

The Journal of the National Eating Disorder Information Centre

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ACCEPTANCE



EQUITY



AWARENESS



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Words of Welcome

We are very excited to share the inaugural Journal of the National Eating Disorder Information Centre. This journal is borne out of our desire to provide information that is research-based, evidence-based, and it represents best practice. We want the journal to share new information from the field, build community and move the conversation forward.

Our inaugural journal was by invitation only. The papers that appear in this journal reflect work presented by the authors at our 2017 body image and self-esteem conference: Acceptance. Equity. Awareness. Our hope for this journal is to enrich the conference presentations for conference delegates, refresh memories, and share exciting new research and ideas with those not in attendance. We are proud that this journal champions the work of Canadian researchers working tirelessly in the field of eating disorders and body image in order to improve the lives of individuals and shed light on these often misunderstood and under-researched disorders. We hope that the papers in this journal provide you with insight and information that you can utilize in your professional practice, interpersonally, or even in your own life.

Our 7th biennial conference: **Radical Unlearning** is being held May 9-10, 2019 at the University of Toronto's Chestnut Conference Centre.

We look forward to seeing you at our 7th biennial conference and to the articles that we will consequently publish in our 2020 Journal. The theme of Radical Unlearning incorporates equity, innovation and positive body identity. The term "unlearning" allows those who are learning to navigate new ideas and norms in a non-judgmental, compassionate manner. We hope this will be an opportunity to learn – and unlearn – collaboratively, and to unpack the negative and erroneous messaging that individuals may have received.

Sincerely,

Suzanne Phillips, Program Manager, NEDIC

Acceptance, Equity and Awareness: Introduction to Edition 1 of The NEDIC Journal

Lorayne Robertson and Joli-Scheidler-Benns

We have argued for many years that body equity is one missing aspect of an inclusive nation. When Canadians speak about inclusion, they generally consider first the well-established grounds for discrimination from The Canadian Charter of Rights and Freedoms. Yet areas of inclusion continue to emerge in our society and need to be recognized in research and in thoughtful discourse. Canadians are naturally diverse in body sizes and shape, as well as their physical abilities, and the ways that they want to be active. In Canada, people have a right to “be” that includes every aspect of their personhood. A body-equity approach includes everyone in a diverse population and speaks against body-based bias, prejudice and discrimination.

We would encourage readers of this journal to embrace the theme of the 2017 conference “Acceptance, Equity and Awareness” and think beyond discrimination. Consider the possibility of how bodies of all sizes, shapes, genders, colours and abilities are not only accepted but celebrated and normalized in discourse, in media and in prevention and treatment. As we become more inclusive as a nation, we will develop more individualized and personalized approaches for all bodies and we will recognize that there is both discrimination and risk inherent in many of society’s perfection codes.

As our awareness grows, we will shed the moral overtones that for generations have been associated with size and acknowledge that health is not determined by size. Rather than attaching stigma to individuals, we need to recognize as a society that there are broad systems that determine access to nutrition, exercise and health supports.

As the editors of this inaugural journal, we are proud to support the Canadian authors who support inclusion and equity. In the first article, Margo Maine explains that the majority of women at midlife are preoccupied with weight and distress over their shape, appearance and diet. She presents Nine Truths about Eating Disorders at Midlife and Beyond. She urges the same type of compassion for eating disorders as that with which we would approach breast cancer or any public health problem.

In the second article, Niva Piran theorizes the societal structures of privilege and powers that are connected with living in our bodies in Privilege and the Body. She presents the Developmental Theory of Embodiment as a lens that can be used to examine, for example, social stereotypes and social power and their relationship to embodiment. In the third article, Booty Shorts and Sexting, Angela Grace examines two case studies and then applies Piran’s theory of embodiment in order to identify the social justice issues such as silencing and create an action plan that includes empowerment.

Aligning with the themes from this conference, Andrea LaMarre and Kaley Roosen (Navigating Differences within Eating Disorders and “The Other”) challenge us to consider that conversations about eating disorders which continue to carry assumptions that limit our capacity to engage in deeper ways with persons who struggle. They offer a model of compassionate care that recognizes systemic problem relationships. They encourage us, instead, to look to ways to engage with diversely embodied persons with eating disorders.

The fifth paper in the journal informs readers about another equity-conscious and caring treatment approach, Ann McConkey and Lisa Naylor from the Women’s Health Clinic in Winnipeg present A Weight-Neutral Approach to Health and Wellness. As HAES® practitioners, their emphasis is on health-promoting behaviours and changes to improve the quality of life for persons of all shapes and sizes.

