BANA
BE YOURSELF

A publication of the Bulimia Anorexia Nervosa Association

SUMMER 2021

A Mental Health and Wellness Magazine

Special Guest Columist:
Glenn Waller,
Renown Author and
Professor of Clinical Psychology,
University of Sheffield, UK

Memorial Tribute to:
Dr. Richard Moriarty,
BANA Founder

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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

A Legacy of Love

Saying Goodbye to our Founder and Friend

by Patrick Kelly

The staff and Board of the Bulimia Anorexia Nervosa Association are deeply saddened at the passing of our Founder Dr. Richard (Dick) Moriarty on June, 23, 2021 at the age of 88.

Dr. Moriarty was a husband, a father and professor but for the past four decades, he along with his wife Mary, were also a guiding light to those in the Eating Disorder world.

BANA originated as a response to grief, compassion for others and out of a gap in services for those with eating disorders and their families in Windsor and Essex County. One evening in February in 1983, concerned citizens met in the Human Kinetics Building of the University of Windsor because an eating disorder had touched their lives in some significant way.

Of these, most were family members with loved ones who struggled daily with the disorder, while others were battling the disorder themselves This gathering included one family, the Moriarty's, who had recently lost their daughter to the disorder.

At the time, they were all looking for the same things: information, kindness and support. This event marked the beginning of BANA's now 38-year journey.

Dick and Mary quickly stepped into the forefront of the movement. Selflessly, if you'd ask him, he'd point to countless others, (and he knew all their names) that had allowed BANA to grow from grassroots to a leader in the prevention and treatment of eating disorders; but we all knew that it was Dr. Moriarty's ability to reach out and touch the hearts of people opened doors for BANA.

It was his compassion, sheer determination and love that built the very milestones that our foundation now stands on.

From humble beginnings at the University of Windsor and to the launch of a hotline so people could find resources, he was there. From publishing pamphlets and information packages, to hosting Speaker's Bureaus, and conducting research, Dick would be the one you could always call on. He made sure BANA was incorporated as a non-profit, launching summer camp programming for adolescents and young adults - the first of its kind in North America.

In 1989, Dr. Moriarty was instrumental in securing funding from the Ministry of Health and Long Term Care for long-needed clinical services; assisting BANA in becoming the first community based outpatient program in this region to provide mental health services for eating disorders for both adolescents and adults.

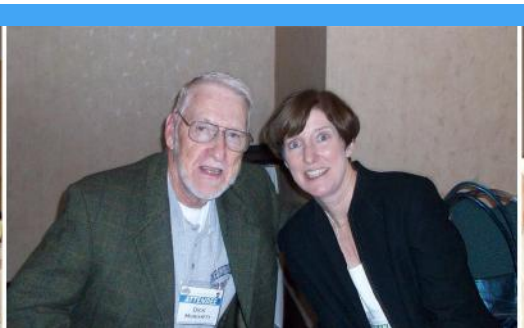
For decades he served as a mentor, a driving force, a goodwill ambassador and our #1 cheerleader.

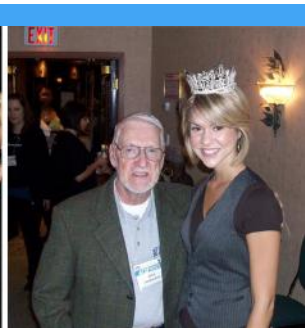
Today, as a community-based outpatient eating disorders program, BANA, prides itself on its multi-disciplinary team approach with a staff of social workers, a dietitian, a supervising psychologist and a health promotion team - a vision Dick insisted on and championed for since day one.

Over the years, countless lives have been changed and even saved thanks to his efforts. Along the way, tens-of-thousands of individuals, families, educators, mental health and wellness providers have been immeasurable and positively impacted by the legacy of Dr. Moriarty. He has and will continue to; support, encourage and inspire, us all.

To our founder and friend, we will miss you. We owe you so much; and we hope that we can continue to make you as proud of us, as we have always been of you.

All of our love, your friends at BANA





My Journey . . . So Far

By Stacey Prieur

Where to begin?

Usually, every journey has a beginning and an end; if we see an eating disorder as a journey, each has a beginning, but not all have an end. My journey is still ongoing; my battle with my eating disorder (ED) has not ended. It is a process. It has had its peaks and its valleys. It has had times of stillness and quiet; just a whisper; a faded presence. Then there have been fierce rages and chaotic screams where ED has roared and fought me, beaten me, worn me down. Here is a brief outline - a glimpse of my battle - because as everyone with an ED knows it is a complicated, complex matrix of why, when and how.

And so my story begins.

I was eight when my dad died unexpectedly at the age of 37. It was crushing and crippling. My mother, only 32 at the time, had no job, four young children, and mental health concerns - bipolar disorder. She did her best, made mistakes as all grieving people do, as all human beings do. My oldest sister and my mother often butted heads; there was always tension between them. My sister was overweight and my mom was critical of that. My mom once made a comment to me, innocently enough, where she told me I was gaining weight and that I was starting to look like my sister.

My eight-year-old-self interpreted this as, "well, your sister is "fat", mom doesn't like your sister, so if you get fat then mom won't like you either". Was this it? The loss of my dad, the comment from my mom? Was it the boy I had a crush on who called me a hippo? Was it that I was an over achiever, a people pleaser, a perfectionist? Does it matter? Because as I look back on all the reasons why - why did I get Anorexia Nervosa - it does not change anything. It has been with me for over 40 years; but I have fought long and hard to not let it define me, control me, or overtake me. So maybe the beginning is not the important part of my journey, but only a faded memory of a time so long ago.

My distorted body image, my battle with food and the scale grew and developed. Like a small spark igniting the brush to become a raging forest fire. By fourteen I had already been on so many diets. There were times I could not bear to look at myself in the mirror or wear my bathing suit at a pool party without an oversized shirt to hide myself. I wanted to be athletic and thin like my friends, not chubby and smart like people kept telling me I was.

In grade 9, I made the cheerleading squad to my surprise. I had overwhelming enthusiasm and used my loud voice to scream and cheer - to cover up that I was not the most flexible or skilled cheerleader. I felt like I was the largest girl on the squad. I started dieting, yet again. I ate less and less. I practiced my cheers every night in my mother's living room for hours.

I started to lose weight and I was overjoyed.
My friends praised me and commented on my weight loss.

I remember being in my friend's bedroom once; she was very thin and wore tight designer Jordache jeans, and I was envious. She told me to try her jeans on - she was sure they would fit me now. The feeling of putting on her jeans and zipping up the zipper... I was in heaven. You would have thought I won a million dollars in the lottery. But then the compliments stopped. I was told I was too thin; I was losing too much weight; I needed to eat more.

" They just want me to be "fat" again", I thought, "can't they see I am not too thin? I still see the chubby girl when I look in the mirror".

My mom's friends held an intervention. Karen Carpenter, the folk singer, had just died of Anorexia. It was on the news, splattered on the tabloids. They showed my mother the articles to snap her out of her denial that her daughter was sick. I was hospitalized for two months, and forced to eat and gain weight.

But I was not cured; ED was still on my shoulder whispering to me, hissing his criticisms and hatred. And so years went by of maintaining a "safe" weight to keep me out of the hospital, but inside I felt no better and struggled everyday with weight, food, the scale and the consequences ED had on my relationships.

So when does the next phase start; where does my journey take a turn towards light and healing?

I had been told by medical professionals that I would most likely never have children; I'd had Anorexia too long and during puberty. I had irregular cycles and was likely not ovulating. My husband was so accepting and loved me for me. Loved me even with ED on my shoulder. He was accepting that we might not have children.

But I was heartbroken, I wanted to be a mom. There is guilt with ED: guilt that I caused this; I had a choice to diet, not eat, cause damage to my body. I know now that this was not my choice. ED is an illness, and without proper treatment it has potential to be an uncontrollable rollercoaster of side effects.

The healing began when I became pregnant with my first child, a daughter. She was my miracle. She saved me. I was able to ignore ED, quiet his voice, push him away. I was able to eat to nurse my baby. Then I got pregnant with my second daughter and the positive cycle continued of eating for my babies.

But I learned along the way that I was also eating for me; engaging the process of nourishing my body and my soul. My husband loves to say it was him - he saved me. I tease him that it was the girls. Truly it was all three of them - the unconditional love, the encouragement and the support. The journey took an amazing turn.

I would love to say that was the end of the Anorexia, the end of ED. Of course it was not. After the death of a dear friend from anorexia nervosa, I realized I needed tools. I needed an arsenal to fight ED. My body is changing and aging. Menopause is around the corner.

I needed to not end up like my friend; I needed to be here for my family. I am not done. I have so much I want to accomplish still on this journey.

I went to BANA. They gave me tools and helped me build skills to stifle ED. They helped me quiet him and make him take a back seat in my life. ED may never be gone, may never fully disappear. But I've learned to control ED, instead of ED controlling me.

I've heard ED be related to substance abuse; you may have glistens of it throughout life, but you can learn to cope, to overcome the triggers, and to live a healthy life. I am grateful for BANA, my family and my friends for helping me on my journey – well… my journey so far.

Photo credit Pixabay via pexels

Living a Valued Life

"The definition of a quality of life is living in accordance with your values. Explore and clarify your values, and work to engage in activities to support them in order to improve your day-to-day life."

