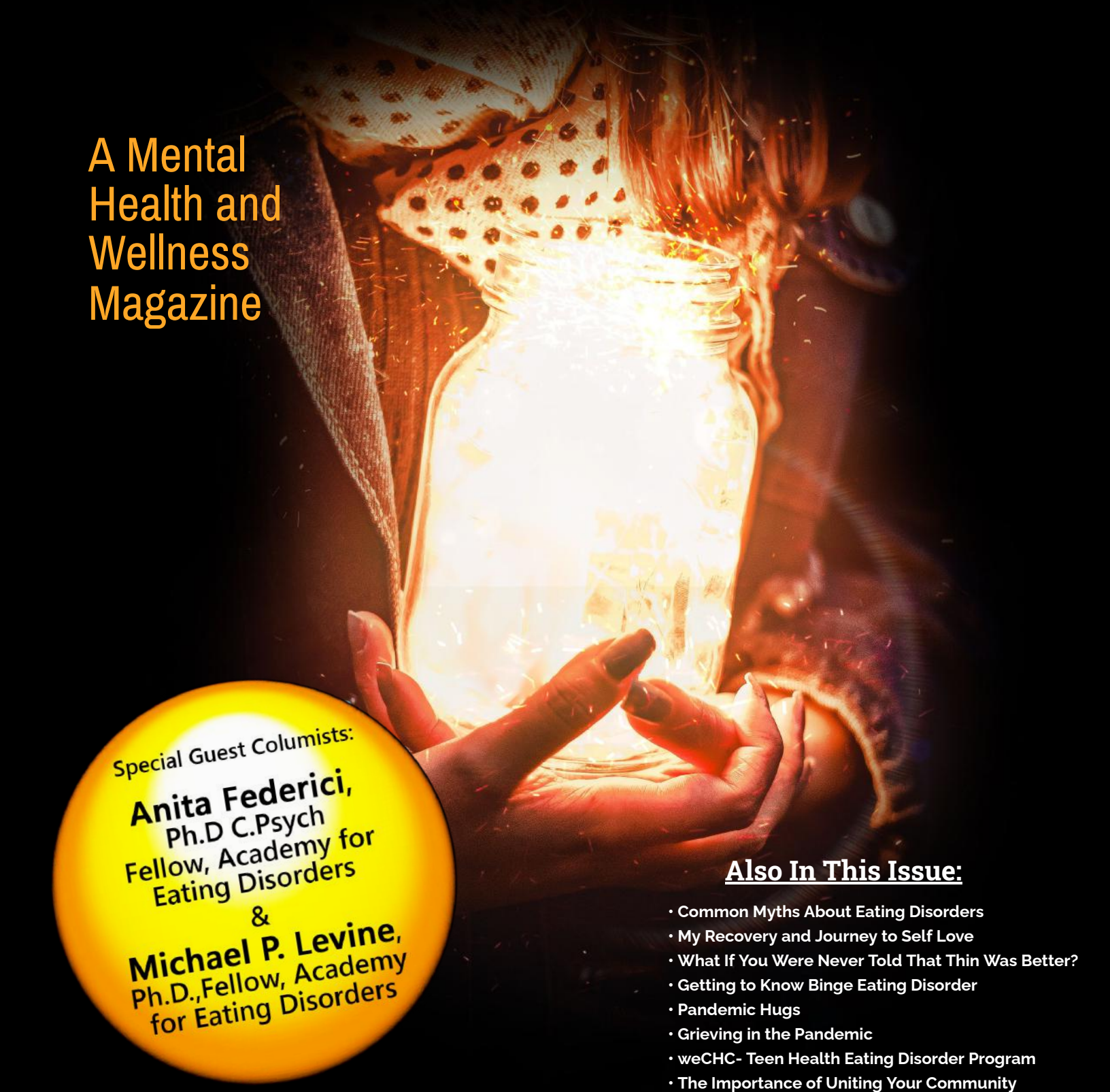
BANA
BE YOURSELF

A publication of the Bulimia Anorexia Nervosa Association

SPRING 2021

A Mental Health and Wellness Magazine



Special Guest Columists:

Anita Federici, Ph.D C.Psych Fellow, Academy for Eating Disorders

&

Michael P. Levine, Ph.D.,Fellow, Academy for Eating Disorders

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Publisher:
Luciana Rosu-Sieza
BANA Executive Director

Editor-in-Chief:
Patrick Kelly
BANA Communications and Office Administrator

Associate Editor:
Sara Dalrymple
BANA Clinical Therapist

Contributing Writers:

Lori Market
BANA Clinician

Stephani Fenkanyn
BANA Health Educator

Marisa Casey
BANA Health Educator

Guest Columnists:
Michael P. Levine, Ph.D., FAEDW MSW BA Psych.

Anita Federici, Ph.D, FAED, C.Psych

Leigh Ann Hello

weCHC Teen Health

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Publishers Note:

Hello Readers!

I am honored and delighted to welcome 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, our organization, 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 Patrick Kelly, Editor-in-Chief and all 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 month to come.

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

Sincerely, Luciana Rosu-Sieza, Executive Director

Common Myths about Eating Disorders

*** 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.

Eating disorders are complex and challenging mental health diagnoses often surrounded by stigma, myths, and misconceptions. It is important to understand the truth about eating disorders and how it affects those in our community. We have addressed some of the most common myths and misconceptions below.

"I know lots of people with an eating disorder, it's not that big of a deal"

People with eating disorders experience impairment in their everyday life, and often struggle with anxiety, depression and other mental health challenges in addition to the medical and physical ones associated with the disorder. Research shows that those with eating disorders have the highest mortality rate of any psychiatric illness.

Some of the possible medical side effects of an eating disorder:

- **Malnutrition**
- **Low weight/ Obesity**
- **Growth Delays**
- **Menstrual Irregularity and Fertility issues**
- **Increase risk of suicide and self harm behaviours**
- **Gastrointestinal issues**
- **Immune deficiency**
- **Cardia arrythmias**
- **Skeletal myopathies and Osteoporosis**
- **Refeeding syndrome**
- **Rectal prolapse**
- **Cerebral atrophy**
- **Cognitive problems**
- **...and many more...**

All people with eating disorders are extremely thin or underweight

While there are some people with eating disorders who are underweight, people of all body shapes, sizes and weights can struggle with eating disorders. A person's weight does not determine their diagnosis, the severity of their disorder (except in the case of Anorexia Nervosa, where BMI dictates severity) or their overall health.

This myth represents the common misconception that Anorexia Nervosa is the only "serious" ED diagnosis; however, Bulimia and other diagnoses have similar mortality rates. Individuals who abuse laxatives or diuretics, or engage in self-induced vomiting are at significantly higher risk of sudden death due to electrolyte imbalances. Chronic excessive exercise also can increase the risk of death in individuals with eating disorders by increasing the amount of stress on the body.

Eating disorders only affect teenagers

People of every age, race and cultural background can develop an Eating Disorder. Pop culture often portrays Eating Disorders as something that teenagers or people in their 20's struggle with; however, our intake department sees individuals of all ages, including children and the elderly. Within our community, BANA works exclusively with the adult population, the Teen Health Centre (WeCHC) works with adolescents, and the Regional Children's Centre (WRH) works with children. No matter what age, any individual with eating disorder concerns can contact our general intake number, where they will be connected with appropriate services. (see inside back cover for details)

Men don't get eating disorders

People of all genders struggle with Eating Disorders. Historically, there has been a lot of stigma and shame around men's mental health, which has contributed to the belief that men are not at risk for developing an eating disorder. However, a 2007 study by the Centers for Disease Control and Prevention found that up to one-third of all those suffering with an eating disorder are male. BANA and our community partners work with folks of all gender identities, as eating disorders do not discriminate.

Real Facts: The below is a snapshot of BANA Active Clinical Service Recipients in Windsor – Essex and the Surrounding Areas as of March 2021

- **The average age of recipients is 34.86 years**
- **Our clients are most often diagnosed with:**
  - **Bulimia Nervosa (53%)**
  - **Binge Eating Disorder (34%)**
  - **Anorexia Nervosa (6%)**
  - **Other Specified Feeding or Eating Disorders (7%)**
- **61% report some form of suicidality**
- **64% report some form of abuse/trauma**
- **Nearly 40% report additional medical diagnoses**
- **76% have completed post-secondary education**
- **17.5 % work in the healthcare field**
- **80% have co-morbid mental health diagnoses**

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

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My Eating Disorder Recovery and Journey to Self-Love

By Isabella A.

Photo credit Kilian M via pexels

As a 23-year-old who has overcome an eating disorder, suffered from anxiety and depression, and survived suicidality, I feel an obligation to share my story in the hopes of inspiring others. If you have struggled with an eating disorder, or have a friend or family member going through recovery, I hope my story can give you the hope you need to keep fighting and to keep showing up. In order to tell the story of my eating disorder recovery and journey to self-love, and how BANA helped transform my life, I first need to help you understand where I started.
Recognizing my Eating Disorder

Growing up I was always an anxious kid; now, I recognize this as "high-functioning anxiety". In high school this anxiety was accompanied by depression, which ultimately led to grappling with suicidality and an attempt when I was 18 years old. It was during this time that my eating disorder began, but it wouldn't be until years later that I realized the extent and damage of my eating disorder, and I finally sought out the help I needed.

I was always athletic growing up. I danced, played soccer and baseball in the summers and I LOVED swimming. Unfortunately, these sports I loved negatively impacted my self-esteem, body image, and confidence. I set high standards for myself from a young age and was always striving for excellence.