The journal closes with two papers that focus on prevention. In Adolescent Girls Use Power Tools, we report research that was designed to build protective factors for adolescent girls who explore critical media literacy and health. Joli Scheidler-Benns has designed a critical media health literacy framework that helped to examine whether or not adolescent girls could learn to think more critically through a program of body positive activities. In the final paper, Learning about Real, Lorayne Robertson explores the intersections between critical media literacy and body equity. She argues that students who are exposed to more critical forms of literacy can recognize and

respond to media that promote stigma and stereotypes. She holds out hope that today's adolescents can rewrite media scripts to promote body-fair messages.

We hope that readers of the inaugural journal will experience a flood of memories from the 2017 conference. We believe in the platform of an open journal and we encourage readers to share articles broadly in support of the goals of NEDIC.

Lorayne Robertson and Joli Scheidler-Benns

Editors, The Journal of the National Eating Disorder Information Centre

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Nine Truths about Eating Disorders at Midlife and Beyond

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Abstract

*Age does not immunize women from eating disorders. In fact, increasing numbers of midlife and older women are seeking eating disorders treatment, despite prevailing beliefs that these conditions only affect the young. Body satisfaction used to increase with age, but today the majority of midlife women express significant weight preoccupation and distress over their shape, appearance, and diet, threatening the health, well-being, and status of women across the globe. Inspired by the **Academy for Eating Disorders Nine Truths About Eating Disorders**, this paper presents **Nine Truths About Eating Disorders At Midlife and Beyond** and introduces Relational Cultural Theory as a treatment approach. Eating disorders are a life-threatening and treatable disease, not a character flaw or a cosmetic issue. We must approach eating disorders affecting women in midlife and beyond just as openly, seriously, and compassionately as we approach breast cancer and other public health problems.*

1. Introduction

Not so long ago, age seemed to immunize adult women from the body image, weight issues, and eating disorders that plague the younger years. Although most cases still appear in adolescent girls and young women, an alarming shift is occurring.

Flanked by Spanx and Botox, eating disorders are on the rise among middle-aged and older women. In fact, inpatient admissions between 1999 and 2009 in the US showed the greatest increase in this group, with women over age 45 accounting for a full 25% of those admissions [1]. Some adult women have suffered eating disorders throughout their lives. Others had a clinical eating disorder when younger and recovered partially or fully, relapsing in midlife, or were subclinical but able to control their symptoms until midlife. A small number develop eating disorders for the first time as adults. Inspired by the *Academy for Eating Disorders Nine Truths About Eating Disorders* [2], in the next section I examine these truths at midlife.

2. Nine truths about eating disorders at midlife and beyond

Truth #1.

Eating disorders in women at and beyond midlife are now a major public health problem, rivaling the frequency of other serious illnesses. While 12.4% of US women have breast cancer [3], 13.3% of US women 50 and older report eating disorder symptoms [4]. The lifetime prevalence of eating disorders in a UK community sample was as high as 15.3% of midlife women, with Other Specified Feeding and Eating Disorders (OSFED) the most prevalent. Only 27.4% in this study sought help or received any treatment for the eating disorder [5].

Truth #2.

Eating Disorders are multidetermined biopsychosocial disorders. Genes create vulnerabilities to be tempered or intensified by other factors, including the environment, early development, physical conditions, and social experiences or expectations [6]. Eating disorders still occur disproportionately in women so gender is the greatest risk factor [7]. The shared heritable environment includes toxic intergenerational attitudes toward, weight, food, and body image that contribute to disordered eating.

Truth #3.

Now globalized, eating disorders are found on all continents, increasing across Asia and Arab countries and in a broad range of cultural, racial and ethnic populations [8]. Our world is in transition, and women, therefore, are in transition. This new cultural context includes: exposure to the “war on obesity,” weight bias, and the misinformation promulgated by the diet industry; an overpowering consumer culture with constant exposure to strict and unrealistic media images of beauty; shifting gender roles due to industrialization, urbanization, and modernization; and the trend toward highly

palatable prepared and fast foods and the adoption of a more sedentary lifestyle, contributing to increased BMIs and eating issues. As Christiane Northrup, a holistic physician, asserts: “The state of a woman’s health is indeed completely tied up with the culture in which she lives and her position within it” [9]. Contemporary globalized consumer culture clearly creates risk for women.

Truth #4.

Age does not immunize women from body image preoccupation and eating disorders. Disordered eating and a fear of aging appear to go hand-in hand for many women [10], with weight cited as the greatest bodily concern in a study of women aged 61 to 92 [11]. Disordered eating is common and equally frequent in African American, Hispanic, and Caucasian women aged 42-55 [12]. Similar patterns are found in other countries. For example, while 4.6% of Austrian women aged 40-60 met the full criteria for a clinical eating disorder, another 4.8% met the subthreshold standards. However, both groups report the same degree of psychopathology, distress, and impairment, suggesting that we must take subclinical eating disorders as seriously as full spectrum [13].

Truth #5.