1. Values tend to change as we pass through different stages of life. For example, the things that a teenager values are usually very different than what a parent values. Think back to a different stage of your life. How were your values different? How are they the same?

2. Everyone has a personal set of values, built from their unique life experiences. One important factor in what we value are the values of our friends, families, and society. How do your values differ from your friends and family? How do they differ from the society you live in?

3. Think of a person who you respect or look up to. What do you think their most important values might be? What strengths or qualities do they have that you admire?

4. We can learn a lot about our own values by the way we react to other people. Think of behaviors that you disapprove of, or dislike, from others. What does this tell you about your own values? How would you behave differently if you were in their position?

5. Think of a value you have now that you did not used to have, or a value that has become more important to you. What life experiences led to this value changing? How does this change affect you now?

6. The values we hold do not always align with our actions. Some values are difficult to live up to, or other priorities get in the way. Which of these values do you hope to focus on in the future? What life changes would you need to make to accomplish this?

7. How our values are shown differ from setting to setting. For example, your family might see a different side of you than friends, co-workers, or an authority figure. Think of three people from different parts of your life. How do you think each of them would describe your values? What evidence do they have?

Raise Your Voice in Support of Over 900,000 Ontarians with an Eating Disorder

In a campaign supported by BANA, Body Brave, NIED, National Eating Disorder Information Centre, Sheena's Place and the WaterStone Foundation we are asking Ontarians to take action and help make a difference for so many lives at risk.

During this last year, we have seen a dramatic increase in the need for eating disorder treatment and support programs. The publicly funded healthcare system needs to do better to meet the needs for individuals with eating disorders.

The pandemic has created "the perfect storm for eating disorders". Hospitals, private clinicians, and community-based organizations have experienced an exponential increase in demand across the province. The Hospital for Sick Children is reporting a wait time for an assessment of 10 months and an increase in referrals of **55% since the start of the pandemic.** Body Brave, a Hamilton-based charity that provides eating disorder treatment and support has reported an **increase in requests for help of 169% from March 2019 to March 2021.**

BANA, a Windsor-based registered non-profit that provides outpatient treatment, education and support services for individuals affected by eating disorders has reported an **increase in calls of 86% in February 2021 over last year**. At the same time, hospitals have had to reduce or close eating disorder programs due to other COVID-related priorities and social distancing requirements.

If not treated, the impact of ED's can be lifelong chronic illness and even death. In fact, **eating disorders have the highest mortality rate of any mental illness**, yet government funded treatment in Ontario is scarce and, in some regions of the province, non-existent.

We are in a crisis and while the Government has committed to investing in prevention and early detection programs for children and youth, there has been no commitment to increasing community-based eating disorder treatment in the province of Ontario.

WE NEED...

A stepped-care government funded system that starts in the community, ends in the community, and provides access for early intervention. We know that the earlier eating disorders are diagnosed and treated, the better the outcomes;

WE NEED...

More training and resources for family physicians so that they can detect and treat eating disorders at an early stage, and refer to appropriate specialists before a crisis occurs; and

WE NEED...

The Government to take eating disorders seriously. Eating disorders are not a choice and they deserve the same attention and investment as cancer, heart disease, and all adequately funded illnesses.

AND WE NEED YOUR HELP TOO...

Collectively, we have launched a mailing campaign, which will allow constituents to send a letter to their local MPP to show their support and call for action from our elected officials.

WITH SUPPORT FROM

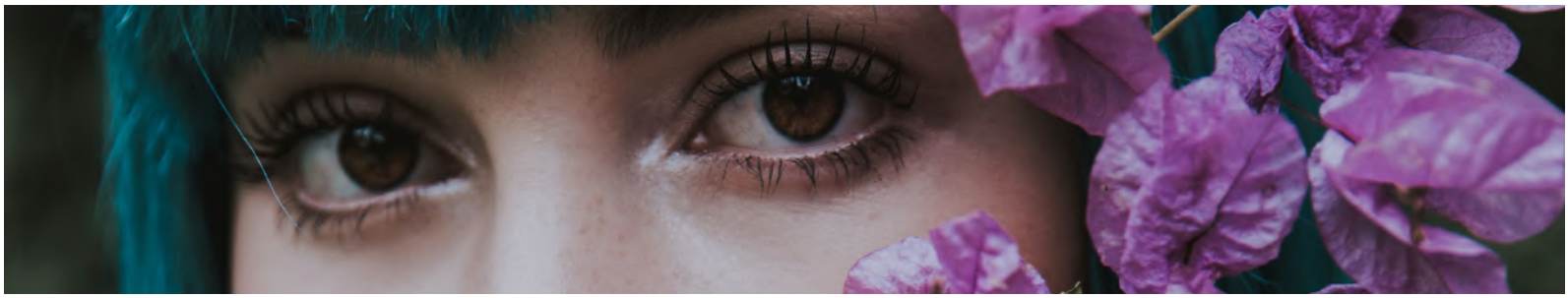
BODY BRAVE
nedic National Eating Disorder Information Centre
SHEENA'S PLACE Support for eating disorders
NIED National Initiative for Eating Disorders
BANA
WATERSTONE

The campaign will be live until August 30, 2021 so we encourage people to continue to write letters throughout the summer months. If your MPP expresses an interest in helping out, please forward their response to info@waterstonefoundation.ca

Just click the link below to support this initiative by contacting your local MPP.

Campaign site:

https://mppletterwriting.good.do/eating-disorder-funding/eating-disorder-action/



Getting to know Bulimia Nervosa

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

***** 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.**

Bulimia Nervosa is an eating disorder that is quite often misunderstood. While the general public typically believes bulimia to be exclusively binge eating following by vomiting, the diagnosis actually includes alternative forms of purging behaviour that often go overlooked.

In March of 2021, BANA collected data on our active clients to determine how frequent each eating disorder diagnosis is in the Windsor/Essex community. ***What we found is that Bulimia Nervosa is the most frequently diagnosed eating disorder, at a rate of approximately 53%.***

It is important to remember that embarrassment, shame, hiding and secrecy are highly enmeshed in symptoms of Bulimia Nervosa; therefore, the disorder can often be overlooked by loved ones, medical professionals or the individuals themselves.

DSM-5 CRITERIA FOR BULIMIA NERVOSA

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 eatin

b) Recurrent inappropriate compensatory behaviours that are used to prevent weigh-gain; typically referred to as purging behaviours. These can include self-induced vomiting, misuse of laxatives, diuretics or other medications (such as diet pills), fasting/dieting, and excessive exercise

c) The binge eating and compensatory behaviours both occur at least once a week (on average) for 3 months

d) The way the individual evaluates themselves is unduly influenced by body shape and weight

e) The disturbance does not occur during episodes of anorexia nervosa
Severity Ratings: based on the frequency of compensatory behaviours

Mild = average of 1-3 compensatory behaviours/week

Moderate = average of 4-7 compensatory behaviours/week

Severe = average of 8-13 compensatory behaviours/week

Extreme = average of 14 or more compensatory behaviours/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 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.NG

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

COMPENSATORY BEHAVIOURS

Compensatory behaviours – also referred to as purging behaviours – are methods individuals use to "make up for" having binged, overeaten, or broken dietary rules. Compensatory behaviours have the goal of attempting to prevent food/eating from influencing weight/shape. Contrary to the belief that these behaviours are effective weight/shape control strategies, the empirical research demonstrates that these behaviours are highly ineffective, and tend to influence the body's electrolytes and fluid retention rather than fat. All compensatory behaviours pose health risks, some of which could be life-threatening. While some of these health concerns tend to resolve with recovery, others can be permanently damaging. It is important to note that if you are engaging in any compensatory behaviours, we recommend visiting your primary health practitioner regularly to investigate these health risks.

Compensatory behaviours are typically the most misunderstood criteria of Bulimia. As society changes, professionals in the field of eating disorders may notice new compensatory behaviours arise that were not considered before. Although the DSM-5 does not include excessive use of supplements, chronic use of shape-wear, or utilizing caffeine, cigarettes or other substances for weight-control purposes, these may be considered in future editions (of course, this is only speculation).

Beyond the commonly thought-of self-induced vomiting, individuals may misuse laxatives, diuretics or other medications to attempt to control their weight/shape. It is important to note that these medications serve an important medical purpose; however, when not used as prescribed or for medical purpose, they can be considered disordered.

DIETING, FASTING AND EXCESSIVE EXERCISE

Three compensatory behaviours that are noticeably on the rise in today's society are dieting, fasting and excessive exercise. Although diets are a definite precursor of eating disorders – an overwhelming majority of our clients have a long history of yo-yo dieting – not everyone who diets has or will have an eating disorder. However, it remains true that dieting may always be triggering for individuals with a history of an eating disorder, and most professionals in the field would caution not returning to a lifestyle of dieting after treatment.

Much of the researched-based, empirical information on dieting is contradictory to what the general public believes; research has shown time and time again that dieting increases an individual's non-dieting weight over time. After ending their diet, many individuals may regain weight and evidence suggests they will likely surpass the weight they were prior to the diet. Many dieters focus on the short-term results of dieting, such as success with immediate weight loss (although, it can be argued much of this loss is not actually fat); however, many overlook what occurs with their weight once they cease the diet and return to their typical eating. When weight is "regained", this triggers the desire to return to dieting and "do better next time", and so the "vicious cycle of dieting" continues.

