DISORDERED EATING AND OBESITY

Working Together to Promote the Health of British Columbians

For more information or to provide comments or feedback, please contact Kiera Ishmael at kishmael@cw.bc.ca

Disordered eating (DE) is a serious health and social problem for British Columbians. Recent evidence suggests that public health messages focusing on the benefits of weight loss or the consequences of obesity may inadvertently promote disordered eating. As such, this document recommends a collaborative approach among those working to prevent obesity and reduce the incidence of disordered eating. Concrete suggestions are provided for actions to reduce the unintentional harms that may result from obesity reduction policies and programs.

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DISORDERED EATING – AN EMERGING PUBLIC HEALTH CRISIS

Disordered eating is increasingly recognized as an emerging public health crisis. DE is characterized by unhealthy attitudes about one's body – such as weight concerns and poor body image – and by unhealthy behaviours, ranging from skipping meals and chronic or crash dieting to binging and purging.

It is estimated that at least one in four teen girls suffer from disordered eating[1], with as high as 8.2% of girls engaging in self-induced vomiting.[2] Body image concerns afflict an even greater percentage of people, with 53% of female adolescents in the healthy Body Mass Index (BMI) category trying to lose weight.[3] Disordered eating amongst males is also increasingly problematic, with 25% of adolescent males dieting and 20% desiring weight loss.[4]

Prevention experts are concerned about the increasing prevalence of DE, given the relationship between disordered eating and eating disorders (EDs). Research shows that adolescents who diet 'severely' are 18 times more likely to develop a clinical eating disorder and those who diet 'moderately'[i] are five times more likely to develop a clinical or sub-clinical eating disorder.[5]

While EDs are much less common than DE (i.e. the prevalence of Bulimia Nervosa is estimated at 1.1% among females and 0.1% among males[6] and Anorexia Nervosa at 0.56% for females and 0.16% for males[7]), evidence suggests that *as public health messages about obesity reduction become increasingly prevalent, the incidence of both EDs and DE will increase.*[8,9,10] This is particularly problematic for those that end up with serious clinical eating disorders given the long-term health consequences of eating disorders, including the risk of mortality. Anorexia, for example, is associated with extremely high mortality rates, estimated as high as five to eight percent[11].

[i] Moderate and severe measures derive from the adolescent dieting scale, considering calorie counting, food quantity at meals, and meal avoidance.

WHY NOW? TAKING ACTION ON WEIGHT STIGMA, DISORDERED EATING AND PUBLIC HEALTH

While the causes of eating disorders are complex, research shows that disordered eating – including negative body image and unhealthy behaviours – is closely associated with weight stigma.[12,13,14,15,16] Weight stigma is also associated with higher rates of depression and other mental health issues.[17,18]

Although weight stigma is widely considered to be the result of cultural factors, recent evidence suggests that public health policies concerned with the prevention and reduction of overweight and obesity may *inadvertently* promote weight stigma.[19,20,21] Global public health messages increasingly recognize the complex environmental causes of obesity, however these same messages frequently place responsibility on the individual, conceptualizing obesity as a straightforward consequence of energy in exceeding energy out. This approach assumes that obesity can therefore be reduced or prevented, largely through an appropriate combination of diet and physical activity.

Eating disorder prevention experts are additionally concerned about a trend in the literature supporting the notion that all overweight and obese people are unhealthy. This thinking promotes stereotypes and encourages dangerous weight loss, especially among the estimated one-third to one-half of obese people who are in fact metabolically healthy (i.e. at no additional risk from their current weight[ii]).[22] Encouraging weight loss among this demographic may be particularly ill advised considering the difficulties in sustaining long term weight loss and the health consequences of weight cycling, which has been demonstrated through numerous studies to be more dangerous than maintaining a high but stable weight.[23,24,25,26]

EXPLORING SOLUTIONS – HOW CAN WE COLLABORATE TO ADDRESS EATING DISORDERS AND OBESITY?

A collaborative, integrated approach to obesity reduction, addressing both weight stigma and preventing disordered eating and eating disorders is highly recommended as a first step to improving the health of all British Columbians. Collective efforts should be targeted towards creating an environment that makes the healthy choice the easy choice and encourages healthy eating without promoting dieting or weight preoccupation. Such a comprehensive approach would serve to improve the quality of current and emerging prevention and early intervention initiatives while *avoiding unintentional harms and reducing weight stigma.* Advances have already been made in British Columbia, with a focus on collective action across a variety of sectors, in the field of preventing disordered eating. Some emerging promising practices include the following;

[ii] As measured by triglyceride, high sensitivity C-reactive protein, glucose, high density lipo-protein, cholesterol, insulin resistance and hypertension (Shea, Randell, & Sun, 2010).