Social media contributed to my already low self-esteem and body image. Apps such as Instagram - which are constantly flooded with fitness influencers, social media celebrities and main stream actors/actresses - promote unrealistic and often unhealthy habits. Mental illness and eating disorders run in my family, and so it was a combination of all these things that led to the development of my eating disorder.

Seeking Help

I first learned of BANA in October 2018. At this point in my life I was 20 years old, living at my university, hiding an eating disorder that was worsening my anxiety and depression, and damaging relationships with my friends, family, and most importantly; the relationship I had with myself. My confidence was at an all-time low, I lacked energy to do the things I used to love and was experiencing emotional and physical side effects from my eating disorder. With the encouragement of friends and family, I began treatment at BANA.

Trusting the Process

When I first began treatment, I can say with 100% honesty and certainty that I was very skeptical. I was down-playing the severity of my eating disorder to myself and was convinced I didn't really need help. Once I met with my dietitian and therapist, I allowed myself to consider the option that: "hey, maybe they can help me, and maybe I do need help"? From day one, I placed my trust into the hands of BANA; I allowed every suggestion, every tool, every activity a chance. I became honest with myself, my friends and my family. I pushed myself out of my comfort zone, and most importantly, I kept showing up.

Loving Myself

My eating disorder - like many others - not only affected my physical appearance, but predominantly impacted my self-worth. The most important lesson I've learned through BANA was learning how to love myself unconditionally. Cheesy... I know (LOL). But truly, the biggest change I made that to this day keeps me grounded is choosing to love myself. Sounds simple doesn't it? Simple and easy, however, are not the same. A simple concept, yet one of the hardest things I have ever done and continue to do daily.

Learning to love yourself doesn't happen overnight. It takes consistent and intentional positive self-talk, reflection, patience, and honesty with yourself and those around you. If it wasn't for BANA, I'm not sure what my relationship with myself would look like today. For me, self-love includes accepting my body for where it's at and appreciating what my body does for me. It's about putting my happiness and wellbeing first.

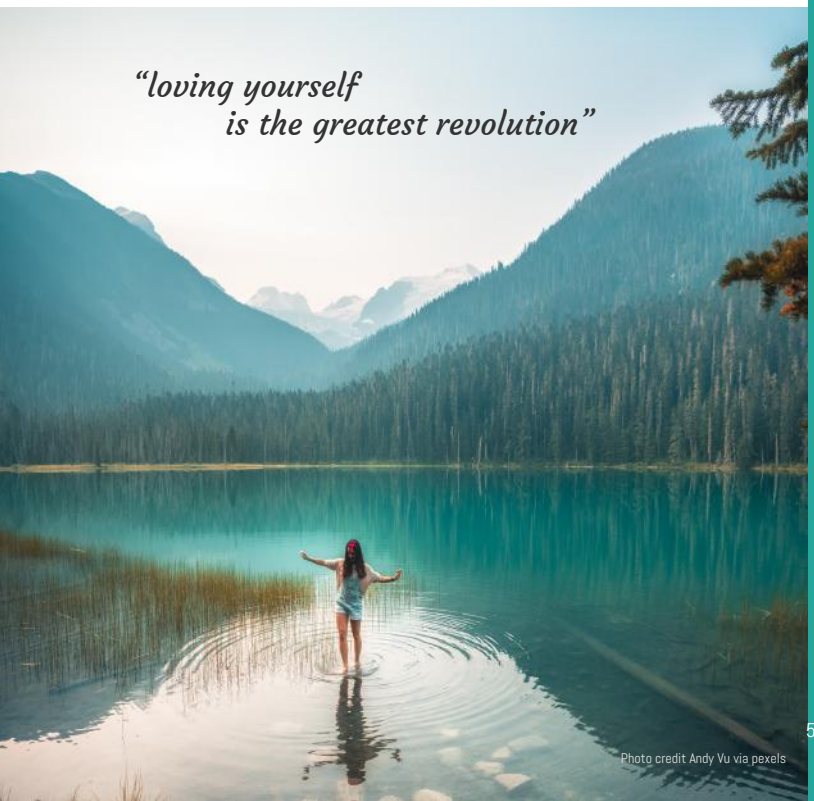
This includes saying "no" more often, rather than sacrificing my well-being to appease others, and recognizing when I need a break or am feeling overwhelmed. Self-love means moving my body in ways I enjoy and that make me feel good, and fueling myself properly so I can be the best version of myself. Now, when I look in the mirror, I see more than the person standing in front of me. I no longer only focus on the things I wish I could change, or don't like about myself. Instead, I see a strong, confident, smart, beautiful, kind woman. I see someone who is happy, who listens to her body, who seeks help when she needs it, and who has the energy to give back. This is something I wish for everyone to experience.

Maintaining

Although I have come a long way in my eating disorder recovery and journey to self-love, it is just that... a journey. Each day I need to remind myself that it takes work to be in a healthy relationship with yourself. It takes a support system that is there for you for the good, and more importantly, the bad. There will be set backs, as there is with anything in life, but the important thing is that you continue to show up. Lucky for me,

I have amazing friends and a loving family that stood by me and continue to support me. I have chosen to follow social media influencers that are educated, qualified and promote body acceptance and balance. BANA provided me the education, the tools, and the support to grow, and to continue growing on my own. I now have the necessary tools to practice gratitude, self-awareness, acceptance and above all- prioritizing my well-being and happiness.

I currently work as a Registered Nurse in mental health. My experiences have empowered and inspired me to use what I have learned and continue to learn, to help others. I hope that my story will inspire you, no matter where you're currently at, to put your own well-being first. To put your happiness first; to not feel guilty or afraid to ask for help; and above all else: to love yourself.



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5 Things You Can Do to Love Your Body More

By Stephani Fenkanyn, CNIP, MSC (OT)

1) Focus on what your body does for you.

Without our beautiful bodies, we wouldn't be able to experience all we are able to in the world! Shifting your focus to the abilities of our body sheds light onto how wonderful they really are. For me, I love my strong legs that allow me to go for jogs along the water. For another, it might be the body that brought her children into the world. For another, it might be mobile arms that help him go for swims in the ocean.

Can you name 2 things you love about your body because of what they do for you?

2) Engage in movement to feel good (not to lose weight)

What type of movement lights you up inside? What do you find fun and makes you loose track of time? Maybe its jumping rope for you, or dancing to your favourite song. It could be a nice, juicy stretch session, trying out new yoga poses, or meeting your friends to toss the ball around at the park. A walk after dinner with a family member might make one feel at peace or for someone else a sweaty hike on a beautiful day has a positive effect on their mood.

Make your choice of movement something you enjoy doing rather than focusing on burning calories. This makes you more likely to engage in movement daily and it cultivates a more positive and beneficial relationship with exercise.

3) Honour your hunger and fullness.

Our bodies are smart. They know exactly what we need. Practice intuitive eating principles by tuning in to the body to assess how hungry or full you are. You can do this before, during and after your meals. To get into this habit, keep a note of this in a journal and rate your hunger and fullness on a scale from 1-10 at each of these times.

4) Seek out positive role models that look like you

What we see in the media is inundated with what is called the 'thin ideal', but the reality is, most people in our population don't look like this! A study found that only 5% of the general population have the body of the typical model seen in the media. This is why you need to be decisive and selective with what you are exposed to most frequently. Seek of role models that look like you and you can relate to. Bodies come in all shapes and sizes and representation of them matters!

5) Stop focusing on the numbers

The scale doesn't give us a full picture of our overall health. Weight science literature tells us that there are way more considerations that come into play in determining our weight, such as genetics, hormone health, access to food and the environments we are brought up in.

Reminder: You do not have to start doing all of these at once. Pick 2 and try to integrate these practices into your daily life to start and keep track of how you're doing.

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

Stephani Fenkanyn is a Health Educator at the Bulimia Anorexia Nervosa Association (BANA)

BE YOURSELF

HEALTHY. HAPPY. HOPEFUL.

The Podcast

Hosted By:
Stephani Fenkanyn
BANA Health Educator

Andrea Dinardo, Ph.D
Psychology Professor, TEDx Speaker, and former school Psychologist

Thriving Under Pressure & Turning Self-Criticism into Self-Compassion

Ary Maharaj, M.Ed. RP (Qualifying)
Outreach & Education Coordinator
National Eating Disorder Information Centre

Raising Awareness and Encouraging Advocacy

Marisa Casey, B.Ed,
Health Educator
Bulimia Anorexia Nervosa Association

Managing an Eating Disorder During the Holiday Season

Frank Renaud
Former UWindsor/CFL footballer and mental health advocate

Viewing Mental Health from a New Perspective

Sara Dalyrmple, MSW, RSW
Clinical Therapist
Bulimia Anorexia Nervosa Association

Learning About Eating Disorder Treatment at BANA

Sarah Berneche
New Author, anti-diet Registered Holistic Nutritionist® and Certified Intuitive Eating (IE) Counsellor

Exploring Intuitive Eating, Disordered Eating and Enjoying It All

Noelle Montcalm
2016 Olympian, Registered Nurse and Mental Health Advocate

An athlete's perspective on caring for your mental health during life transitions.