Healthy vs. Unhealthy Exercise

FACTORS	UNHEALTHY	HEALTHY
MOTIVES, PURPOSE, OR FUNCTIONING	• For weight loss • Compensation • Self-Punishment • Degrading • Impedes on daily life or functioning	• For health and general wellness • Supportive • Fits well into daily life • Beneficial
LENGTH OR FREQUENCY	• Surpasses 60 Minutes • Sometimes "doubles-up" • Adds extra time if concerned about weight or something that had been eaten • No rest days	• Typically recommends 60 minutes per day • Incorporated rest days
LISTENING TO BODY	• Still exercises despite illness, injury or tiredness/exhaustion • Ignores body	• Takes rest days—even if unplanned—if body is ill, injured or tired • Listens to body
FLEXIBILITY	• Very rigid and inflexible	• Adaptive and flexible
EMOTIONS AND FEELINGS ASSOCIATED	• Dread the exercise • Guilt, anxiety, shame if unable to exercise • Punishment • Drained	• General contentment • Excitement • "Feel good" • Positive • Energized

We see that more and more, fasting is included in many diets – essentially, efforts to delay eating as long as possible. Fasting meets Bulimia criterion when the individual uses it as a response to having "mis-eaten". For example, if the individual binged the evening before, they may fast as long as possible the next day to "make up for last night's binge". Compensatory fasting is typically required to occur for a minimum of 8 wake hours to meet the diagnostic criteria.

Excessive exercise is a hot topic, and one that is faced with a lot of defense and debate. In society today, fitness has become very trendy, and many face pressures to engage in excessive or rigid exercise in order to "fit in". Societal standards of "the ideal body" currently reflect toned and muscular physiques, making driven exercise even more compelling. It is a well-researched fact that exercise is an important factor in mental and physical health. However, exercise crosses over to unhealthy and disordered when motives, thoughts and behaviours become degrading rather than supportive.

Arguably, motives for exercise should be health directed, rather than solely weight-focused. Excessive exercise may incorporate longer-than-recommended periods of engagement (for example: going to the gym two times a day for an hour each visit, or adding an extra 45 minutes to your routine after you've had a binge). If individuals are still engaging in exercise, despite illness or injury, this is also seen as disordered. Other markers of excessive exercise are when one is dreading the exercise; feels guilt/shame/anxiety if unable to exercise; utilizes it as a form of self-punishment; and/or allows exercise to disrupt functioning or daily life. It is important to regularly check in with yourself, and your thoughts and motives behind the exercise you engage in.

THE WEIGHT MYTH

Contrary to popular belief, Bulimia Nervosa is difficult to spot. Unlike Anorexia Nervosa, where clients may be noticeably underweight or emaciated, most individuals who have been diagnosed with Bulimia are of normal to above-average weight. In fact, weight is the primary difference between the diagnoses of Bulimia Nervosa and Anorexia Nervosa – Binge/Purge Subtype.

OVERVIEW

Bulimia Nervosa is very often misunderstood, and many individuals may find it difficult to identify symptoms. If any of the criteria outlined in this article hit-home, but you're not sure if they meet all the requirements for a diagnosis, do not hesitate to contact us through general intake. We can meet with you to discuss potential symptoms, and can support you through some of your concerns.

Our general intake number is: 1-855-969-5530

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

Giving The Gift of a Lifetime

Photo Credit: Lukas via Pexels

So what is "Planned Giving"?

In its simplest term, planned giving is a financial gift that the "future you" will be leaving to a charity or cause that you love and support. It does require some preparation as many individuals prefer to consult their lawyer or financial planner, often making the gift part of their Will.

I know this already sounds complicated, doesn't it? Good news, it's not!

Let's face it, it is typically beneficial to have a Will or some form of financial planning in place to protect those we care about after we are gone. The inclusion of a charitable gift would only add a few minutes to your planning process and a few lines in your paperwork.

So why plan on Planned Giving?

Simply put, it's your money and it's your legacy. A planned gift in your Will allows you to leave a final contribution to support a cause you truly believe in, perhaps in a way that you may not have been able to before.

You may be concerned that a planned gift would decrease the benefits that you could leave your family when you pass on; however, under tax regulations, the funds that Revenue Canada would normally claim on your estate could be committed to your charity of choice. In fact, (added bonus coming up), if your net income in the year of your death is lower than the amount you gift, your executor can claim a rebate against your previous year's income and add that to your estate, bringing even more benefit to your heirs.

Will my gift really benefit the charity?

Yes, it most certainly can. Most charities - especially community-based organizations - often struggle to maintain funding sources. Never has that been more the case than over this past year.

Many charities rely on fundraising events and community outreach to raise funding dollars for programs and services. Even in the best of times this is a daunting task, but covid-19 has made this especially difficult by ceasing the ability to host events and campaigns, causing many funding initiatives to come to a screeching halt.

Also, unlike government funding and grants that often have restrictions and timelines on how and when the funds are used; gifts from Wills, in most cases, are received as unrestricted, allowing the charity to use them in times of need at their own discretion. Even better, unlike other funding sources, planned gifts can be saved and invested so that the yearly interest goes on to support programs for years to come.

It's always beneficial to talk to the charity you are considering leaving a planned gift to in order to explore how to best use your bequest.

Final thoughts?

As we mentioned, it's your money to use as you see fit; however, the last thing your charity would want is to cause distress for your grieving loved ones over a donation. It's imperative that you talk to your family about why you have decided to leave this gift; to inform them of the benefits a planned gift adds to your estate; and to express what the planned gift and charity means to you.

If you are interested in leaving a planned gift to BANA, please contact our Executive Director, Luciana Rosu-Sieza at 519.969.2112 or luciana@bana.ca to arrange a meeting with our team.

Thinking Outside the Volunteer Box

Photo Credit: Mikhail Nilov via Pexels

This Issues Featured Charity:

Charlotte's Freedom Farm

www.charlottesfarm.ca

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

There is also a lot of great evidence and empirical support suggesting that animals are beneficial to mental health. Studies have found increased levels of dopamine and serotonin (our "happy hormones") in individual's after spending time with animals; one study even demonstrated that 97% of their participants showed improved mental health outcomes after animal interactions (Canada Protection Plan, 2019). Animals have also been linked to a stronger sense of connection and purpose, improved social skills, and increased engagement in health behaviours.

ABOUT CHARLOTTE'S FREEDOM FARM

Charlotte's Freedom Farm is a local hobby and rescue/rehabilitation farm near Dresden, Ontario, Canada. Many of their animals arrived as orphans or with health problems, and it is the mission of the farm to provide their animals with rehabilitation and a life of peace and prosperity. Currently, the farm is home to a variety of critters, and engages volunteers in the care-taking and socialization of the animals as well as the farm. Volunteer work has benefits for of course the animals, but also the volunteers!

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

We recently connected with Lauren Edwards from Charolotte's to ask her a few questions about the farm.

1) How did Charlotte's Freedom Farm come to be?

In 2017, I rescued a little 4-day-old lamb who had a bad back leg. After rescuing dogs, cats and small animals for over 10 years, I had moved to a small farm in Comber and she was my first rescue 'farm' animal. From there, I rescued another little sick lamb (Emmit) and 3 little orphaned goats. Over the next year I found myself being asked to take in more and more animals who needed a place to go. Two years later I purchased a much bigger property in Dresden, ON. We are now home to over 180 rescued animals, including: goats, sheep, cows, ducks, chickens, geese, peacocks, dogs, cats, alpacas, pigs, a llama, rabbits and pheasants!

2) What is one thing you would want the community to know about Charlotte's Freedom Farm?

Every animal at the farm has enough space, proper housing, full vet care and a great diet. Our goal is to give the animals here the best life we can, and to show people how amazing and full of personality these animals can be. We run solely off donations and have a volunteer program that runs 3 days a week - Wednesdays, Saturdays and Sundays from 10-2 - and we ask people to commit to weekly or biweekly. We plan to offer public volunteer days in the future as well.

3) What role do volunteers play at Charlotte's Freedom Farm?

Volunteers are the heart of the rescue. We are a family at Charlotte's. All the volunteers become just as close with the animals as we are. The volunteers help with everything from cleaning to animal care to helping with tours and events. We have a fundraising committee as well as other opportunities for people who want to volunteer but can't make it out to the farm in a weekly or biweekly basis.

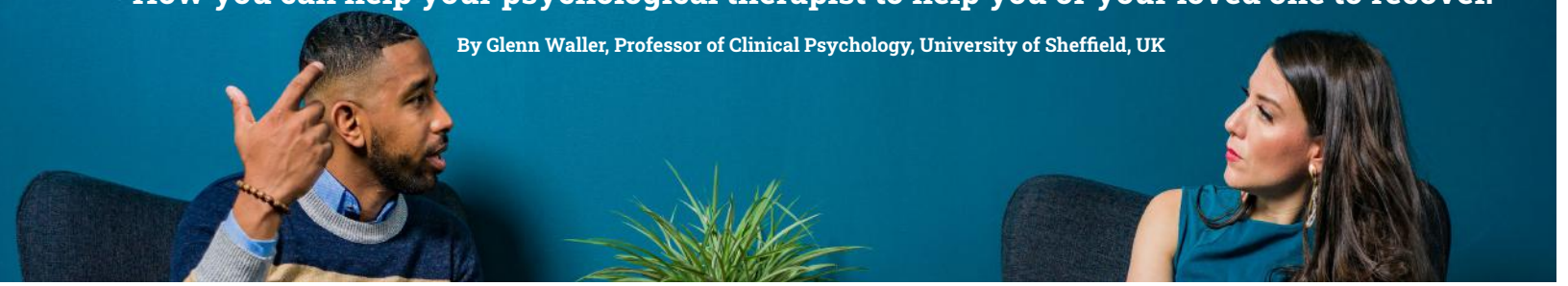
4) How can people help?