1. **Prevention Subcommittee of the Provincial Eating Disorders Network:** An intersectoral, inclusive province-wide committee dedicated to the reduction of the structural determinants of DE. The subcommittee currently includes stakeholders from Ministries, Health Authorities, community agencies and more.
2. **Action Schools! BC 'Being Me: Promoting Positive Body Image' Resource:** This collaborative initiative includes Action Schools! BC supplementary classroom resources for teachers in K to 7 education, with a focus on positive body image, resilience and the prevention of disordered eating.
3. **Fraser Health Authority Weight Bias Training:** The Fraser Health Authority has provided leadership in reducing weight bias by providing weight bias training to mental health clinicians and a range of health care professionals.
4. **Family FUNdamentals Project:** Family Services of the North Shore, Jessie's Legacy, in collaboration with BC Mental Health and Addiction Services (BCMHAS) is developing a province-wide educational program to promote healthy eating, positive body image and positive parenting strategies to prevent DE among children in preschool environments.

For a comprehensive list of initiatives underway specifically designed to prevent disordered eating please see Appendix A.

NAVIGATING THE ROAD AHEAD

Many positive steps have been taken in British Columbia to address risk factors leading to disordered eating and critical inroads have been made to bridge the gap between those attempting to prevent DE and those working to reduce or prevent obesity. An increased focus and strengthened collaboration is required, however, to further integrate key prevention efforts and to ensure that supportive environments that both promote healthy choices and avoid unintentional harm are developed.

Obesity reduction is a major public health priority featured in the new Healthy Families BC strategy. A range of obesity reduction and healthy eating initiatives are being implemented, providing a unique opportunity to reflect on how best to design these new and emerging initiatives to avoid unintentional harm and reduce weight stigma.

The following are some **simple, low *to no* cost, effective actions** that can be used to promote health and reduce unintended harm.

1. **Using healthy weight language:** Framing obesity reduction or prevention policies and programs as promoting healthy weights will help prevent the development of weight stigma and disordered eating. Health care professionals and policy makers are encouraged to reflect on the language they use and to abandon discussion on 'obesity reduction' and instead focus on promoting healthy weights for all. This approach recognizes the natural diversity in body weights and avoids promoting the stereotype that it is necessary to be thin to be healthy.
2. **Social marketing about the natural diversity in body weights:** A social marketing initiative about healthy bodies coming in a range of sizes is important to avoid promoting unhealthy slimming practices such as crash dieting in the name of health. To reduce costs this campaign can be woven into existing and/or planned healthy eating and physical activity initiatives.
3. **Weight bias training for health care providers:** Building on the success of the Fraser Health Authority Weight Bias Training, other Health Authorities may wish to consider implementing similar initiatives to ensure health care providers do not inadvertently promote weight stigma. Evidenced through research trials, weight bias training is an effective tool in reducing internalized weight bias among providers.[27]
4. **Tracking progress:** Measuring progress in reducing obesity is an emerging priority in British Columbia. Opportunities to simultaneously track for body image dissatisfaction and eating disorders should be integrated into existing and emerging measurement where it is cost effective to do so. Additionally, all surveillance activities should be considered in the context of a "do not harm" approach.
5. **Learning about the benefits of a non-diet approach to health:** A non-diet approach to health suggests that in order to improve health, individuals should be encouraged to develop healthier eating and exercise habits, without focusing on weight loss. Such an approach promotes healthy eating and exercise for all people, regardless of size and has been evidenced through Randomized Control Trials to be effective at improving physiological health and health behaviours as well as reducing DE.[28,29,30,31,32]

Healthy eating and regular exercise are key to healthy living, however they cannot be separated from a consideration for healthy relationships with food and positive body image. Collaborative efforts to reduce weight stigma, dieting, weight cycling and disordered eating will ensure that obesity prevention and healthy living initiatives are designed and implemented to minimize or reduce potential harm and maximize the likelihood of success.

REFERENCES AND ENDNOTES

[1] McVey, G., Tweed. S., & Blackmore, E. (2004). Dieting among preadolescent and young adolescent females. *Canadian Medical Association Journal*, 170, 1559-62.

[2] Jones, J.M., Bennett, S., Olmstead, M.P., Lawson, M.L., & Rodin, G. (2001). Disordered eating attitudes and behaviours in teenaged girls: a school-based study. *Canadian Medical Association Journal*, 165 (5), 547-552.