Carly Deslippe
Yoga Teacher, Reflexologist and Reiki Practitioner

Using Movement, Gratitude and Being Aware of Your Energy to Enhance Your Mental Health

Sierra Parr
Founder and Host
Lemon Soul Studios and Podcast

Being Real & Raw Online and Embracing the Sour Parts of Life

Jenny-Lee Almeida
Mental Health Educator
Canadian Mental Health Association

Canadian Mental Health Association
Windsor-Essex County
Empowering transitions to wellness

Mental Health Challenges during COVID-19

Mackenzie Kovaliv
Mental Health Worker
Owner, Veg Out Windsor

Being a Positive Influencer for Today's Youth

Christine Hamel-Fuerth
Physical Education Teacher
Guidance Counsellor, Coach and Mother

Supporting girls through healthy active living

Chris Rwabukamba
Ex-CFLer, Entrepreneur, Coach and co-creator of Change the Game

Male Athletes, Masculinity & Role Modelling

Marisa Casey, B.Ed,
Health Educator
Bulimia Anorexia Nervosa Association

Promoting Positive Body Image In Our Community

Dianne Bondy
Author, Activist and Inclusive Yoga Instructor

Learning To Love Your Body

Sara Santarossa
University of Windsor
Ph.D student

Media for Moms & Daughters

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WHAT IF YOU WERE NEVER TOLD THAT THIN WAS BETTER?

By: Marisa Casey, BA BEd MCL Sc,

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Imagine how much mental space would be freed up if we did not walk through life with this idea that: "thinner is better", or "thinner is healthier".

Imagine:

Waking up in the morning and picking an outfit without thinking – "How does my butt look in these pants?"

Grocery shopping without reading food labels, or debating between "normal" and "low fat" option.

stop waiting to wear those shorts you are saving for when you "get to your goal weight."

If you worked out because you loved your body, not because you ate fast food last night

You looked at a photo of yourself and were amazed at the beautiful person you saw, regardless of your weight, shape and size

The above examples reflect the overwhelming messaging and pressures of diet culture. Some would argue that diet culture doesn't exist anymore, or that in today's day-and-age everyone knows diets don't work and the average citizen is more concerned with health and wellness than thinness.

It may be surprising to some, but for most of human existence no one dreamed of restricting their food intake to lose weight. Getting enough food was the main concern, and higher weights signified prosperity and well being. Fat on the body meant higher social status, a better chance of weathering famine and disease, and a greater likelihood of fertility. Thinness meant poverty, illness and death.

Fast forward to present day, it is apparent that western culture supports a diet culture. This way of thinking about food and bodies is so embedded in the fabric of our society, in so many different forms, that it can be hard to recognize. It often masquerades as health, change in lifestyle, wellness, and fitness.

By and large diet culture is a system of beliefs that equates thinness, muscularity and particular body shapes with health and moral virtue. It promotes weight loss and body reshaping as a means of attaining higher status and self-worth; demonizes certain foods and food groups while elevating others; and dismisses people who don't match its supposed picture of health.

Diet culture often associates food with character, morality, and guilt. Society often praises individuals for having self control, discipline, or willpower if they can stick to a highly restrictive or prescribed diet. Additionally, if you take a moment to look you'll start to notice that food labels are about fear. They try to make food safe or unsafe, or demonize food when the truth is all foods fit. Labels also often try to link certain foods with shame, guilt and self worth – think about the term "guilt-free". What we see in the eating disorder world is that these forbidden foods of today are the binge foods of tomorrow.

Diet culture makes us think that our body size is flexible and easily changed. Go into a grocery store and read any of the magazine covers. One, if not many of them, will be touting a new diet or how to lose X-amount of weight. The problem with this type of media is that it reinforces the idea that body shape and size is easy to control and manipulate. The reality is our body's "set point" weight is the non-dieting number on the scale that your weight naturally hovers around, give or take a few pounds. It is normal for our weight to fluctuate on either side of a set point. If we drive our bodies way outside of those boundaries, our bodies will fight to bring us back closer to our set point. However, this is not the message that the media would have us believe.

Diet culture teaches us to ignore our body's cues – just think of phrases like "no pain, no gain". Dieting and fitness messaging is frequently associated with will power and emotions. Often linking a smaller body size with more determination or an ability to push our bodies to the absolute maximum. This raises an important question around the relationship with exercise, and our motives behind it. Instead of punishing ourselves and our bodies for eating or not eating something, we should instead move towards the idea of doing exercise because it is good for our bodies as well as our mental health.

These ideas may cause some internal conflict or force you to challenge your beliefs, however, once you see diet culture it is hard to unsee it.

It is important to recognize that diet culture is a form of oppression, and dismantling it is essential for creating a world that's just and peaceful for people in ALL bodies.

How to identify and move away from diet culture:

1. Clean up your social media feeds. Unfollow anyone who makes you feel like you're not doing enough or who shares diet culture messages.

2. Reject diet culture – change the language you use around food, bodies and health. Use the check-in question: "Would I say this to a friend?" before you say or think something to yourself. Recognizing internalized weight bias in ourselves is an important first step.

3. Find a community and support system. Unlearning diet culture and relearning how to nourish and treat your body from a place of respect is hard work! Luckily, you don't have to do it alone.

Marisa Casey is a Health Educator at the Bulimia Anorexia Nervosa Association (BANA)

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

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Getting to know Binge Eating Disorder

***** 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.**

Binge Eating Disorder (BED) is an eating disorder that is quite often overlooked and misunderstood. Interestingly, prior to the year 2013, BED was not distinguished as its own diagnosis in any diagnostic manuals – it was considered as a "feature" within the "Eating Disorder Not Otherwise Specified (EDNOS)" diagnostic category. Many did not consider it to be an eating disorder, specifically due to the misconceptions surrounding control.

We often see clients who have received this diagnosis act in surprise, as they had "no idea" what they were experiencing was a mental health disorder, and have reportedly felt alone, ostracized, and full of self-blame.

Many of these individuals' symptoms have been historically misjudged, or attributed to laziness or "fatness". Receiving the diagnosis provided some of our clients with validation – their struggle was finally acknowledged, what they are going through is empirically supported, and they are not alone in these experiences.

DSM-5 CRITERIA FOR BINGE EATING DISORDER

a. The individual is experiencing recurring episodes of binge eating; binge eating is characterized by the following:

• Eating an amount of food that is definitely larger than what most individuals would eat in a similar period time under similar circumstances; this is done within a discrete period of time, typically within a 2-hour period

• There is a sense of lack of control over eating during the episode; feelings of being unable to stop or control how much one is eating

b. The binge-episodes are associated with 3 or more of the following:

• Eating much more rapidly than usual
• Eating until uncomfortably full
• Eating large amounts even when not physically hungry
• Eating alone due to feeling embarrassed over how much one is eating
• Feeling guilty, depressed, or disgusted with oneself

c. Experiencing marked distress regarding binge eating being present

d. The binge eating occurs at least once a week (on average) for 3 months

e. The binge eating is not associated with recurrent use of inappropriate compensatory behaviours (as in Bulimia Nervosa), and does not occur during the course of Bulimia Nervosa or Anorexia Nervosa

Severity Ratings: based on the frequency of binge episodes

Mild = average of 1-3 binge eating episodes/week
Moderate = average of 4-7 binge eating episodes/week
Severe = average of 8-13 binge eating episodes/week
Extreme = average of 14 or more binge eating episodes/week

BINGING VS. OVEREATING

Often at BANA, we hear some confusion surrounding what constitutes a binge. For diagnosis, it is required that the portion size is objectively large, meaning most people would agree that is too much food to have within a given period of time. However, some people experience subjective binges, where not everyone agrees that the portion meets criteria but it is larger than what that individual typically eats.

In the case of subjective binges, the individual themselves feel out of control despite portions not being excessive. Beyond objective and subjective binges, there is overeating. Overeating may only be slightly more food than what is typical; however, the individual may not feel out of control. Overeating is a relatively normal behaviour, as most of us likely overeat from time-to-time.

Below is a small chart that can help outline these differences

Type:	Portion:	Control:
Objective Binge	Definitely Large	Out of Control
Subjective Binge	Not Agreeably Large	Out of Control
Overeating	Not Agreeably Large	In Control

THE CONTROL MYTH

"Just stop eating" or "just practice self-control" – some examples of comments we frequently hear directed towards those struggling with BED. The underlying implications behind comments like these is that control is easily accessible to individuals with BED.

However, as clearly stated within the DSM-5, the sense of lack-of-control is a symptom of this disorder; therefore, it is not as simple as flicking "on" the control switch. It is much more complex.

The myths regarding control imply that recovery from BED is as "simple" as resolving problematic eating (we use quotations here, because resolving disordered eating can be challenging in and of itself). However, treatment for BED goes beyond regulating ones eating patterns – it also considers emotions and events that can trigger episodes of binge eating, as well as types of food-labelling that have been linked to the disorder and its symptoms.

Research has shown that one of the most frequent causes of binge eating is undereating, due to the physiological and psychological deprivation that can come from restricting, fasting or dieting. We see this at BANA, as many of our clients with BED have a long history of attempting to control their chaotic eating with dieting and/or restrictive measures.

If lack-of-control was truly the factor responsible for binge eating, then we would not see individuals' binge as a result of troublesome emotions /events, or undereating; however, we see this every day.

Comments that undermine control can be very damaging to individuals with BED. They subjectively experience this sense of loss of control, yet most people around them tend to assume that this condition is self-induced and easy to stop. Most of the time, these individuals know they are eating more than what is recommended, and do not need to be reminded of this regularly. In other words, they likely know what the problem is but do not know how to solve it. These conflicting messages are often internalized, causing those with BED to believe there is something inherently "wrong" with them for not being able to "just stop". This internal and external blame-game can be defeating, and cause feelings of depression and hopelessness. As mentioned above, these individuals may turn to food to cope with distress, thereby contributing to the cycle of the disorder.

A NOTE ABOUT WEIGHT STIGMA

One major misconception about BED is that those who have the diagnosis are all "overweight or obese". This is not the case; individuals with BED are of all weights, shapes and sizes. This misconception could be partly attributable to those who meet criteria of the disorder but are not of above-average weight could be "missed" by professionals or the individual themselves. Being overweight is often seen as a "marker", despite this not actually being a diagnostic criterion.