Individual's interested in getting connected with Charlotte's Freedom Farm can fill out a contact form at: www.charlottesfarm.ca/contact-us/ or donations can be made at:www.charlottesfarm.ca/donations/ .

Being an Active Member of the Therapy Team:

How you can help your psychological therapist to help you or your loved one to recover.

By Glenn Waller, Professor of Clinical Psychology, University of Sheffield, UK



I have been working as a clinical psychologist in the field of eating disorders for about 33 years now, as a therapist and a researcher. While I deliver cognitive-behaviour therapy, I have full respect for any therapy that has the evidence to show that it helps as many people to recover as possible – cognitive-behavioural, family-based therapies, the Maudsley MANTRA model, specialist supportive clinical management, and a specific form of psychodynamic therapy.

I have learned from excellent colleagues, but I have learned just as much from the dedication of the patients and carers who I have worked with over the years. I have learned that recovery requires effective therapies, therapists who will deliver them well, and patients and carers who throw themselves into the work needed to get better.

However, when we think about this, we have clinicians who are well trained and therapies that are well-developed. However, those who have eating disorders or who care for such patients do not have that sort of training – you have to make it up as you go along, looking online, and discussing with others in the same position. That hardly seems like a good way to get therapy off on the right foot.

So, how do we help you to get the best out of your therapy, when you do not have that background? I have often mulled over what I would like my patients to know before they come to see me, so that they are ready to give therapy the best chance possible. As a result, here are my thoughts about how you can become an active partner in therapy.

No therapy is perfect, so there is no guarantee that you will recover with a specific type, but you can certainly boost your chances or those of your loved one if you follow this guidance.

TIPS ABOUT HOW TO GET THE BEST FROM YOUR THERAPY

The following are some of my 'top tips' for anyone who is going to enter therapy for an eating disorder, so that they have a strong chance of recovery. You might not like them, but I can only say they are what I would say to any relative of mine who was in that position.

Ask the right questions first

Based on what I have already said, the first thing that you can do is to ask your would-be therapist to explain their therapy model, and to tell you what the wider evidence is about how effective you can expect it to be. If the therapist is vague about either of those issues, then think about whether this is for you - an effective therapist should be able to explain the therapy modality and discuss projected outcomes.

You might still want to work with that therapist, as they might be a supportive person or your goal might not be to recover, but you should be aware that your chances of long-term recovery are limited. That is a choice that many people will make, and it should be respected, as long as it is an informed choice. It does not stop you from seeking out different therapies in the future. My advice is always to ask questions, and always be prepared to listen to the explanations

'Doing therapy' vs 'talking therapy'

A critical issue is that the effective therapies require the patient to be an active participant - to 'do therapy', rather than simply being 'in therapy'. So, think about whether your treatment is a 'doing therapy' rather than a 'talking therapy'. Some individuals prefer a 'talking therapy' with no behavioural changes (especially no change in eating, being weighed, etc.).

Obviously, that can come from the individual being more motivated to stick with the eating disorder (e.g., feeling in control, resisting pressure from other people), even when it has downsides. Sometimes, though, the lack of active engagement in therapy can come out of hopelessness. Hopelessness because many things in life have gone wrong. Hopelessness because you have tried to find your own way out for many years. Or (too often by far) hopelessness because you have been through one or more episodes of therapy that were never likely to help you, because they were not therapies that had any evidence behind them.

Part of the reason that I hate it when patients are described as 'treatment resistant' is that they have never had the opportunity to undertake a therapy that might have worked.

Keep an open mind about behavioural change, and get going from the start

Effective therapies for eating disorders all need some kind of change in behaviour – eating differently, being weighed and knowing your weight, working with your loved one to establish an eating pattern, changing behaviours that keep you pinned down in the eating disorder, etc. All of these are necessary if you or your loved one are going to recover. This takes a willingness to be brave and to take risks with your anxieties, but we know that patients and carers who do that are likely to do much better than those who do not take those risks.

I am always impressed by the sheer bravery of the patients and carers who I work with, as well as their complete shock when it works and they can act differently without putting on weight, and so on. The best motivator that we have is when we can give the patient a metaphorical pat on the back, and say: "Well done – now, time for more…"

However, there is a twist to this need for behavioural change. All the evidence says that you will do best if you initiate change from the start of therapy. So, whatever your therapy, make the changes from the start, rather than trying to negotiate: "Yes, I will change, but not just yet". In particular, think about that very common statement that we hear from patients: "But none of my previous therapists have asked me to eat differently/know my weight/keep a food diary". My reply to that one is always: "And yet you still have the eating problem? Time to do something different rather than just repeating the same old ways." So take a deep breath, and buy into early change, for your own sake.

It is about food

It is a common trope that 'It's not about food' (there are at least two books called that – you might have one on your bookshelf). That needs to be reconsidered. My take on that is that when the eating and body image problem started, it was probably not about food – it might have been about control, self-esteem, trauma, emotional issues, family patterns, teasing, the changes of puberty, or any of a countless number of individual experiences. However, by the time that you are sitting there in the clinic with your therapist, the eating disorder is very much about food – starvation effects, restriction, terror about what eating will do to your weight, use of food to control emotions, fears about body image as a result of eating patterns, and more.

So don't try to ignore the need to change your eating – that is your key goal in the first part of therapy. The therapy will get you to a place where you can deal with those other issues, if necessary, but only if you do the first part so that you are stable enough to get to the emotional and historical issues.

Body image matters, but...

Addressing body image is really important to ensure effective therapy for an eating disorder. Fortunately, we have some very effective methods for dealing with poor body image. However, we also know that you are unlikely to benefit from those techniques unless the eating element is sorted first. So, help your therapist to get you to the point where you can work on those issues, by working on your eating first.

Weight change

There are two things that no-one with an eating disorder is likely to want to hear, but that everyone needs to learn to tolerate if they want to recover...

(1) If you are underweight, you will need to gain weight to recover. However, clinicians are not psychic and cannot tell you what weight will work for you, so you are going to need to be prepared to work on weight gain slowly and experimentally, to find out how much weight.

(2) If you want to lose weight during therapy, then the therapy cannot work

So please bear with your therapist, and focus on recovering rather than perpetuating your eating disorder by holding onto old patterns.

Safety first

And finally...having an eating disorder involves physical and psychological risks. Make sure that you listen to your clinicians about your health issues, and make sure that you are safe by taking their advice and keeping them updated with any changes or new problems. You are not 'being a bother': you are being sensible. But don't let your fear of change stop you from taking a different kind of risk – facing your fear in order to get well.

Conclusion

Evidence-based psychological therapies give you the strongest possible chance of recovering from your eating disorder, though of course you need to be sure that you are physically safe, too. Please consider being an active part of the therapy team by following these basic rules. That way, all the work that has gone into developing these therapies has the opportunity to help you and your loved one too. I am absolutely sure that there are approaches here that will sound scary, but I have seen so many people recover from their eating disorder that I would like everyone who reads this to have the best possible chance to share in that experience. So take a deep breath, and be prepared to feel the fear but to make the change anyway. Then you can tell others how it feels not to have an eating disorder ruling your life, too.

Glenn Waller is Professor of Clinical Psychology at the University of Sheffield, UK. He has published over 320 peer reviewed articles and four books on the treatment of eating disorders.

As well as his clinical work and supervision, he is a trainer in cognitive-behavioural therapy for eating disorders who teaches nationally and internationally.

Assessing Mental Health Services through a Newcomers Lens

Photo Credit: Ivan Samkov via pixels

BY: HIBA M. HAMED, (H)B. ARTS. SCI., MSW, RSW

Whether being from a White, Chinese, Asian, Black, Filipino, Arab, Latin American, Korean, Japanese, or other diverse race and ethnical background we are humans and require working in holistically to nourish and set free our mind, body, and soul." -H. Hamed

NEWCOMERS TRYING TO ACCESS MENTAL HEALTH SERVIC

As a first-generation Lebanese Canadian born in the capital city of Ottawa, Ontario, and raised in Southern Ontario, it has been challenging to be a visible minority - a female Muslim with a headscarf. Both my parents immigrated to Canada in the 1980s due to war-torn communities and economic crisis within our home country back in the Middle East. I would say from experience it is not always easy to access mental health services for newcomers, especially when there is a language barrier for seeking healthcare, transportation, employment services, education, and other underlying needs and obstacles.

It is essential that newcomers who immigrate to Canada be provided with acceptance, empathy, and active listening from providers as there are enormous barriers and gaps to be bridged for newcomer populations.

For instance, newcomers face stigma from within their own culture for seeking mental health services. Newcomers might be told by their community that they are either "sick" or "crazy" if they seek such services.