Clear differences appear when comparing eating disorders in adult women with the younger population [14]. Older women tend to experience significant shame for having a “teenager’s problem” and greater difficulty admitting the need for help, having invested more years speaking the language of fat. They often have a painful awareness of what they have lost in their relationships and in health. Their motivation for treatment is also different as they may be concerned about the impact of their eating disorder on their children and hope not to pass it down to them. Adult women definitely experience more obstacles to treatment due to other responsibilities, including their families, their jobs, and their roles in their communities. Just as with younger women, developmental transitions place midlife and older women at risk for disordered eating and body image issues. These include increased anxiety about appearance and health due to the natural aging process, the loss of power and status as woman age, and multiple stressors and losses that accompany adult development.

Truth # 6.

Relational Cultural Theory (RCT) provides an effective therapeutic framework for the treatment of eating disorders [15]. RCT conceptualizes eating disorders as disorders of disconnection that begin as self-protection when relationships are challenged. Despite wanting a relationship, women use eating disorder symptoms to maintain emotional safety and distance. Over time, the relationship with the eating disorder replaces and competes with true relational possibilities [16]. The relational model challenges the eating disorder by offering growth-fostering relationships based in connection and mutuality. Instead of the “power over” medical model of traditional treatment, RCT is a feminist framework promoting a “power with” collaboration. Fluid expertise, a core concept of RCT, refers to the shared resources and insight that both the client and clinician bring to the treatment experience. The primary therapeutic tool is mutual empathy [17].

Truth #7.

The most current findings in neuroscience uphold the basic tenets of the relational model [18]. Neuroscience has taught us that the human brain is “hardwired to connect,” and that isolation actually causes the human brain to atrophy. Similarly, RCT challenges the paradigm of the separate self in traditional psychological theories and views isolation as the major source of suffering for people. Eating disorders are strategies of disconnection from interpersonal pain. Recovery requires reconnection in healthy relationships that provide mutual growth.

Truth #8.

When it comes to medical issues, adult patients suffer the same medical sequelae as younger patients in that every system is affected by malnutrition [19]. However, despite long-term stability, medical complications can emerge quickly in older patients. Adult women also experience some unique issues medically. For example, depleted fat stores will likely increase menopausal symptoms and muscle-wasting can reduce metabolic rate and hasten neuromuscular decline. In elderly, dieting is especially risky [20]. Cognitive impairment secondary to dieting may also be greater [21] and the mortality risk associated with low weight is greater as people age [22].

Truth #9.

Psychoeducation is a powerful tool for the treatment of eating disorders at midlife and beyond. In RCT language, psychoeducation is effective because it is a “power with” modality. By giving the patient information to guide her decisions about behavior change, it levels the power differential, increases the mutuality of the clinical relationship, and makes women more effective collaborators in their care.

Most women in contemporary culture know endless techniques to change their bodies to make them look a certain way, but they know next to nothing about the female body’s essential internal processes. The truth is that the female body is remarkably resilient, able not only to survive adverse circumstances, but also to maintain the human race. I usually introduce these facts to my patients as *The Magic of Women’s Bodies*. I would like to call it *Facts, Fat, and Femininity*, but most women would stop listening at the word *Fat*. Yet fat is essential to survival for women as individuals and for the survival of the species.

3. The Magic of Women’s Bodies

Women’s bodies are hard wired to respond to starvation. Only 10 % of women die in famine while 50% of men do! Our bodies are incredibly resilient and designed to survive [23].

- Before puberty, a girl’s body has about 12 % body fat. During puberty, fat cells multiply to make up about 17 % of body composition - enough for ovulation and menstruation. Our bodies need fat to develop and survive.
- A mature woman’s body will have about 22% body fat- enough energy for an ovulating female to survive famine for nine months [24]. In other words, the human race survives because of the adult woman’s natural resource –adequate body fat!
- Women gain fat first in the breasts, buttocks, hips, and thighs to protect our fertility, reproductive, and feeding organs. Once more, the female body has innate survival skills
- During the transition through menopause, women experience an average weight gain of 12-15 pounds, while metabolism slows 15-20% [25].
- During this transition, hormonal shifts increase the size of fat cells surrounding our reproductive organs as these produce estrogen,

offsetting the shutdown of the ovaries. This natural process allows women to maintain bone density, decrease the risk for osteoporosis, and manage symptoms of menopause. The female body knows how to take care of itself.

- Moderate weight gain at midlife is associated with longer life expectancy for women! [25,26]

4. Conclusion

These important and empowering facts can help women to make peace with their bodies and to accept the female body’s inherent wisdom. For example, I shared these facts with a woman who came to me in her early 70s for assessment of her eating and body image issues. Returning the next week, she hesitated before sitting down, proudly announcing: “I used to see this roll around my middle as my spare tire and I hated it. Now I see it as my life preserver!” She is absolutely correct. Adequate body fat is a life preserver for women, but the dieting industry does not want anyone to know that.