Individuals with BED can face significant weight stigma; beyond individual and social-level stigma, a great deal of stigma is also systematic/institutional. For example, not being able to fit in airplane seats or wheelchairs, or not being able to find clothing that fits (or have a variety to choose from), are often seen as the individual's problem, rather than something businesses/industries should solve. Although there are measures that the individuals can take themselves (such as attending specialized eating disorder treatment programs), there are also countless measures that could be taken on a grander scale so that these individuals do not face further ostracization and discrimination. *Recall: attempts to lose weight – particularly dieting/restricting, weight-loss programs or procedures - can actually reinforce the disorder, rather than resolve it.

One potential step that could be taken is the education and training of professionals in the medical field regarding BED, symptoms and their perspective causes, and weight-stigma. Many clients disclose that when they visit their doctors, other concerns are not taken seriously because they have "not lost weight yet" – so long as they are still overweight, they will not be sent for further testing or considered for alternative treatments. Of course, we do not dispute that being overweight can present with health risks; however, we argue that not everyone who is overweight is facing or ever will face these health problems. More simply put: just because someone is above-average weight does not mean they are unhealthy.

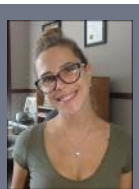
OVERVIEW

BED is an eating disorder that receives a lot of criticism from the general public, and is often met with fat-shaming and pushing for weight-loss. We believe it is important for those who work in fields related to health and wellness to be educated on BED, as to minimize the risk of triggering or shaming this population.

Note: Because BANA was established in 1983, and due to the fact that BED was not officially considered its own diagnosis until 2013, our title "Bulimia Anorexia Nervosa Association" did not include this diagnosis. However, we still incorporate treatment of BED within our services and programs.

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

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

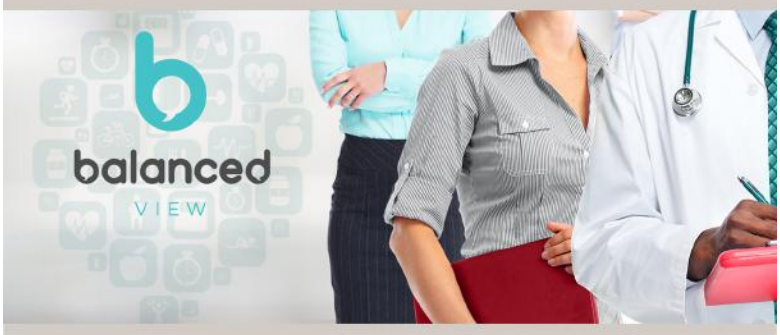


Did you know...

as of March 2021, **34%** of BANA clients had Binge Eating Disorder

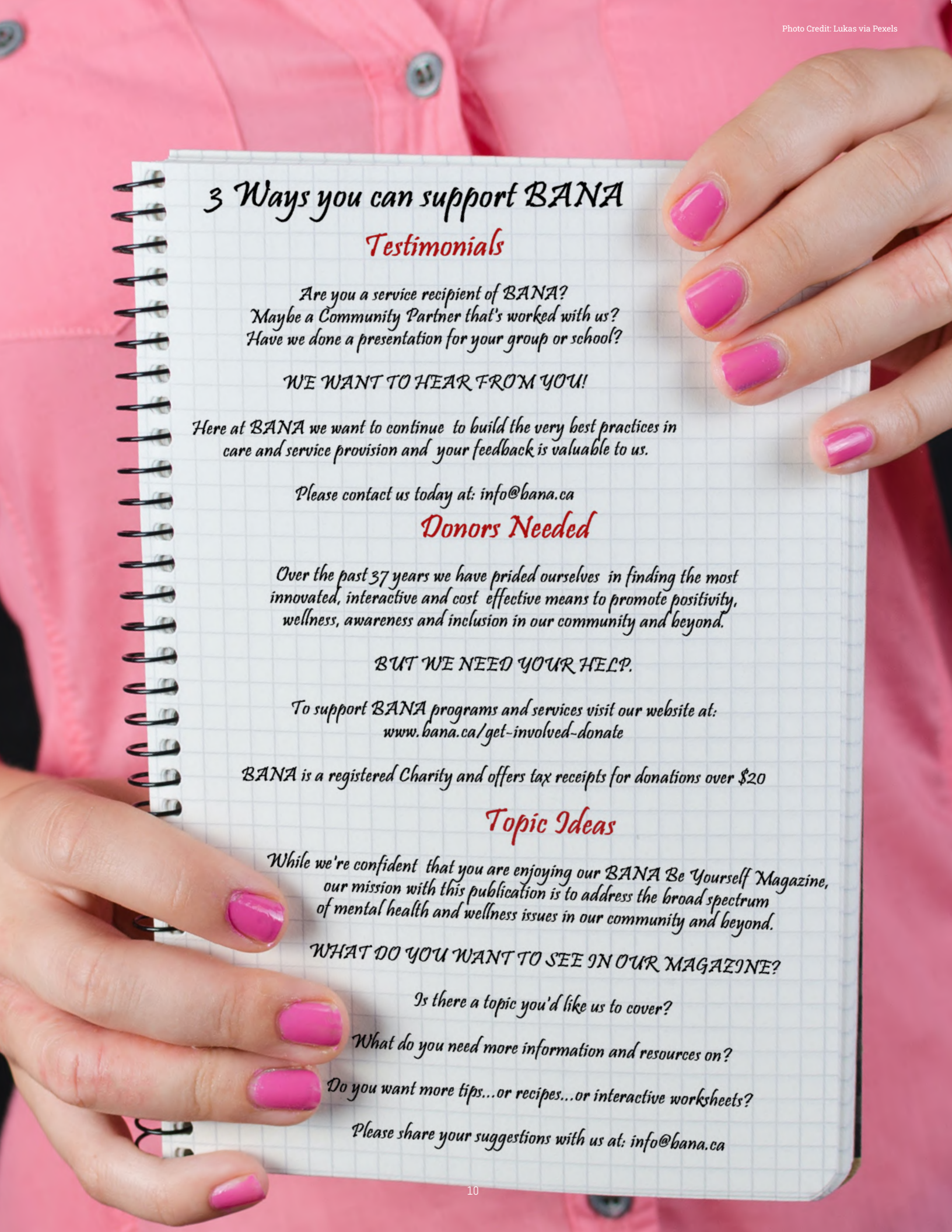
Causes of Binge Eating

- Genetic and Biological causes
- Comorbid mental health concerns *(depression, anxiety, susbtance abuse, trauma)*
- History of weight stigma
- Frequent or restrictive dieting
- Negatively Labelling foods *(bad, junk, etc.)*



To learn more about reducing weight bias and stigma in health care settings, **Balanced View** offers a FREE online course:

Visit: wwww.balancedview.bc.ca



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While we're confident that you are enjoying our BANA Be Yourself Magazine, our mission with this publication is to address the broad spectrum of mental health and wellness issues in our community and beyond.

WHAT DO YOU WANT TO SEE IN OUR MAGAZINE?

Is there a topic you'd like us to cover?

What do you need more information and resources on?

Do you want more tips...or recipes...or interactive worksheets?

Please share your suggestions with us at: info@bana.ca

An Invitation to Join the Levine Prevention/Sociocultural Factors Email Community

by Michael P. Levine, Ph.D., FAED MSW BA Psych.

From 1979 until my retirement in 2012 I was a Psychology professor at Kenyon College in rural Ohio. And through a set of coincidences that were either luck or fate, in mid-1983 I stumbled into the prevention of eating disorders (EDs), even though my Ph.D. was in personality psychology and until mid-1983 the one thing I had learned about anorexia nervosa from abnormal psychology textbooks was totally wrong ("It's a rare disorder and might not even exist"), and I had never heard of bulimia nervosa.

And by 1998 I was fortunate to be co-editing a prevention book with distinguished Canadian prevention expert Dr. Niva Piran and a number of contributors, including Dr. Lori Irving, a passionate, charismatic young researcher who had recovered from anorexia nervosa and was engaged in prevention studies and advocacy work in southwestern Washington state.

And I was conducting prevention and risk factor research with my feminist Kenyon colleagues and gifted researchers, Dr. Linda Smolak and Dr. Sarah Murnen. And I was on the Board of Eating Disorders Awareness & Prevention (EDAP), a forerunner of the National Eating Disorders Association, serving with trend-setting ED experts and community advocates such as Dr. Margo Maine (Connecticut), Ms. Mary Pabst (LCSW; Maryland), and Dr. Brenda Sigall (Maryland).

And in the late 1990s, the field of EDs prevention was small, fragmented, and marginalized. At conferences and in print, many leaders in the recognized EDs subfields considered prevention a luxury awaiting clarification of risk factors and refinement of treatment.

Some even regarded prevention as a naïve, misguided waste of the minimal resources allocated to the EDs field and a potentially harmful source of unhealthy weight management information.

Moreover, throughout the 1980s and 1990s the impetus (including passion) for prevention blossomed from the mounting evidence for the role of sociocultural factors, including sexual objectification and the construction of gender roles, in promoting the spectrum of negative body image, disordered eating, and EDs. This created resistance from those who feared feminists, as well as from those who could not see past the "bio" in the complex meanings of an "biopsychosocial illness".

And in the late 1990s a communications phenomenon became readily available to our small band of advocates for prevention. it was called "email." It is hard to remember that, following the lead of AOL.com in 1993, Hotmail.com launched in 1996 and Yahoo.com in 1997. Indeed, it is impossible now to recall how transformative email once was.