In addition, newcomers come with various unique experiences based on the country they came from in order to seek peaceful refuge. For example, newcomers may have to face a war-torn country, violence, trauma, post-traumatic stress disorder, anxiety, stress, depression, isolation, domestic violence and abuse, floods, grieving a loss, fires, earthquakes, etc.

Lastly, services that come from most non-for-profit organizations do not have enough funding or up-to-date knowledge and/or tools to support the newcomers' unique needs. For instance, only having one or two language pamphlets instead of a variety of language pamphlets, or lack of diverse interpreters for newcomer counselling services.

Majority of newcomer services within the community seek annual funding and grants from the government of Canada, through Immigration, Refugees, and Citizenship Canada (IRCC) which helps to facilitate the arrival of newcomers and relevant programming (IRCC, 2021). One program by the IRCC is the Newcomers' Mental Health and Well Being Program; this Ontario-based program introduces holistic mental health services to help newcomers settle in Canada (Canadian Visa, 2020). With the Covid-19 pandemic, the mental health field received more awareness worldwide.

The government of Canada announced an investment of over 9 million dollars for distress centers, introduced by the Ministry of Health and Honourable Patty Hajdu, due to the increase of stress, anxiety, depression, and loneliness being reported (Government of Canada, 2021).

In my opinion, education on mental health for newcomers through notorious mental health organizations would be beneficial, and should be reinforced and promoted just as much as physical health. If these initiatives are not taken, more newcomers will face blockages and may fall off path for attaining their short or long-term goals in life, as well as for meeting their basic daily needs (e.g., raising family, going to school, finding a job, transportation, housing, food, supporting family back home and other basic necessities).

SOCIAL, CULTURAL, AND ETHNIC STIGMAS AND OBSTACLES NEWCOMERS FACE

With the ongoing Covid-19 pandemic, newcomers are facing challenges with accessing technology, internet, and gaining support when the whole community went virtual. Not all newcomers have enough funds or access to support their daily living. Therefore, newcomer centers play a crucial part by offering funds, coupons, workshops, webinars and support to help ease the challenges newcomers may face.

According to Zahra Premji from CBC News British-Columbia (2020), the digital divide left the newest arrivals feeling isolated and abandoned. A Vancouver story of 24-year-old Shewit Berhane, a newcomer from Ethiopia, discussed how the pandemic made her dependent on the virtual world - a need she could not meet - and adds that the lack of affordable devices can turn into a vicious cycle when you want to integrate into the community but do not have the right tools (Premji, 2020).

Picture of Berhane and 17-month-old daughter in Canada Photo Credit: (Ben Nelms/CBC)

Similarly, Fatima Al-Hammoud - 33, living in New Brunswick and is a privately sponsored refugee from Syria - said it has been challenging to rebuild her life in Fredericton. "When I first came here it was very hard for me to reach out to people, because my English wasn't very strong," she said. "Everything was different. The language, the weather, the culture." A recent Statistics Canada survey found that immigrants were more likely than Canadian-born respondents to be worried about maintaining social ties and family stress during the pandemic (Silberman, 2020).

Professor of psychology at the University of Toronto-Scarborough, Steve Joordens, claims human beings naturally seek out connection as a way of dealing with anxiety. However, Joordens states that certain cultures - such as individuals from the Middle East - face the added challenge of cultural stigma around mental health and seeking help. Many newcomers also face disconnection from extended family and time zone access (Silberman, 2020). Social Isolation overall is linked to health problems, including anxiety, depression and in turn a compromised immune system (Silberman, 2020)

HOW SUPPORT SYSTEMS MAY DIFFER FROM WESTERN FAMILIES

There are numerous therapeutic approaches that can be applied to help newcomers reach their potential goal and achievements in life. For example, psychodynamic therapy, behavioural therapy, cognitive behavioural therapy, humanistic therapy, and many more (Raypole, 2019). It is just a matter of knowing how, when, and where newcomers can seek therapy for mental health.

Currently, newcomers can simply seek support for mental health from holy institutions, schools, non-for-profit organizations, or evidenced based literature. However, a newcomer may not understand certain therapies that may be applied in western society, in comparison to their place of origin.

Therefore, it is essential to be open-minded and share a two-way exchange in communication with newcomers and the community to bridge the gaps within the system. With this said, an individual who comes from abroad and settles in Canada may face a huge culture shock, and may be struggling in determining what will best fit with their needs.

In brief, according to the Merriam-Webster dictionary (2021), "culture shock" is defined as a sense of confusion and uncertainty, sometimes with feelings of anxiety, that may affect people exposed to an alien culture or environment without adequate preparation.

Therefore, it is important to learn from different cultures, attend the celebration of the nations, and have a diverse, inclusive, and equitable system in place to enable newcomers, Canadian citizens, and permanent residents to work in unison. With open-mindedness towards learning about different cultures and backgrounds, and possibly using focus groups and events, we can foster more understanding of the differences and gaps (for instance, language barrier, culture and historical compentency social isolation, traditions, holidays) that require to be bridged within the community.

WHAT WOULD MAKE ACCESSIBILITY, ACCEPTANCE, AND UNDERSTANDING EASIER FOR NEWCOMERS

There are numerous ways newcomers and Canadian citizens can access mental health services. Primarily through non-for-profit organizations, such as the Canadian Mental Health Association, and/or the local hospital for extreme cases. Refer to the article sources below for a list of resources of newcomer organizations in the Windsor-Essex County community which offer a wide range of wellness and mental health services that are accessible.

Accessibility begins by normalizing mental health with promotional items, education, focus groups, awareness weeks or events, and fundraisers within the community. Newcomers would benefit from having an open application with a newcomer organization to help with settlement and smooth transitioning.

Some programs and services include one-on-one direct services to newcomers with complex needs, comprehensive newcomer's settlement needs assessment, referrals to appropriate community programs and resources, group activities that provide coping strategies, support, skill-building and self-help opportunities (CultureLink, 2021).

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

A Taste of Beirut with the refreshing Mint Lemonade Drink

Mint Lemonade is one of Hiba's favourite summer drinks when she travels over to Beirut, Lebanon. However, due to several travel restrictions and tough times, she thought she would share a taste of Beirut with the famous mint-lemonade summer quencher. It is the perfect drink during the hot summertime for any age, race, shape, and population. The mint leaves are the addition that makes the drink more refreshing and decorative. This drink will be found on numerous restaurant menus.

Did you know?

***Lemons**: Not only does the lemonade taste wonderful, but it also has a lot of health benefits-lemons are high in vitamin c. They also contain B-complex vitamin, calcium, iron magnesium and potassium. Make this mint lemonade and you will never be able to drink the bottled or powder store-bought lemonade again.*

***Mint:** Mint's scientific name is Mentha requienii. Its name was derived from the Greek mythological figure "Minthe", a nymph who was transformed into the fragrant plant.*

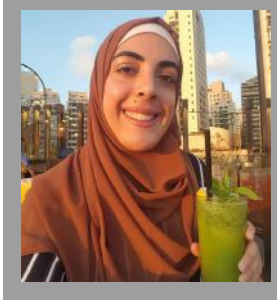
For millennia, mint has been used as a symbol of hospitality. In Ancient Greece, it was rubbed on tables to welcome visitors. The herb was used to clear the air in temples and homes. In the Middle East, mint tea was and still is offered to guests upon their arrival.

Hiba has gathered a simple yet easy mint-lemonade recipe to make with family and/or within the community.

Ingredients:
1 ½ cups granulated sugar (300 g.)
2 cups water
3 lemons, sliced (ends cut-off)
1 cup (packed) mint leaves
Add crushed ice, or ice cubes as needed

Process:
1. *Wash and dry mint and pluck leaves.*
2. *Place sugar, water and lemon slices in a saucepan and bring to a simmer. Let the mixture simmer gently for about 20 minutes. Cool. If not using that day, cover and refrigerate (up to several days).*
3. *To make the minted lemonade: Pour the syrup, 1/3 of the lemon slices, 2 cups of water and the mint into a blender. Blend at high speed for one minute. Strain the lemonade.*
4. *Pour the lemonade over crushed ice or in a cup with ice cubes. Serve with a straw.*

Source for recipe:
https://www.tasteofbeirut.com/minted-lemonade/



Hiba M. Hamed is a Professor at Collège Boréal as well as a French Youth Social Worker and Mental Health Counsellor at Nisa Homes

Picture of Hiba Hamed, staff, and Youth Leadership Program (Syrian and Middle Eastern Newcomers) at Downtown Mission on Canada Day from WEST Inc. in 2017

Unfair to Compare

Photo Credit: rodnae-productions via pexels

By Sara Dalrymple, BA. Psych, MSW, RSW

Have you ever compared yourself to another individual and ended up not feeling very good about yourself thereafter? Have you ever looked at someone else and thought, "If only I looked like them, my life would be different, all my problems would be solved, and I would be happy"? If you can relate, it may be that you are making unfair comparisons. Most people compare themselves to others in many different contexts – Am I raising my kids right? Am I in a healthy relationship? Am I where I should be in my career for this age? Am I taller, shorter, as fashionable?