[3] McCreary Centre Society. (2008). A Picture of Health: Highlights from the 2008 BC Adolescent Health Survey. Vancouver: the McCreary Centre Society.

[4] Flynn, M.A.T. (2003). *Community prevention of obesity in Canada: The technical document.* Calgary: Author. Retrieved September 25, 2010 from the Calgary Health Region web site: http://www.calgaryhealthregion.ca/programs/childobesity/pdf/the_tech_doc.pdf

[5] Patton, G. C., Selzer, R., Coffey, C., Carlin, J. B., Wolfe, R. (1999). Onset of adolescent eating disorders: Population based cohort study over 3 years. *British Medical Journal, 318*, 765-68.

[6] Garfinkel, P., Lin, E., Goering, P., Spegg, C., Goldbloom, D., Kennedy, S. et al. (1995). Bulimia nervosa in a Canadian community sample: Prevalence and comparison of subgroups. *American Journal of Psychiatry, 152*, 1052-58.

[7] Woodside, D.B., Garfinkel, P.E., Lin, E., Goering, P., Kaplan, A.S., Goldbloom, D.S., & Kennedy, S.H. (2001). Comparisons of men with full or partial eating disorders, men without eating disorders, and women with eating disorders in the community. *American Journal of Psychiatry, 4*, 570-4.

[8] O'Reilly, C. (2011). Weighing in on the Health and Ethical Implications of British Columbia's Weight-Centered Health Paradigm. British Columbia: Simon Fraser University

[9] Bacon, L., & Aphramor, L. (2011). Weight regulation: A review of the evidence for a paradigm shift. *Nutrition Journal*, 10(9). Retrieved January 25 2011 from the BioMed Central web site: http://www.nutritionj.com/content/10/1/9/abstract

[10] O'Hara, L., & Gregg, J. (2010). Chapter 28 Don't diet: Adverse effects of the weight centered health paradigm. In F. De Meester, et al. (Eds.), *Modern dietary fat intakes in disease promotion, nutrition and health*. (pp. 431-441). Springer Science+Business Media.

[11] Steinhausen, H.C. (2002). The outcome of anorexia nervosa in the 20th century. *American Journal of Psychiatry*, 159, 1284-93.

[12] Ibid 4.

[13] Daníelsdóttir S, Burgard D, Oliver-Pyatt W. *AED Guidelines for Childhood Obesity Prevention Programs*. Academy of Eating Disorders; 2009.

[14] Puhl, R.M., & Heuer, C.A. (2009). The stigma of obesity: A review and update. *Obesity, 17*, 941-964.

[15] Haines, J., Neumark-Sztainer, D., Eisenberg, M.E., & Hannan, P.J. (2006). Weight teasing and disordered eating behaviors in adolescents: Longitudinal findings from Project EAT (Eating Among Teens). *Pediatrics, 117*, 209-215.

[16] Lenny R. Vartanian and Sarah A. Novak. Internalized Societal Attitudes Moderate the Impact of Weight Stigma on Avoidance of Exercise. Retrieved from http://www2.psy.unsw.edu.au/Users/lvartanian/Publications/Vartanian%20&%20Novak%20(2011).pdf

[17] Eisenberg, M.E., Neumark-Sztainer, D., & Story, M. (2003). Associations of Weight-based teasing and emotional well-being among adolescents. *Archives of Pediatrics and Adolescent Medicine, 157*, 733-738.

[18] Friendman, K.E., Reichmann, S.K., Costanzo, P.R., Zelli, A., & Ashmore, J.A. (2005). Weight stigmatization and ideological beliefs: relation to psychological functioning in obese adults. *Obesity Research, 12*, 907-916.

[19] Ibid 5.

[20] Puhl, R.M., & Heuer, C.A. (2010). Obesity Stigma: Important Considerations for Public Health. *American Journal of Public Health, 100(6)*, 1019- 1028.

[21] Lewis, S., Thomas, S.L., Hyde, J., Castle, D., Blood, R.W., & Komesaroff, P.A. (2010). "I don't eat a hamburger and large chips every day!" A qualitative study of the impact of public health messages about obesity on obese adults. *BMC Public Health*, 10, 309. Retrieved from http://www.biomedcentral.com/1471-2458/10/309.

[22] Shea, J.L., Randell, E.W., & Sun, G. (2010). The prevalence of Metabolically Health Obese Subjects Defines by BMI and Dual-Energy X-Ray Absorptiometry. *Obesity (Silver Spring)*. Retrieved November 6, 2010 from the PubMed database: http://www.ncbi.nlm.nih.gov/pubmed/20706202

[23] Diaz, V.A., Mainous, A.G. 3rd, & Everett, C.J. (2005). The association between weight fluctuation and mortality: results from a population-based cohort study. *Journal of Community Health, 30(3)*, 153-165.