And in 1998 I began sending my prevention-oriented colleagues 4 or 5 emails per month—amazingly, you could simultaneously send more than one person the same email—about recent publications pertaining to prevention, such as the rare outcome study or research on risk factors with implications for prevention. And, thus, was born the awkwardly named Levine Prevention/Sociocultural Factors email Group (LPEG).

The eight original members (1 in Canada, 7 in the USA) were myself and the 7 professionals in bold above sophistication to prevention as a translational science.

If I had known how long the LPEG would last, that the group would become something of an international community, and how it all would influence my life, I would have paid more attention to its development. I do know that, as of mid-April 2021, this email list, now powered by MailChimp's TinyLetter platform, consists of 1000 people in 47 countries.

And I do know also that, for prevention and to some extent for me, everything changed significantly at the end of the 20th century and the beginning of the 21st (Levine & Smolak, 2021). Five people entered my personal, professional, and political (advocacy) life. And more importantly, they began to publish (in journals and edited volumes) and to present (at conferences) research that transformed the nature and status of EDs prevention.

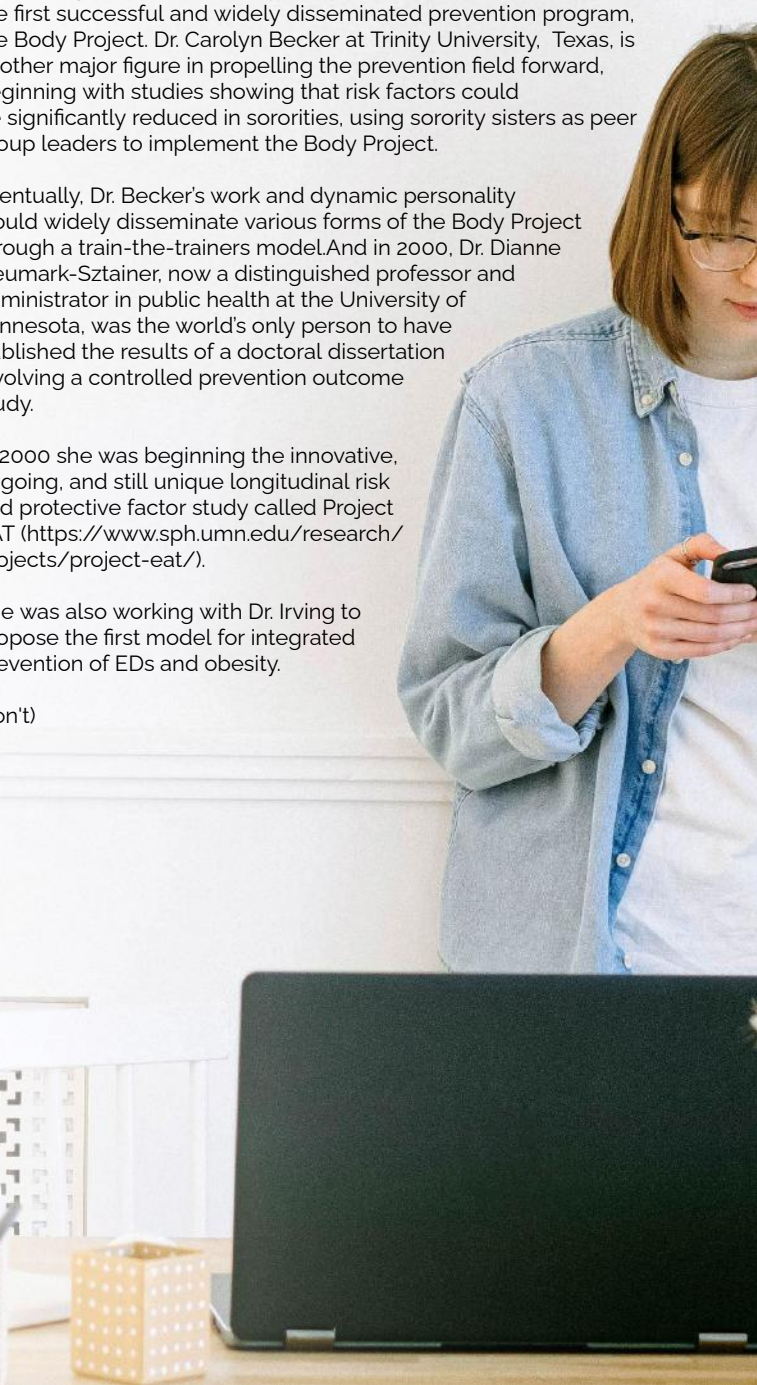
Dr. Eric Stice (now at Stanford University) is a clinical scientist who had contributed significantly to risk factors research in the 1990s. In the early 2000s he was beginning to develop what would become the first successful and widely disseminated prevention program, the Body Project. Dr. Carolyn Becker at Trinity University, Texas, is another major figure in propelling the prevention field forward, beginning with studies showing that risk factors could be significantly reduced in sororities, using sorority sisters as peer group leaders to implement the Body Project.

Eventually, Dr. Becker's work and dynamic personality would widely disseminate various forms of the Body Project through a train-the-trainers model.And in 2000, Dr. Dianne Neumark-Sztainer, now a distinguished professor and administrator in public health at the University of Minnesota, was the world's only person to have published the results of a doctoral dissertation involving a controlled prevention outcome study.

In 2000 she was beginning the innovative, ongoing, and still unique longitudinal risk and protective factor study called Project EAT (https://www.sph.umn.edu/research/projects/project-eat/).

She was also working with Dr. Irving to propose the first model for integrated prevention of EDs and obesity.

(con't)



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And, given my narrow academic background, until I met Dr. Neumark-Sztainer I actually did not know "public health" was a discipline and a profession. And it was not until I began reading studies by Harvard's Dr. S. Bryn Austin that I fully understood that prevention has always been the "sine qua non" of public health—and that the spectrum of body dissatisfaction and disordered eating is a major issue for public health. As an epidemiologist, a prevention specialist, and a prolific, versatile researcher, Dr. Austin brought sophistication to prevention as a translational science. She has also widened the scope of research and advocacy, with special emphasis on populations that had been excluded from attention in our work. One outcome of Dr. Austin's research skills, advocacy, and leadership is her founding and ongoing direction of the world's only institute dedicated to the field: Harvard's Strategic Initiative for the Prevention of Eating Disorders (STRIPED; https://www.hsph.harvard.edu/striped/).

And in 1999 Dr. Piran introduced me to Dr. Gail McVey (Canada), who was then forging connections to support her development from risk factor researcher to prevention researcher and advocate. Another dynamic leader, throughout the 2000s Dr. McVey would become the world's foremost expert on integrating prevention research, coalition building and professional development for mental health practitioners, and governmental advocacy —all in the process of integrating various forms of in-person and online EDs prevention with early identification and treatment.

Currently, Dr. McVey is the only person in the world working directly with a state or provincial government (Ontario) to co-ordinate multi-region prevention programming and treatment services through collaborations with professionals in psychology, public health, medicine (including nursing), dietetics, mental health, education, and non-profit advocacy/support organizations (including BANA).

A*nd*, after 38 years, I remain amazed and humbled that such people are members of my TinyLetter Group. And, after all these years, the growth of the LPEG, particularly in the past 5 years (~800 people have joined), and the high quality of the increasing number worldwide of new and mid-career researchers, advocates, and leaders have given me a broader, deeper, and brighter sense of the future of prevention that I could have ever imagined. And, although Dr. Irving, who died suddenly in 2001, did not live to see prevention flourish over the past 15 years, those newer leaders—along with the surviving founding members, Drs. Neumark-Sztainer, Carolyn Becker, S. Bryn Austin, and Gail McVey, and scores of others in the LPEG—are embodying and enacting her Bolder Model of personal-professional-political advocacy in prevention (Irving, 1999). And, benefiting from mentoring by the first two Bolder Models, Drs. Maine and Piran, I have (finally) realized that the Levine Prevention/Sociocultural Factors Email Community is one way of expressing my personal-professional-political conviction that two principles are fundamental to prevention.

First, prevention is more likely to be successful when it builds on and fosters the 7 Cs: Consciousness-raising, Competence, Connections, Change, Choices, Confidence, and Courage. Second, prevention is more likely to succeed when it builds on, encourages, and represents authentic collaborations (connections) between different types of people. In this regard, it took me far too long to grasp what was developing right in front of me. My prevention talks have always emphasized that "prevention is about us and our cultures."

Nevertheless, it took the expanding membership of the LPEG to show me in concrete terms that the "we" framing prevention involves (in alphabetical order): academic researchers, activists and advocates, anthropologists, artists, caretakers, CEOs of non-profit organizations (including BANA), clinical psychologists, communications experts, dietitians, educators, economists, emergency room physicians, feminist fashion designers, graduate students, health educators, high school students, internal medicine specialists, journalists, lawyers, media literacy experts, neuroscientists, nurses, occupational therapists, public health researchers, psychiatrists, recovered people, reference librarians, social workers, sociologists, teachers, trainers/coaches, undergraduate students, writers, and yoga instructors (to name a few).

If you are interested in joining the free (no cost) Levine Prevention/Sociocultural Factors email Group, or receiving more information about this community, please email me at levine@kenyon.edu.

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

Michael P. Levine, Ph.D., is Emeritus Professor of Psychology at Kenyon College in Gambier, Ohio, where he taught from 1979 through 2012.

A Fellow of the Academy for Eating Disorders, he has written or co-edited six books on prevention and three prevention curriculum guides.

Email: levine@kenyon.edu


Michael Levine with close friend, noted eating disorders expert, and Bolder Model Dr. Margo Maine

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PANDEMIC HUGS

"When this is all over, I'm going to give you a great big hug."

Why wait?