Although most comparisons tend not to be helpful – as they may often lead you to feel negatively about yourself, or distract you from focusing on more productive things – they are still a relatively "normal" behavior. But what happens when your comparisons disrupt your functioning, impair your sense of self-worth, or cause you to make drastic changes or efforts towards an "ideal standard"? In cases such as these, it may be best to begin thinking critically about the way in which you compare. We're here to help! Here are some things to think about when it comes to your appearance-related comparison-making.

THE SET-UP:

In many cases of comparison making, you may not realize that you have already set yourself up to feel negatively. Typically, when we compare, we may be envious of someone else – and in order to have envy, you may have identified an area in which you are self-conscious, or feel you are lacking/falling short. By making a comparison, you may be simultaneously and subconsciously communicating to yourself that you are inadequate. By this point, you have already made a decision that the individual you are comparing to is better than you in some capacity; no matter how you approach the comparison, you will likely not come out favorably.

For example: say you are comparing yourself to another individual based on who has a nicer car. You select a person who has a nicer car than you have, and then you make the comparison. Of course, the outcome will be that this person has a nicer car than you have, because that is the basis in which you have selected them.

How can you combat this? Well, if you are to make comparisons, keep them open-ended. In our example, you could have compared cars without any specific criteria. Rather than deciding to compare on which is nicer, you could merely compare them. What are the differences? Similarities? Pros and cons of each? It's not a race or a competition, but rather a curiosity. may see, and areas you believe were likely manipulated. You may be surprised to find that the magazine is all marked up with red by the end of it.

AND STILL, once these images have been edited, the best of the best are selected to post and advertise. There may be hundreds of images and clips that were taken, and only a very small handful has made it through to the judges.

THE SELECTION:

Who are you comparing yourself to, and how did you select them? Do you think there may be any bias in the way in which you have selected them? Are you comparing based on objective facts, or based on assumptions, your values or cultural preferences? Do you think this person represents the general population, or could they belong to a "niche" group? Are you comparing only to certain ages, genders, or body types? Where are you (in terms of location) when you are comparing?

Often times when making comparisons, you may select people who you perceive to meet an ideal of some kind. Maybe they are your goal weight; maybe they have the sense of fashion you wish you had; maybe they're fit and toned like fitness icons; maybe they have the curves the media praises.

In order to think critically about who you are comparing to, it is important to ask yourself what percentage of the general population meets the "ideal standard of beauty"?

It is likely that the people you are comparing to only represent a very small portion of the population? If you're only looking at certain age categories, styles, genders, or body types, it may be helpful to open up your selection to include everyone – not just certain subgroups. Not everyone is lean, tone, 21, youthful, and a fashionista.

What may be even more likely is that you could be overlooking or ignoring everyone else – making these "ideal" people seem much more common than they really are. Don't believe us? Try the activity below to put it to the test. You may also be in a location that does not offer a variety of different and unique people to compare to. For example, if you're at a gym, it is likely that majority of individuals there reflect fit, athletic body types because it is a niche environment. If you compared at a grocery store, where everyone has to go from time-to-time, you may have a more representative sample.

Activity: Instead of comparing yourself to those you deem attractive, compare yourself to every third person you pass on the street/come in contact with (the mall is a good place to do this, as it offers a range of people). You will see there is a wide range of body types and appearances that exist – ones you may have overlooked in the past.

CONSIDER THIS:

If you are going to compare to an individual you deem attractive, try to evaluate them under the same lens you evaluate yourself. You may have a tendency to be self-critical, or to only pay attention to your flaws and "problem areas".

When comparing, are you only paying attention to the person's positive attributes and attempting to compare those to your perceived flaws (rather than your positive attributes)? If so, try looking for their flaws (quietly and to yourself; we do not encourage bullying), just like you do with yourself. You will find that everyone – yes, EVERYONE – has flaws if you look for them.

Also try to consider other aspects of their life outside of appearance; are you assuming they are happy, successful, in a great relationship, have a great personality, and so on just because they are physically attractive?

A lot of the time, unseen characteristics can change a person's attractiveness. This is important to think about when comparing; just because someone is physically appealing does not mean they "have it all" or are considered attractive across-the-board. Have you ever met someone you were not initially attracted to, but got to know them better and found them more and more attractive? Remember, attraction is subjective, and there is a lot more to attractiveness than what meets the eye – pun intended.

THE MEDIA:

The media has a way of guiding us towards certain standards for beauty and body-types. But how representative are these images? We pit ourselves against individuals in the media because they seem so "perfect", but are they actually?

First and foremost, it is important to remember that the media is very selective with who they flaunt. Typically, the most "attractive" people are selected from audition groups to be in commercials, magazines, TV shows, etc. Once selected, these individuals have an entire beauty team making sure they look as flawless as possible. Airbrushing, makeup artists, hair stylists, fashion gurus – all plucking and prying away at the "unacceptable flaws". Do you think this person looks that way in their day-to-day life? Did Beyoncé actually "wake up like this"?

It doesn't stop there. Once the media images are developed, they are edited. Heavily. Lengthening the neck, blurring the pores and cellulite, enhancing the eyes, shrinking the waist. The list goes on and on. Not even the "attractive" individual they selected looks like this in real life.

Activity: grab yourself a magazine and a red sharpie. Go through the magazine and circle any edits you may see, and areas you believe were likely manipulated. You may be surprised to find that the magazine is all marked up with red by the end of it.

AND STILL, once these images have been edited, the best of the best are selected to post and advertise. There may be hundreds of images and clips that were taken, and only a very small handful has made it through to the judges.

Lastly, the most important thing to remember when it comes to the media is people only post what they want you to see. What you're seeing is the result of a very careful and selective filtration process. The majority of individuals won't share that unflattering image; won't post about their distressing body image; won't let you have online access to their flaws so long as they can help it.

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In summary, it is important to keep the above considerations in mind if you are going to engage in comparison making. A lot of bias, selectivity, and manipulation is involved in the comparison-making process. Do what you can to challenge your comparisons in order to prevent them from impeding on your self-worth. No matter the societal ideal, you are always worthy and beautiful.

For 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

Getting To Know...

Ottavia Lepera

Over the years BANA has encountered many fascinating people with amazing stories that we've always wanted to share. We hope our "day in the the life" featurette will bring you a little closer to them

Photo Credit: Mail Tilson TORONTO

My name is Ottavia Lepera and I am 26 years old. I own a business as a mobile Esthetician here in Windsor, and I am a signed Curve model. Over the last 8 years of modeling, I have had the pleasure of traveling across Europe, USA and Canada working with amazing brands.

Growing up as a young girl I was often bullied by other kids on account of my weight and appearance; the words they would say to me replayed in my head over and over again. I started to believe the things that were said to me because I didn't look like the women in the magazines or media.

Those words stuck with me for a while, and held me back from so many events and activities because I didn't want to be seen. I wish I could go back in time and tell my younger self that I am beautiful, and our bodies and people's opinions do not define who we are.

In this generation, social media is available in the palm of our hands at all times. It has become increasingly difficult to not compare our bodies, careers and lifestyles to others. The truth is if we remove the filters and "perfect" caption and get down to the true everyday life of some of these influencers, it's not always as fabulous as it seems.

When I first started modeling in the plus sized industry it was just starting to blossom. Brands were still heavily editing images, and they only used sized 12-14 plus sized models. When brands capture your images and pay you, they get to decide and control how to edit your image. It was difficult to see my images so edited and my body completely reshaped; it was supposed to be my body but I didn't recognize it.

That feeling I would get while looking in magazines as a young girl... I now knew the reality of it.

Social media has given me a platform to share my untouched images and has allowed me to share my journey, struggles and opinions. One topic I like to explore is filters and editing. Selfie dysmorphia is a real issue that most of us don't realize affects us. A few years ago, I watched multiple videos of celebrities having their images edited and I remember feeling worse because how could I ever compete with these unrealistic expectations?

I started to talk about PhotoShop and the negative impacts it can have; and became aware that things are not always as they seem in the media, but I was also quick to forget about the work applied to the magazine covers.

Today, editing pictures has become the norm, as it can be done on almost every platform. These filters and editing apps make it very tempting to start mental wish lists of things I could change; a more defined jawline, bigger lips, higher cheekbones, smoother skin, the list goes on.

Most images and videos we see while we are scrolling on social media, through magazines or online shops are EDITED! As a model, I have experienced moments of self doubt after seeing heavily edited shots of myself. Honestly, I love filters; however, it's important we keep it real and recognize that we are beautiful unfiltered too!

Follow my journey on Instagram @ottavialepera

Photo Credit: jenniferenujiugha via pexels

Understanding and Overcoming Internalized Weight Bias

By By: Erin McMahon

Weight bias refers to the negative attitudes, stereotypes, and beliefs about others and yourself due to body weight and size. These biases can be both implicit - where negative weight-based comments are being directed toward yourself - or explicit - where the attributions are being directed toward another person. The stigma surrounding weight can become manifested or internalized by the individual, leading to feelings of incompetence, self-hatred, or devaluation. When one internalizes these negative beliefs about themselves, it has been shown to be associated with poor body satisfaction, depression, and disordered eating habits [1].

There are various forms of weight bias and weight-related stigma. These may range from teasing, bullying, or harassment, to prejudice and discrimination, rejection or exclusion from society or groups, mass media portrayals of individuals of higher body weights, and microaggressions such as weight-related commentary. An example of this type of commentary may go something like this: "Did you lose weight? You look so good now!", or "Are you sure that's your size?", when approached by a sales associate at a clothing store.

