also by my experience working with clients with eating disorders and other health concerns, and by the values I place on fully informed consent, patient autonomy, wholistic health (not just physical health) and equitable care for every person regardless of their weight or health behaviours.

My concluding premise is that we should critically question the assumption that many of us should be pursuing weight loss, because: *without medication or surgery it has not been shown to be sustainable by any diet or exercise method, AND that this pursuit carries the risk of harm in the form of weight cycling, disordered eating and suboptimal physical and psychological functioning. At the very least, we should all be fully informed of these considerations before making a decision to pursue weight loss.*

Finally, what are some possible outcomes I would wish for readers of this article? Here are a few possibilities:

No matter what your body size is, consider what it could be like to not engage in another weight loss diet. Try focusing on self-care and health behaviours you enjoy and feel you could sustain. Consider food choices based on taste, pleasure, hunger, and nutrition; not just calories! I realize that if you are living in a larger body, this is not an easy decision to make.

Do some more reading about health and weight. See some suggestions in the resource link below.

- Try changing the conversation away from weight and weight loss in different areas of your life.
- Consider curating your social media feed: add weight-affirming accounts, and remove accounts that make you feel badly about your weight or appearance. Unfollow accounts with extreme health advice.
- Advocate for yourself if you don't wish to be weighed or have your weight discussed in healthcare appointments.
- If you are a healthcare practitioner, read more about weight bias and discrimination and take steps to address it in your practice. It is an ongoing journey for all of us.
- If you work in healthcare, also consider changing the conversation away from weight loss as a first-line recommendation, or weight as a primary indicator of health. Consider reducing harm and increasing effectiveness by discussing health behaviours and wholistic health.
- Be gentle with yourself. Weight bias is the ocean we all swim in. Challenging weight assumptions is hard work. I believe it is a worthwhile pursuit.

For article resources visit: https://bana.ca/magazineresources/

Photo Credit: Shvets Productions

Anne Williams is a Registered Dietitian with 29 years of experience in clinical nutrition. She has worked with people experiencing kidney failure and dialysis, cancer, and chronic health concerns in hospital, community, and primary care settings. She is privileged to have worked in the field of eating disorders for the last 20 years, 17 of them as part of an outpatient adult treatment team. Anne is passionate about weight-affirming and equitable nutrition messaging.

BALANCED EATING IN CHILDREN

One of the most important things you can do for your child's health is to teach them balanced eating habits. Our relationship with food follows us throughout our lifetime and it's crucial for children to have a strong foundation of balanced eating as they continue to grow and develop.

WHY IT'S IMPORTANT:

Recent studies show that a balanced diet, with a primary focus on nutritious foods can have a profound effect on your child's health, helping them to stabilize their mood, sharpen their minds, avoid a variety of health problems and even decrease the risk of suicide. A balanced diet has an extreme effect on your child's mental and emotional wellbeing by preventing conditions such as depression, anxiety, schizophrenia, bipolar disorder and ADHD.

THE "HOW"

As a parent, it is your goal to make nutrition appealing. Here are some ways you can be a role model in promoting a healthy and balanced lifestyle:

EDUCATE YOURSELF:

If you aren't already educated on dietary requirements, it is important to be aware. foodguidecanada.ca is a great resource for outlining specific nutritional values, portion sizes and necessary food groups as your child continues to grow.

PARTICIPATE & ENCOURAGE HEALTHY HABITS:

Children are likely to imitate your behaviours and actions. Engage in healthy activities, make mealtimes a priority and choose nutritious foods with your child. Healthy habits can be as simple as drinking enough water, encouraging snack time every few hours, a regular meal schedule and engaging in enjoyable exercise.

DISGUISE:

If your child is resistant to whole foods or more nutritious options, there are many ways you can disguise foods to make them more appealing. For example, adding a yogurt dip with fruit or adding zucchini into a muffin recipe. myfussyeater.com has many additional recipes and ideas to incorporate into your meal plans.

FIND THE BALANCE:

Everyone loves treats, they are meant to enhance our experience! Foods like (but not limited to) birthday cake, ice cream or pizza are all meant to be enjoyed. Labelling those foods as "unhealthy" and restricting them can encourage eating disorders in youth. The key component is to find the balance of allowing yourself and your child to enjoy those treats, while also eating foods that are nutrient dense. We want to promote a balanced relationship with food, which means consistently eating nutritious foods and meals while also creating space for treats in moderation.

AVOID THE BATTLE:

Parents might find themselves bargaining or bribing their kids, so they eat the nutritious foods when it's convenient for the parent. A better strategy is to give kids some control while limiting the kind of foods available in your home. You can do this by establishing a predictable schedule for meals and snacks, avoid forcing your child to finish their plate because it teaches them to override their feelings of fullness. Use food as a tool to nourish your body instead of a bribe or reward, or a way to show love.

Starting a foundation of balanced choices prepares your child to make beneficial choices on their own. Their relationship with food begins with you and will impact their wellbeing for the rest of their life. Primarily, it's what your child eats consistently that matters most. Enjoying popcorn with a movie or ice cream on a hot summer day is a pleasure. It's a matter of finding the balance, adding nutritious food choices and participating in enjoyable exercise that is crucial to your child's development.

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FEB. 15	VS. LIGHTNING	7:00PM
FEB. 20	VS. LIGHTNING	2:00PM
FEB. 26	VS. UNITED	2:00PM

MARCH		
MAR. 3	VS. TITANS	7:00PM
MAR. 10	VS. TITANS	7:00PM
MAR. 17	VS. FIVE	7:00PM

APRIL		
APR. 2	VS. GALAXY	2:00PM
APR. 13	VS. FIVE	7:00PM
APR. 16	VS. TITANS	2:00PM
APR. 21	VS. TITANS	7:00PM
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