[24] Ernsberger, P., & Koletsky, R.J. (1999). Biomedical rationale for a wellness approach to obesity: an alternative to a focus on weight loss. *Journal of Social Issues, 55(2)*, 221-60.

[25] Lee, D.C., Blair, S.N. & Jackson, A.S. (1999). Cardiorespiratory fitness, body composition, and all-cause end cardiovascular disease mortality in men. American Journal of Clinical Nutrition, 69, 373-380.

[26] Lissner, L., Odell, P.M., D'Agostino, R.B., Stokes, J., Kreger, B.E., Belanger, A.J., et al. (1991). Variability of body weight and health outcomes in the Framingham population. *New England Journal of Medicine, 324*, 1839-1844.

[27] McVey, G.L., Gusella, J., Tweed, S., & Ferrari, M. (2009). A controlled evaluation of web-based training for teachers and public health practitioners on the prevention of eating disorders. *Eating Disorders: Journal of Treatment and Prevention*, 17(1), 1-26.

[28] Bacon, L., Stern, J., Van Loan, M., & Keim, N. (2005). Size acceptance and intuitive eating improve health for obese, female chronic dieters. Journal of the American Dietetic Association, 105, 929-936.

[29] Ciliska, D. (1998). Evaluation of two nondieting interventions for obese women. Western Journal of Nursing Research, 20(1), 119-135.

[30] Goodrick, G.K., Poston, W.S.C., Kimball, K.T., Reeves, R.S., & Foreyt, J.P. (1998). Nondieting versus dieting treatment for overweight binge-eating women. Journal of Consulting and Clinical Psychology, 66(2), 363-368.

[31] Provencher, V., Bégin, C., Tremblay, A., Mongeau, L., Boivin, S., & Lemieux, S. (2007). Short-term effects of a "health-at-every-size" approach on eating behaviours and appetite ratings. Obesity(SilverSpring), 15(4), 957-966.

[32] Rapoport, L., Clark, M., & Wardle, J. (2000). Evaluation of a modified cognitive-behavioural programme for weight management. International Journal of Obesity, 24, 1726-1737.

APPENDIX A:

Disordered Eating and Eating Disorder Prevention Initiatives in BC

The following is an overview of a range of existing and emerging disordered eating and eating disorder prevention initiatives in the Province of British Columbia to supplement the promising practices discussed in the body of this text.

1. **Mindcheck.ca:** Mindcheck.ca is a website for youth and young adults which aims to: i) increase awareness of mental health and substance use problems and decrease the stigma associated with these issues; ii) improve recognition of mental health and substance use problems in youth and young adults; and iii) increase the use of effective self-care strategies by youth and young adults. Mindcheck.ca is one component of a health literacy project implemented by the Early Intervention Project within Child, Youth and Young Adult Mental Health and Addictions Services in the Fraser Health Authority. Mindcheck.ca will be expanded and enhanced to fulfill a provincial mandate for youth and young adult mental health literacy in 2011. As part of this expansion, information on body image and the prevention of eating disorders, including early intervention resources will be added to the mindcheck.ca website, with an ultimate goal of increasing mental health literacy among youth and young adults who use the site. www.mindcheck.ca
2. **Kelty Mental Health Resource Centre Eating Disorders website:** The Eating Disorders microsite of the Kelty Mental Health Resource Centre provides in depth resources and eating disorders information, including early identification, early intervention and system navigation/referral information. A complete listing of resources related to different eating disorder topics has been compiled. Stakeholders from the Provincial Eating Disorders Network and the community have been consulted to inform the content of the microsite. The information gathered from the consultations has informed the site's design, content and functionality, and was used to develop an effective and meaningful "user flow" experience. www.keltyeatingdisorders.ca
3. **Jessie's Legacy- Eating disorders prevention resources and support for people in BC:** Jessie's Legacy, a program of Family Services of the North Shore, provides educational, informational and supportive services for youth and families, educators and professionals. Included within this are many web-based resources, family support groups and media literacy initiatives. Disordered eating prevention website and resources can be found at http://www.familyservices.bc.ca/professionals-a-educators/jessies-legacy
4. **The Go Girls! Healthy Bodies Healthy Minds Program:** This program, affiliated with Big Brothers/Big Sisters, is designed to help young teenage girls appreciate their bodies and develop healthy relationships with food and exercise. For more information please see http://www.bigbrothersbigsisters.ca/en/Home/Programs/GoGirls.aspx