Another facet of internalized weight bias may be the way in which an individual perceives their identity, believing that their personality traits are associated with a certain body type. For example, how much the person identifies with stereotypes associated with a higher weight, such as being "lazy", "unsuccessful", "unattractive", and so on.

The stigma surrounding weight was created by society idealizing thin, lean, and muscular body types. We have been taught that we are personally responsible and able to control our weight when a majority of the regulation of body weight, size, and shape is genetic, and this is something we are unable to change!

Our bodies have their own control system designed to regulate body weight consistently; this is our bodies natural "set-point".

This system works by adjusting food intake and energy expenditure (the speed of one's metabolism) in proportion to your bodies current weight versus set point weight [3]. The human body has a weight range that it is genetically predisposed to maintain; this weight is very individualized, meaning that set point varies from person-to-person, regardless of factors such as height and gender.

The idea that we are personally responsible for controlling our weight stems from Attribution Theory. "Attributions" are how individuals perceive the causes of everyday experiences that occur over their lifetime, and this theory assumes that people are determined to understand causes of others' behavior - essentially "why people do what they do" [5]. Thus, if you fail at something and believe it was within your own control, you will begin to associate the failure with negative feelings; this often comes in the form of blame.

When viewing weight as being controllable, individuals of higher body weights are seen as personally responsible and at fault for their weight status. When viewing weight loss as "successful", this strengthens the belief that weight is controllable and increases these weight-biased beliefs and attitudes contributing to the stigma surrounding those of higher weights

Attribution Theory also explains physical attractiveness in that many individuals associate positive personal traits to those who are considered "attractive".

When walking down the street and seeing someone perceived as "good-looking", we often believe that they have good behaviors and outcomes, such as they're "well-liked", "smarter", and "wealthy".

Whereas individuals of higher weights are seen as unattractive because our society idealizes thinness and assigns negative personal traits to people of a higher body weight.

This can be seen in mainstream media and news through the stigmatizing terminology and images used to depict people of higher body weights; the lack of positive media representation of varying body sizes and shapes; as well as promoting diet culture using devices and quick-fix diets with an assumed goal to completely eliminate larger bodies in society.

Weight bias and stigma can also be perpetuated by medical professionals who jump to attribute an individual's medical diagnoses to their weight and Body Mass Index (BMI). Doctors are the second most common source of weight stigma and behind their lead follows nurses, dietitians/nutritionists, and mental health professionals from various healthcare settings [6].

More than half of primary care physicians - without prior knowledge of eating disorders, disordered eating behaviors, and body image - continue to view "obese" patients as awkward, unattractive, ugly, and lacking the knowledge or ability to follow their prescribed treatment order. Additionally, more than one-third associate negative characteristics to their patients such as weak-willed, sloppy, or lazy [7].

Not only do medical professionals hold these beliefs, but their students carry these biases as well.

One study found that 72% of medical students reported they preferred people they deemed as thin to persons of a higher body weight, and 33% of the same students openly admitted to having anti-fat attitudes [8].

A majority of health care facilities do not accommodate for the needs of patients in larger bodies; this may include seating, handrails or ramps, equipment and beds, doorways, hallways, and restrooms. This subjects patients of larger body sizes to the idea that they do not fit in and cannot be accommodated for, because their size does not fit into societal "norms".

This can enhance feelings of isolation and foster avoidance in obtaining health care due to a fear of being criticized for their weight. In literature, it has been shown that people who think they are overweight engage in fewer health behaviors, and an increase in disordered eating, depressive symptoms, weight gain over time, and internalized weight bias. [11].

These personal experiences of weight bias result in body dissatisfaction which can then lead to compensatory behaviors, such as binge eating, purging, restricting, excessive exercise, and muscle building [11].

There is a difference between experienced weight bias and internalized weight bias. When a person begins to internalize weight-related commentary, they tend to self-direct and believe the stereotypes are applicable to themselves. They begin to self-blame, self-criticize, or devaluate themselves.

This may lead to the individual losing motivation to achieve their own goal of change, wondering "why should I even try?". When an individual is in a psychological state where they are concerned that they may be devalued, discriminated against, rejected, or negatively stereotyped as a consequence of their weight, they will engage in that stereotypical behavior because they no longer hold the mental capacity to escape the stigma they were subjected to. This can also lead to increases in their avoidance of situations in where they may be subjected to weight bias once again.

Weight stigma is a continuous cycle, and having these experiences can lead to psychological distress & diminished health, abnormal eating & physical activity behaviors, and impaired physiological health [14]. Once these negative beliefs and attitudes become internalized, it can have a harmful impact on the individual and can lead to increased weight gain… where the weight stigma cycle continues.

Simply put, weight stigma is associated with greater weight bias internalization, which is associated with greater psychological distress, and increased psychological distress is associated with greater disordered eating behaviors [14].

This would suggest a cycle-type paradigm involved in the negative effects of stigma and its impact on health, as well as the need for social policy to be aimed at preventing stigma surrounding persons of larger bodies!

Weight bias internalization and psychological distress mediates this relationship between weight stigma and disordered eating behavior, continuing this constant loop.

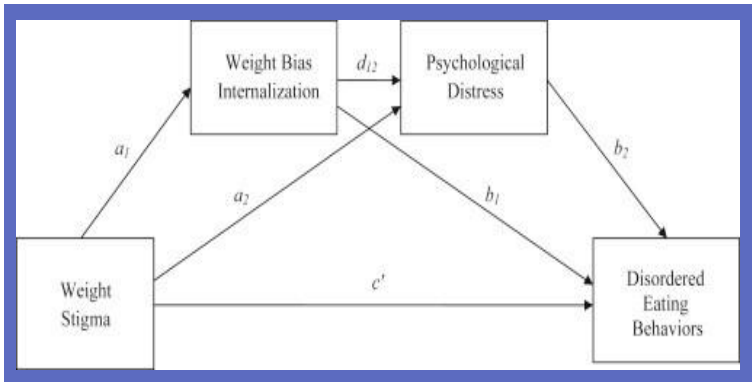

Figure: The Relationship between weight stigma and eating behaviors can be explained by weight bias internalization and psychological distress after accounting for weight status and gender, (Obrien et al., 2016).

So… how can we combat these internalized weight biases? For clients looking to overcome their eating disorder or disordered eating habits, we need to shift from an emphasis of defining health and well-being on the basis of weight and weight loss. We need to move to a weight-inclusive approach where the definition of health and well-being comes from a variety of factors, and health behavior change is key!

BMI is not a great predictor of health, as it only accounts for the weight of skin, bones, and organs in relation to height. We need to change our beliefs that BMI accurately reflects a person's health practices, health status, or moral character. Each one of you has the ability to pursue health and well-being regardless of your BMI. You deserve to receive health care where you are not subjected to stigmatization by health care providers.

Body size is a neutral and naturally varying human characteristic, where your social determinants of health (socioeconomic status, employment, education, childhood experiences, physical environment, social supports and coping skills, health behaviors, access to health services, biology and genetics, gender, culture, and race) influence your individual behaviors [15].

All food has value for your body and is acceptable, and the quality and quantity you choose to consume are determined by your response to physical cues such as hunger, fullness, or taste.

When partaking in physical activity, ensure it is fun, functional, and pertaining to your interests. A Health at Every Size (HAES) approach to loving your body can be adopted as well. This approach shifts the focus from managing your weight to health promotion that allows you to eat in a flexible manner while valuing internal hunger cues of hunger, satiety, and appetite, while also finding joy in movement and accepting natural body size and shape diversity.

It recognizes that health is for ALL sizes, as well as the trauma experienced by people of higher body weights. Lastly, it encourages respectful care where we can acknowledge our own internalized weight biases, and work to end weight discrimination, weight stigma, and weight bias.

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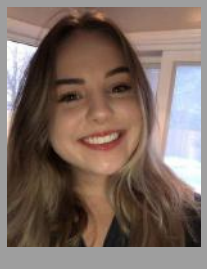

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At the time of this article, Erin is completing her public health internship at BANA under her preceptor Nicole Boulanger where she is observing client meetings and assisting with various BANA projects.

She enjoys travelling, cooking and baking, taking long walks and rollerblading, spending time with friends and family


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FAMILY SUPPORT FOR YOUTHS WITH EATING DISORDERS

By: Shelby Colarossi

Whether you think your child may have an eating disorder or if they are awaiting treatment, we know this can be a very stressful time for your entire family.

There are things you can do during the waiting period to encourage your child's commitment to the recovery process. Many patients are ambivalent towards recovery to some degree anyway, which can then be magnified when treatment is delayed for weeks or months.

Waiting for treatment is unfortunate but unavoidable, as this population requires care from a multidisciplinary team of professionals with a specific level of training and expertise, and we just simply do not have the capacity, resources or enough people trained to be able to manage the need in our community. This situation is not just happening locally; in fact, it is a global phenomenon.

It is important that the entire family remembers not to place blame, and that everyone tries to be patient during the waiting period and recovery process. It is a long journey and eating disorders are serious illnesses, but people can -- and do -- recover fully.

This time can be very distressing not only for your child but for all members of your family. What used to be a fun family event can become an intense power struggle when it revolves around food. Things such as family dinners with discussions about the events of the day can become filled with feelings of anger and often resentment. Above all, the stress of knowing that the affected family member may die from this illness can cause severe family strain. Know that you have done the right thing by reaching out to get help.