There is no doubt that the pandemic has been filled with many struggles, frustrations, fears and uncertainties. Yet, another vital predicament coinciding with the pandemic is the destructive narrative running rampant in both our minds and our bodies.

For example, in the very beginning of the pandemic we were given terms like social distancing and self isolation. These had a very real impact on the way we handled the pandemic right from the start. Many of us internalized these terms immediately and started believing that we were experiencing both the social distancing and the self isolation simply because of the narrative we were being fed rather than because of any changes actually happening to our current lifestyle.

We felt like we were being socially distanced from the world, when in fact we were given an opportunity to connect even more with people because we had more time; more people were online; and many of us now had a shared experience to connect through.

We were also told that it wasn't safe to hug anymore. Almost instantly memes and gifs were flooding our social media pages, reminding us how sad it was that we couldn't hug. Even people that never liked hugging before during the pre-Covid days suddenly felt a real sense of loss from not being able to hug others. It's another prime example of us internalizing a narrative that feeds on our human need for connection and love. This is all perception of what we choose to hold true for ourselves – are we separated, or are we facing an opportunity for connection?

If we think about it, this is the way we run most of our lives. Many of us don't take the time to stop and think about what's really true for us. We just move through our days reacting to life, accepting our subconscious and subjective narratives as reality. So, if it's true that we fell into feelings of loneliness and separation because we believed we were separated, wouldn't it also be true that we could feel connected and together if we believed we were?

Sometimes it's easier said than done to shift a narrative, especially globally accepted stories like those associated with Covid. However, it does hold the logic that this could happen if we re-framed our immediate world differently. This is an active choice we all get to make.

For instance, I believe hugs are much greater than the quick embrace we typically associate with the word. If we can start looking at hugs in a broader sense, such as an expression of connection or a way to show compassion to ourselves and others - then we may start sharing more hugs and grow our feelings of connection and togetherness, despite the pandemic rules of physical (not social) distancing.

The Quick Science of Hugs

Hugging is as vital to our health and our well-being as proper diet and exercise. When we receive a hug from someone, we put pressure on our skin, which is full of pressure receptors (called the Pacinian or Lamellar corpuscles). These receptors are basically nerve endings that detect vibration and pressure on our skin then send messages to our brain, specifically to the Vagus nerve in our brain.

The Vagus Nerve controls many things, including our heart, lungs and digestive tract, as well as regulates hormones that influence emotions like depression and anxiety. Stimulation of this Vagus nerve triggers an increase in the release of feel-good hormones in the brain like oxytocin, which is considered the love hormone. That's why we feel supported and loved, and create bonds with one another when we hug.

Photo Credit budgeron-bach via Pexels

Once the Vagus nerve has been stimulated, there are many other health advantages you can gain from these increased levels of Oxytocin, such as:

- lowered blood pressure
- lower levels of cortisol or the stress hormone.
- lessened anxiety … tension … even depression.
- We can gain a better capacity to tolerate perceived pain
- We can improve our immune system, which can help prevent illness and aid in the healing of wounds and even the common cold.

Photo Credit: Anna Shvets via Pexels

Mental Hugs

I like to think of hugs in two different ways: physical and mental. Although during the pandemic we've had to limit our physical hugs, it affords us the opportunity to participate more in mental hugs. These are in the form of basic humanity that entails practicing kindness and compassion with everyone around us, including ourselves. This can be done by giving compliments, helping a stranger or even just smiling while making eye contact with others.

Studies show that practicing these mental hugs and spreading kindness also releases Oxytocin to your brain, allowing you to experience those amazing health benefits!!

So, let's talk about a few ways we can start implementing mental hugs into our daily life.

Zoom Hugs

You can give people a hug remotely during your video chats. This is somewhat of a hybrid between a physical and mental hug. Simply ask the people in the room to take their right hand and put it on their left shoulder (you would do this at the same time). Then take your left hand and put it on your right shoulder! Then squeeze! Smile while you are doing this, and make sure that everyone is physically doing it to themselves. If they feel silly and aren't participating, encourage everyone to join along. This will allow them to get those pressure receptors activated and will build connections between you and the rest of the people in the virtual room.

Curate Your Social Media

There was a really cool series of studies, performed by a Behavioural Psychologist at Harvard, called The Mother Teresa Effect. Basically, they had students watch a film of Mother Teresa performing random acts of kindness. They checked their levels of Immunoglobulin A - a key factor of our immune system - before and after the film. The result was a significant rise in this antibody after watching the documentary, which suggests that by merely watching and thinking about love and kindness you can potentially strengthen your immune system. By curating your social media to only be following feel-good accounts, your feed will naturally be filled with uplifting videos, positive photos and stories of love and kindness.

Connect with People Out in Public

There has been frustration that you can't see people's emotions anymore with the masks, but this simply isn't true. There is more to a laugh or scowl than simply what our mouth does. In order to notice these changes we need to get more comfortable with making eye contact with others. Lack of eye-contact and unfriendly interactions were complaints that we had pre-pandemic, that we are now able to work on and improve upon during the pandemic.

Self-Compassion

There is a lot of talk about self-care and self-love. These are all forms of mental hugs that we can participate in, but self-compassion is vital, especially during stressful times like what we are all experiencing right now. Self-compassion is the act of being kind, gentle and understanding with ourselves when we experience pain, failure, and all that it means to be an imperfect human. Self-compassion is the same as the compassion which we would give to a dear friend or family member that was going through a difficult time, only given to ourselves instead. Unfortunately, many of us don't give ourselves the same comfort. Instead, we self-criticize or completely ignore the pain and suffering altogether.

Loving Kindness Meditation

A great way to improve self-compassion as well as compassion for others, and to help activate the Vagus nerve, is to participate in Loving Kindness Meditation (LKM). This is a mental hug that may feel difficult and awkward in the beginning, but will become an enjoyable practice the longer you commit to it. It is basically a form of meditation where you focus your intentions toward thinking loving and kind thoughts about yourself. You do this by repeating some loving phrases while keeping an image of yourself currently or as a child inside your mind. As you progress through the practice you can start focusing your attention on kind and loving thoughts toward others, including more difficult people in your life.

I truly believe that Love is contagious, so I challenge each of us to practice mental hugs every day with everyone we meet in hopes of creating a loving, peaceful and kind community that will then spread to the world around us. Hugs really are a four-letter word that could change our world. Are you ready to be part of that movement? I know I am!

Big hugs,

Leigh Ann Hello

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

Over the last 20 years, Leigh Ann Hello has given thousands of hours in the way of mentorship, speaking at local and international events, facilitating many masterminds and book clubs and I presented on the TedX red carpet to on the topics of Hugs. She is also the founder of **www.bethehugger.com** and co-host of the First Day Pod (podcast) where she shares honestly with their guests and live audience each week in the hope to educates through shared wisdom, education and empowerment. You can contact Leigh Ann though the following mediums:

@bethehugger **@bethehugger** **@bethehugger** **Apple Podcast**

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Radically Open Dialectical Behaviour Therapy: Targeting Emotional Overcontrol to Bolster Eating Disorder Treatment

By Dr. Anita Federici, CPsych, FAED

Why is it that some people struggle so much to manage their emotions while others seem to never feel them?

Why do some fight with urges and impulses and others seem so rigid and overcontrolled? And can these differences help us understand the development and maintenance of eating disorders?

This article reviews the background and application of Radically Open Dialectical Behaviour Therapy (RO-DBT) for eating disorder treatment.

Over my career, I have studied the evolution of theories regarding eating disorders (EDs): why they develop, their unique functions, and how best to treat them. CBT-E and FBT are considered front-line treatments and many ED treatment settings are designed around these particular theories and interventions. While many are greatly helped, there remain large proportions of patients who do not respond adequately to standard treatment approaches (Marino et al., 2020; Reilly et al., 2020).

In my experience, many individuals report feeling that standard programs have not been a good fit and lacked attention or understanding to emotional regulation difficulties and co-occurring symptoms (e.g., trauma, suicide, self-injury, substance use). When they have sought treatment from non-ED providers they are either not appropriate due to the ED or find that treatment helps in some ways but the ED remains intact.

Thus, they cycle through the system, only to perpetually "fall between the cracks", seemingly unable to fit anywhere.

We can better understand treatment responses by integrating our growing knowledge of the neurobiological and bio-temperamental mechanisms that underlie eating disorders. Neurobiology refers to the way our nervous system subconsciously acts to control our behaviour. Bio-temperament refers to the biologically-based characteristics that determine, not just our nature and personality, but also the way we perceive and regulate emotions.

Notably, researchers have discovered that there are important biological differences in emotion regulation and self-control tendencies among those with an eating disorder (Baudinet et al., 2020; Ben-Porath et al., 2020).

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Standard DBT, now widely used in the treatment of eating disorders, is an evidence treatment focused on helping people who struggle with emotional undercontrol: those who have a hard time containing emotions, are more impulsive, have relational ups and downs, and for whom emotions are experienced as intense and often rapidly changing. Individuals suffering with bulimia nervosa and binge eating disorder are more likely to have underlying challenges with undercontrolled patterns and are much more likely to struggle with other symptoms such as chronic suicidal and self-injurious behaviours, substance abuse, and/or other risk-taking behaviours (Ben-Porath et al., 2020).