So yes, your child has a problem, but neither you or your child are the problem. Your child is still your child. They should not feel like this mental illness is their fault, nor should they be punished for it. There is no one to blame; in fact, there is no known cause of eating disorders.

In the meantime, encourage your child to practice whatever healthy coping tools are effective for them, including journaling, affirmations, or other positive activities.

If journaling is new to your child, help them begin this practice by explaining what journaling is; a simple outpouring of whatever thoughts and feelings they are experiencing that day.

They can make a list of what inspires them to recover, and then reflect on their thoughts when there is an urge to embrace disordered food behaviours. They can write what life would look like without an eating disorder, or create a pro and con list about their eating disorder. Whatever they write, taking the time to put their thoughts and feelings on paper will be sure to assist in their recovery process.

Your child may feel the temptation to roll into a ball and stay in bed. It is common to want to shy away from the entire world. As a family member, try not to get angry. Instead, try to talk to your child and encourage them to fight their urge to isolate. You can also distract them by going for a car ride, watching a movie, playing a game together or suggest hanging out with friends.

Shy away from commenting on any physical changes. Eating disorders can twist and turn words, and certain words or sentences can become triggers. "You look so much better" often equates to "you are fat." "I am glad you look healthy again" often equates to "you are fat and don't need to gain weight." "You are so skinny I am worried" often equates to "losing weight is what will get people to care for me."

As long as your child is still vulnerable, try to avoid any remarks on physical appearance, even if the intent is positive.

Don't say things like "that's an unhealthy snack" or comment on the amount they are eating; however, if you think they're still not eating enough, speak out. They might think the same and just not want to point it out themselves.

Show that you care for them outside of their eating disorder. If your child only realizes that you show concern when they've lost weight or because they haven't eaten, then they might think that this is the only way they can get attention. Ask about school, friends or hobbies; and don't forget to show appreciation toward non-recovery related achievements. This way, your child will learn that they are more than their eating disorder and they can be recovered and still be important.Food, meal plans, servings and snacks are all components of the physical recovery, but can be some of the most challenging to maintain.

While family mealtime can look different from one family to the next, the idea of coming together for camaraderie and nourishment is essentially the same no matter the traditions. When a family member is struggling with an eating disorder, this can drastically change the tone and mood at the dinner table. Family meals become much more complex and at times difficult to enjoy. It is hard to enjoy a conversation when attention seems to be focused on food rather than relationships.

On top of that, there are many families juggling busy schedules and various activities. This can make family meals an afterthought or something that happens on the rare occasion when all members are home at the same time. Now more than ever it is important to find a time during the week, at least one day, that your family can come together for a meal and stick to it.

Family members who are able to provide meal support to an individual with an eating disorder serve an important role in their recovery process. Being able to normalize family mealtime and demonstrate a healthy approach towards eating can encourage an eating disorder sufferer in their own recovery journey.

Ensure that the entire family understands that eating disorders are not about food, calories or dieting. An eating disorder is a psychiatric illness that involves many complex factors. While the hyper focus may be on the food itself, these are merely symptoms of a more severe illness.

Affirmations can be an important tool in overcoming eating disorders. Repeating a chosen affirmation on a regular basis can help put an end to negative thinking and help develop new strength and self-awareness. Help or encourage your child to choose one, three or five affirmations. Have your child;

(1) Read them out loud every morning three times.
(2) Read them out loud while standing in place. This prepares their inner self to receive the affirmation.
(3) Read out loud once as they walk around a room or an outdoor area. This helps anchor the meaning in their body and also makes new thoughts and feelings familiar and comfortable in different environments.
(4) Read out loud once in front of a mirror, looking at their reflection as they speak. This helps them see themselves listening and helps them accept the strength and awareness they are giving themself.
(5) Encourage them to do this every morning for one month.
(6) At the end of one month, have them add new affirmations to their list. They can subtract any affirmations from before or they can continue on with any of them. A sense of what is needed to become engaged in the process starts to develop.

Any positive thought or phrase is an affirmation, such as; "I can go anywhere I want to go", "one step at a time", "I am willing to succeed", "I am grateful for who I am", "today I know I have the right to be alive, happy, and full of joy", etc.

It is a challenge to make sure the eating disorder and the recovery is only a part of your family life and not the entire thing. Continue to do things as you did pre eating disorder, such as family trips or mini golf. Strive for a sense of normalcy so that a life without the eating disorder is imaginable. Life without an eating disorder is not only possible, it is achievable.

For more help and information you can go to
www.wechc.org www.bana.ca www.nedic.ca

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

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Grounding Techniques

Practicing grounding techniques can help control flashbacks, anxiety, and other uncomfortable symptoms by turning attention away from thoughts, memories, or worries, and refocusing on the present moment.

One of the most effective and proven practices is the 5-4-3-2-1 technique.

In using this method, you can mindfully take in the details of your surroundings using each of your senses, no matter where you are or what you are doing at the time. Focus your attention on small details that your mind would usually ignore or dismiss, such as amibiant sounds, or the texture/patterns in everyday objects.

5 things you can SEE:
1) _____
2) _____
3) _____
4) _____
5) _____

4 things you can FEEL:
1) _____
2) _____
3) _____
4) _____

3 things you can HEAR:
1) _____
2) _____
3) _____

2 things you can SMELL:
1) _____
2) _____

1 thing you can TASTE:
1) _____

BANA
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On June 22nd BANA held their 37th Annual General Meeting.
As part of the event we recognized individuals and organizations for their commitment to the enhancement of healthy lifestyles in our community.

Please join us in congratulating our award winners.

Outstanding Business/Organization
Andrea LeClair for
Paradise Charitable Gaming Corporation

Outstanding Individual
Dr. Anita Federici

Outstanding Non-Profit
Theresa Marentette for
Windsor Essex County Health Unit

Moriarty Leadership Award
Dr. Wajid Ahmed

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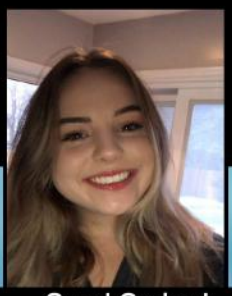
The Podcast

Hosted By:
Stephani Fenkanyn
BANA Health Educator



Guest Co-host:
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BANA Intern

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Featured Guest:
Nicole Boulanger
BANA Dietitian

Episode #17 – Learning more about Nutrition with BANA's Registered Dietitian, Nicole Boulanger

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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.

If I enter BANA's Adult Treatment Program what is required of me?

At BANA, there are general expectations for clients engaged eating disorder treatment:

- **Following BANA policies and procedures**
- **Attendance in scheduled sessions, or contacting BANA to cancel/reschedule when unable to attend**
- **Required weekly weighing, done collaboratively with clinician or dietitian**
- **Completion of daily self-monitoring logs**
- **Completion of assigned homework**
- **To regulate eating, with the support of the BANA clinical team**
- **Attempts to use treatment tools or meet collaboratively outlined goals, when applicable**

Additional Requirement include:

WEEKLY WEIGHING

Once a week, clients will be weighed through a collaborative weighing process. Weighing is a pertinent part of treatment, and clients will be taught how to understand weight fluctuations, as well as how to challenge beliefs about weight/"number on the scale" and it's relation to food and eating. When applicable, weekly weighing is also utilized to monitor weight restoration or maintenance.

SELF-MONITORING LOGS

Clients will be asked to complete daily self-monitoring logs. BANA asks that these logs are completed in "real time", meaning as events are occurring. This "real time perspective" provides the most accurate picture of the eating disorder, and allows clients to develop awareness around their behaviours, moods, and thoughts.

Self-monitoring logs request information on wake and sleep times; eating and drinking times – along with food content, quantity and portion sizes; eating disorder symptoms that occurred; length and type of exercise engaged in (if applicable); as well as thoughts, events and emotions that occurred throughout the day.

REGULAR EATING

A core foundation of any eating disorder treatment is regular (or mechanical) eating – sometimes referred to as "eating by the clock". Generally speaking, this refers to the time of which and how frequently a client is eating.

Clients will be asked to aim for 3 meals and 3 snacks a day, going no more than 3-4 hours without food. Clients, their clinician and dietitian will set goals and develop tools to assist the client in this process.

Regular eating has been shown to:

- **Reduce majority of episodes of binge eating**
- **Address restricting and fasting behaviours, thereby reducing physiological and psychological deprivation**
- **Provide a sense of control around eating**
- **Allow for stronger, more trust-worthy hunger and fullness cues to return**
- **Reduce preoccupation with eating and food**
- **Paired with healthy exercise, allows the body to find it's "set point"**
- **Provide direction for food portioning and balancing work, as well as in**tuitive eating

HOMEWORK

After every session, clients will be assigned homework. It is expected that client's complete homework, as well as consider how homework can be applied ongoingly in order to create change. Homework is a foundational part of treatment, as it strategically encourages clients to incorporate new skills and tools in their day-to-day lives, and within the environment at which the eating disorder was developed and/or maintained.

If homework is incomplete, the clinician and/or dietitian will address this with the client, and problem solve barriers. Homework may include an assigned reading, reflection activity, worksheet, behavioural experiment, exposure exercise, meeting a goal, etc.

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

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