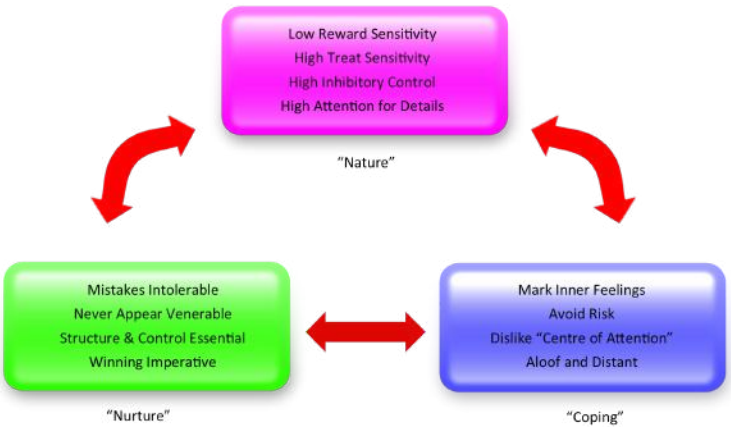
Others, however, struggle with emotional overcontrol; a pattern characterized by excessive self-control, high threat sensitivity, significant emotional suppression, rigid or inflexible thinking styles, avoidance of new experiences, low reward sensitivity, and a strong preference for routine and structure. Those with overcontrolled tendencies are typically socially isolated, highly detail-focused, have problems with perfectionism, and are highly driven. (Lynch et al., 2016). We tend to see this pattern more often in those with anorexia nervosa and ARFID (avoidant and restrictive feeding and intake disorders (Chen et al., 2014; Lynch et al., 2013)

In order to address the problem of emotional overcontrol, Dr. Thomas Lynch developed RO-DBT (Lynch, 2015) and recent studies have shown that this is a promising treatment for the eating disorders field (Baudinet et al., 2020; Ben-Porath et al., 2020; Chen et al., 2014; Hempel et al., 2018; Isaksson et al., 2021). One of the key areas of focus in RO-DBT is on self-control and social signaling. Self-control is the ability to restrain oneself, inhibit or block urges, and suppress emotion.

Why is that a problem?
Isn't that what people strive to do?

It turns out that too much self and emotional control is not very helpful because it gets in the way of relationships and productivity, increases loneliness, and is related to chronic depression, obsessive compulsive disorder, autism spectrum disorders, in addition to anorexia nervosa and ARFID (Gilbert et al., 2020; Lynch et al., 2016). From an RO perspective, restrictive and ritualistic eating patterns are part of a much larger drive to inhibit impulses and suppress behaviours (Hempel et al., 2018; Lynch & Hempel, 2016). In DBT, we commonly say that the symptoms (e.g., restricting intake, excessive exercise, etc.) are not the problem; that they are instead an attempt by the individual to solve the underlying problem (in this case, an overcontrolled biotemperament). "It is a blessing because their capacity for self-control is often admired. It is a curse because their personal suffering arising from [overcontrol] is often overlooked" (Lynch et al., 2016 p.1003). Thus, while we need to focus on weight and nutritional stabilization in ED treatment, a more robust model would involve targeting the temperamental factors that drive the symptoms in the first place.

In RO-DBT, we work with clients to help them understand how their particular biotemperament collides with the environment and results in a set of coping behaviours designed to create a sense of safety. The diagram below (Lynch, 2018) provides a visual representation of how these variables relate to one another.



A. **The "Nature" box** at the top of the diagram highlights factors that are biologically based: Low reward sensitivity, high threat sensitivity, able to inhibit, attention to detail. This means the person operates in a heightened state of arousal/activation/threat. They do not easily feel rewarded or pleasure in life, are hard-wired toward restraint, and have a difficult time accessing the body's safety system. They live in a continual state of tension and hypervigilance to threat.

B. **The "Nurture" box** (left) represents the values and attitudes in one's culture that activate or reinforce the above-named biological temperament. For example, clients will report that making mistakes is intolerable, being vulnerable is a sign of weakness, that winning and overachieving is prized, or that perfectionism and control are valued.

C. **The "Coping" box** (right) draws attention to how a person learns to manage their biology and environment. For instance, if they hide their feelings and don't take risks they can avoid feeling vulnerable or making mistakes. As a result of these interacting systems, the individual often shows little, if any, facial expression, appears defensive, responds in ways that seem inauthentic, and has difficulty expressing emotion. These social signaling deficits exacerbate suffering in that individuals often feel misunderstood and have a hard time with intimacy and connectedness to others.

RO-DBT is a multi-model treatment, meaning that clients receive individual RO-DBT therapy and attend a skills class for 30 consecutive weeks. Phone coaching may be offered and RO clinicians attend a weekly consultation group meeting.

The overarching goals of RO-DBT are to:

- **Increase social connectedness and promote effective and accurate social signaling, and change neurophysiological arousal.**
- **Enhance receptivity and openness to engage with the world with greater curiosity vs rigidity.**
- **Learn how to flexibly respond to change and increase playfulness.**
- **Increase emotional expression and awareness.**
- **Learn to build social connectedness and intimacy.**

For more information on RO-DBT, please see the website: https://www.radicallyopen.net/

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.

She has provided more than 125 lectures, workshops, and invited talks on eating disorders, DBT, CBT, and personality disorders. Known for her engaging and authentic style of training, Dr. Federici has become a highly sought-after consultant for numerous hospitals and community based organizations across North America who are seeking to improve treatment programs or expand access. Her work has been presented at international conferences and published in peer-reviewed journals and invited book chapters.

Contact Info:
267 King Street Midland Ontario L4R 3M4
Office. (249) 492.2673 Fax. (249) 492-2640
Email: Anita@MidlandDBT.com
Web: www.psychology-emotionregulation.ca
Instagram: @dranitafederici

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S.T.O.P.P.-ing Distress

When you are experiencing heightened mental health distress and feel out of control, it can be useful to S.T.O.P.P. This skill will help you to stop for a minute to check in with yourself, and will help you to identify what steps you can take next.

STOP Just pause for a moment.

TAKE A BREATH Notice your breathing as you breathe in and out. In through the nose, out through the mouth.

OBSERVE
What thoughts are going through your mind right now?
Where is your focus of attention?
What are you reacting to?
What sensations do you notice in your body?

PULL BACK - PUT IN SOME PERSPECTIVE
DON'T BELIEVE EVERYTHING YOU THINK!
What's the bigger picture?
Take the helicopter view.
What is another way of looking at this situation?
What advice would I give a friend?
What would a trusted friend say to me right now?
Is this thought a fact or opinion?
What is a more reasonable explanation?
How important is this? How important will it be in 6 months time?
It will pass.

PRACTICE WHAT WORKS – PROCEED
What is the best thing to do right now?
What is the most helpful thing for me, for others, for the situation?
What can I do that fits with my values?
Where can I focus my attention right now?
Do what will be effective and appropriate.

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HOW TO USE STOPP

Practice the first two steps often for a few days - many times every day at any time.

Read through the steps often.

Carry written reminders with you.

Practice STOPP by running through all the steps several times a day, every day... even when you don't need it.

Start to use it for little upsets.

Gradually, you will find that you can use it for more distressing situations. Like any new habit or skill, it will become automatic over time.

The steps explained

Stop! Say it to yourself, in your head, as soon as you notice your mind and/or your body is reacting to a trigger.

Stop! helps to put in the space between the stimulus (the trigger, whatever we are reacting to) and our response.

The earlier you use STOPP, the easier and more effective it will be.

Take a Breath. Breathing a little deeper and slower will calm down and reduce the physical reaction of emotion/adrenaline.
In through the nose, out through our mouth - the brain's reset mechanism.

Focusing on our breathing means we are not so focused on the thoughts and feelings of the distress, so that our minds can start to clear and we can think more logically and rationally.

Observe. We can notice the thoughts going through our mind, we can notice what we feel in our body, and we can notice the urge to react in an impulsive way. We can notice the vicious cycle of anxiety, sadness or anger (etc).

Noticing helps us to defuse from those thoughts and feelings and therefore reduce their power and control.

Pull back / Put in some Perspective. The thought challenging of CBT. Thinking differently. Don't believe everthing you think! Thoughts are thoughts - NOT statements of fact.

When we step back emotionally from a situation, and start to see the bigger picture, it reduces those distressing beliefs. We can do this by asking ourselves questions.

Practice what works / Proceed. This is the behavioural change of CBT. Doing things differently. Rather than reacting impulsively with unhelpful consequences, we can CHOOSE our more helpful and positive response. Shift our focus of attention.

Adapted from: https://www.getselfhelp.co.uk/stopp.htm

Photo Credit: rodnae-productions via Pexels

GRIEVING IN THE PANDEMIC

By: Lori Market, CTP, MSW, RSW

We bereaved are not alone. We belong to the largest company in the world - the company of those who have known suffering.

– Helen Keller

We have been living through a pandemic for over one year. This has led to increased mental health issues and life challenges. Some families in our community have also had to face the death of a loved one during this time. For some, death rituals and traditional ways of healing have become disrupted.

Grieving during a pandemic has multiple complications: limited capacity funeral services, lack of community ceremony and sharing circles, estrangement from family members due to travel restrictions, lack of physical contact promoted by social distancing measures, isolation and estrangement in long-term care homes, less opportunities for socialization and support, etc. I have included information that may be helpful in coping with grief during this unprecedented time.

According to Alan Wolfelt (Wofelt, 2004), there are several stages of healing when experiencing the death of a loved one. Initially, when we lose a precious loved one, our life can feel surreal. We may be in state of shock, denial, and disbelief. It is hard to accept that a person we love is gone and face the reality of their death. Once we move through denial and realize that the death has occurred, we may be filled with an incredible sense of loss. At this stage we may feel overwhelmed by our grief and sadness.

Our minds may struggle to fathom the strains of our hearts. It is an undoing. A leaving. A thread that was previously tangled and intertwined now stretches out to infinity where we can't see it any longer. We may feel angry, confused, sad, and disconnected. During this time, we may feel like we are going crazy and that our pain will never end. This is normal. For with great love comes an enormous sense of loss. Our bodies, too, may be impacted by grief. We may have trouble sleeping and experience physical symptoms such as: exhaustion, stomach aches, headaches, malaise, etc. We may find it hard to eat, forget to eat or drink water, or we may eat more than usual. It is important to remember to care for ourselves and seek support during this time.

It is hard to avoid grief and often it requires us to go through it, even when it feels like we cannot. We will need to embrace the pain of loss and other emotions that arrive. It is helpful to share our grief with others or with a therapist, or consider joining a support group where we are surrounded by others who are also experiencing loss. We may find that we have been changed by this death and it can impact our identity and how we see ourselves in the world.

We may no longer be a husband/wife/partner, a child, a best friend, or a pet parent. We have to find a new identity without them. We have to find our way in the world again. We have to re-invent ourselves, and pull ourselves out from the vestiges of who we were to bring a new meaning in life without them. When we lose them, we don't know who we are anymore. We have yet to learn how to negotiate our lives without them. These are things we will need to learn, and this usually doesn't come easy and fast.

Photo Credits: Lori Market

This pillow was made from the fabric of my aunt Barb's skirt. She was a rheumatoid arthritis warrior, she loved baking, and she was a kind person. This article is my tribute to her

There is healing is in remembering and in our pain. Healing can sometimes result in numbness or scream crying while feeling the gutting knives of our sorrow that threaten to unearth our sanity. We need to feel that loss. Grief will find us anyway. It can hunt us down and throw us to the ground until we stand to face it. When we listen to our pain, we listen to our love. For both cannot run in the rain without each other.

Grief is heavy, it's like carrying a sack of bricks on our backs and it can make simple routines seem like unsurmountable tasks. It is hard to imagine a reprieve from the intensity of pain, but one day it will lift all it needs is time. We will never be free of the pain but we will be lighter. closure is a lie.

Some bricks we are carrying may fall away but there will always be a little pinprick to the heart. It has been my experience with clients and with my own loss, that there is healing in remembering the person who died. There is healing in finding ways to honour them and keep their memory alive for future generations. So, you may wonder, what are some ways to do this?

There are many creative activities that can be used for grief. One method I have used with many clients over the years is called a memory box. We start with a box made from wood or cardboard. Then we paint or decorate it. Once completed, the box will then serve as a container to honour the memories of the person who died. It can hold objects linked to our precious loved ones (a piece of jewelry, a card or note from them, etc.)

We can ask ourselves questions to stimulate further thoughts about them. What is their favourite song or food or activity? What is our favorite memory of them? Who was this person? What gifts did this person bring to the world? This box can also be circulated through our family or circle of friends and, they too, can add their memories. I have found that by including loved ones we can learn new things about the person who died, and receive support and connection during this activity.

Photo Credit: Lori Market

If a memory box is not something that calls to you, there are other possibilities. Some options can include: drawing their portrait, making a quilt or a pillow from their clothing, creating a sculpture to represent your loved one, planting a memory garden with perennial flowers or a planting tree in your yard or in a community space, creating a scrapbook or memory book, cooking a meal then making a spirit plate, storytelling, or creating a collage of memories.

Additionally, there are many expressive writing techniques that can help to cope with loss. Some options include: writing a poem or story, writing a heartfelt epitaph, writing the deceased a goodbye letter, writing a letter containing their positive qualities, or writing all the things we wished we could have said to them. Some deaths may be complicated. We may have regrets. Many have found that writing an apology letter then burning it has provided relief.

There is no right way or wrong way to grieve. Grief is an individual process.

There is no time limit or timeline. There are no rules. It's okay to laugh, to cry, to feel angry, and to share our grief. It is helpful to process our grief thoughts and feelings with trustworthy people. It takes time for the all-encompassing pain to subside, but one day we do wake up and feel the heaviness has lifted. We never truly get over that loss but do find a way that we can live it.

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

Lori Market, is a Clinical Therapist at the Bulimia Anorexia Nervosa Association (BANA) as well as a local artist and author.

Photo Credit: irina-anastasiu via Pexels

Windsor -Essex Community Health Centre
Teen Health Eating Disorder Program during COVID-19

Clients that come to us are treated by a combination of professionals, that include: nurse practitioners, physicians, registered social workers and registered dietitians.

The ideal treatment for young people is Family Based Therapy, also referred to as the Maudsley Method. In this approach, parents are viewed as the expert in relation to their child and the therapist is the expert on the Eating Disorder. Parents play a very important role in the treatment of their child. Our Family Based Therapy Coach keeps parents actively involved in the design of the treatment plan established for their child.

Since the beginning of the Covid-19 pandemic, Teen Health has experienced a significant increase of Eating Disorder clients.

"Eating disorders have skyrocketed because in these uncertain times, food is the only thing some kids feel they can control," says Dr. Joslyn Warwaruk, a physician with weCHC Teen Health. "And, these disorders have the highest mortality rate of all mental health disorders globally."

In a day, Dr. Warwaruk treats four or five teens acutely ill with eating disorders, "post-hospital or trying to keep them out of hospital." Dr. Warwaruk assures parents that there is no harm in taking a prescribed medication for anxiety to improve serotonin levels in your brain. That's far better than kids self medicating with food and recreational drugs.

We understand that COVID-19 has placed families in unchartered territory, and we encourage sharing meals together, playing games and maintaining normalcy at home. Some kids will balk at the idea of family time, but it is proven that everyone feels better when there is structure.

Family interaction is key. Of great concern is the clients that are coming to us at later, more advanced stages.

This is troubling because those with Anorexia Nervosa (AN) present with anosognosia, which is when the sufferer denies there is something not right. It is common for the client to be resistant to treatment, so getting them to cooperate can take time. Effectively treating an Eating Disorder has it challenges, but it can be done, and the best way to prevent an Eating Disorder from progressing to a chronic illness is to respond and treat it in the early stages.

For more information on Eating Disorder Treatment in our community please contact 1.855.969.5530 and for the many services available to youth at the Windsor Essex Community Health Centre – Teen Health please visit www.wechc.org

- Women United -
The Importance of Uniting Your Community

By Luciana Rosu Sieza

One of the great prides I've taken from the past 17 Year at the Bulimia Anorexia Nervosa Association is the generosity of our staff and the time they give to the community. As those of you in the non-profit sector know, it truly takes a village these days and I am always gratified to hear stories about our team making a difference outside our walls. I'm hoping that sharing my recent experience in one of these endeavours might inspire you to do the same.

I joined a local group called Women United about 4 years ago with the hope that I could make a difference by enhancing the lives of those living in Windsor-Essex. I can tell you without a shadow of doubt, my involvement has surpassed any and every expectation I had going in. More than just the opportunity to give back, I've received much in return as well. I've gained a deeper understanding of the issues facing our community, while networking with like-minded women who have the same shared vision.

If I had to take a moment and reflect on what has impacted me the most, it would be the opportunity for direct interaction with local youth and their families. Every single exchange has been a real privilege for me; it always leaves me feeling inspired, motivated and wanting to do more. The wonderful thing about this group, and others like them, is that you are afforded the opportunity to choose how much time you have to devote to upcoming events and projects; giving you flexibility while offering so many meaningful rewards.

Over the past few years I've been able to participate in the annual "Celebrating Women Who Inspire Us" Luncheon, went back to school shopping with the youth, read books and served lunch at the Summer Eats for Kids program, collected hundreds of books for the book drive and made study kits for students for exam time. This small investment of time also introduced me to the inspirational "On Track to Success Program", which offers supports that wrap around a family and encourages kids to graduate high school and go on to post-secondary education – the clearest pathway to a life of prosperity.

I've found a new passion with this initiative because the ongoing success and change we continue to see in the youth is unmatched. My point is, to be part of a strong community, you need to take part in that community.

Women United is one of many opportunities out there if you want to change lives, give back, take action. If you do want to move the needle forward with a group of innovative and inspiring women, feel free to contact me at BANA. Together we can create a world full of opportunity for women everywhere.

Luciana Rosu-Sieza is the Executive Director of the Bulimia Anorexia Nervosa Association

This year given our current environment with Covid-19 Women United, members are thrilled to have Trey Anthony, author of Black Girl In Love (With Herself) as our guest speaker for this year's Women United Celebrating Women Who Inspire Us Live Stream Event May 5th, 2021 at 12 PM EDT.

There is no better time for us to experience Trey's infectious energy, humour, and determination that inspires audiences to go after – and achieve – their dreams.

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.

Photo Credit: any lane via Pexels

How does my age affect where I can get treatment in Windsor-Essex

While BANA's Health Promotion services are provided to all ages, our Clinical Treatment program is for **adults only**. We do, however, host the Regional Intake Program for Eating Disorders.

Individuals of all ages can engage our intake worker by calling toll free at 1**-855-969-5530** or visiting our website at **www.bana.ca** and filling out an intake request under our clinical services section.

So what does this mean for me?

For adults 20 and older

1. Complete an intake for on the BANA website (above).
2. Dependent on the information provided, you will be booked for a specialized eating disorder assessment.
3. If applicable, an eating disorder diagnosis and treatment plan would be established by our supervising Psychologist and Clinical Team.
4. Resources and Treatment will be provided.

**services are provided both in-person and virtually*

For youth 12-25

1. Complete an intake form on the BANA website (above).
2. Participate in a brief phone intake.
3. Referral to weCHC-Teen health for diagnosis and treatment

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

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Change the World by Being Yourself

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1500 Ouellette Ave Suite 100
Windsor Ontario Canada N8X 1K7
P: 519.969.2112 E:info@bana.ca
www.bana.ca