Clearly, age does not decrease the risk for developing an eating disorder. Eating disorders at midlife and beyond must rank as a high priority on our health care agenda. Medical providers, insurers, and government agencies must learn about the unique female physical and psychosocial experiences that create risk for eating disorders throughout adult development. Screening should be routine with simple questions about weight fluctuations, dieting, nutrition, body image, anxiety, and life stressors. This is not just the job for pediatricians.

Obstetricians and gynecologists, family practitioners, internists, and even geriatricians all have a vital role in the fight against eating disorders. Mental health clinicians and dietitians need to collaborate with medical providers to develop resources for these women. Given the competing demands of their families, jobs, and financial resources, adult women face multiple barriers to treatment. We must make it easier for them to access care.

Women also need to feel safe telling the stories of their bodies [27]. Just like breast cancer, eating disorders are a life-threatening and treatable disease, not a character flaw. As a society, we all have a role in addressing this critical public health issue. It is time to approach eating disorders affecting women in midlife and beyond just as

openly, seriously, and compassionately as we approach breast cancer and other public health problems.

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Privilege and the Body: The role of Critical Awareness to Enhancing Positive Embodiment

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Abstract

Societal structures of power and privilege and individuals' experiences of living in their bodies are inextricably connected. Therefore, the complex social processes that privilege some bodies and disenfranchise others have to be understood in order to engage in socially transformative initiatives that can enhance positive embodiment. The Developmental Theory of Embodiment provides a lens through which to examine social processes that either facilitate or disrupt embodiment. The paper, in particular, examines expressions of privilege and disenfranchisement in the physical, social stereotypes, and social power and relational connection domains and their relationships to embodiment. It further suggests that interventions that aim to enhance positive embodiment among girls and women align with social justice, feminist, anti-oppressive, and human rights goals.

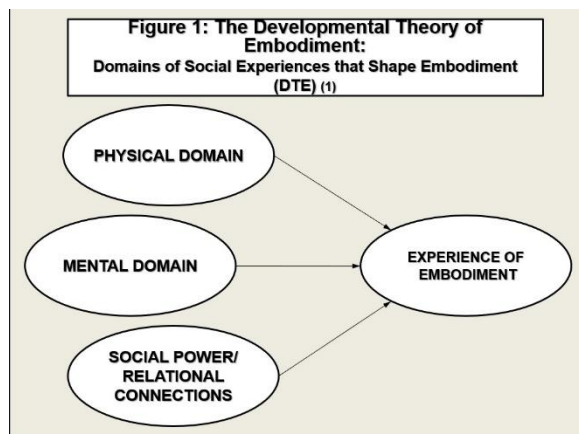
1. Introduction

I got this tummy and I couldn't fit into one of my favorite pairs of pants. I had a dance and it was like, "oh, my God, I have to fit into these pants." People talked behind my back and said how fat I was and stuff. [Friend—a girl] is really overweight but it does not bother her. She knows she can't be teased because she has a boyfriend and he has blond hair and he is real cute, and he has blue eyes, crystal blue eyes . . . Girls like a good blue-colored eyes. I know I do and I think most girls do. Girls want to be really skinny and to have a peach skin or blush . . . I wear long sleeves and skirts cover the black hair on my arms and legs . . . I was not in the popular class anymore . . . I was in the dorks, second class . . . Usually fat people are not in the popular group . . . I felt like I was an outsider. I felt like an alien. I was like, 'I have to lose weight or else I'm gonna be living on Mars for the rest of my life.' [1, p. 98]

In this narrative, Jackie, an 11-year-old girl of Aboriginal heritage and working class background who participated in a prospective interview study with girls, explained her embodied distress and drastic weight loss (16% of her weight) at the onset of puberty. At the intersection of classism (she could not afford to buy another pair of favorite jeans), weightism, racism, and sexism, Jackie felt that losing weight was the only avenue she had to break through her demoted social status. Jackie's experience exemplifies the inextricable connection between societal structures of power and privilege and individuals' experiences of inhabiting their bodies [2,3]. Clarifying the complex social processes that privilege some bodies and disenfranchise others underlies social transformations towards enhanced social justice and individuals' positive embodiment.

2. Theoretical Framework

In a recent book entitled, *Journeys of Embodiment at the Intersection of Body and Culture* [1], I outline the research-based Developmental Theory of Embodiment (DTE), which describes processes that socialize girls and women of different backgrounds into inequity through targeting their bodies. As the DTE suggests, the social processes that shape embodiment take place at the physical, social stereotypes, and social power domains (see Figure 1 for a delineation of the theoretical structure). This paper aims to delineate social processes related to privilege and the body in these three domains in order to inform social transformations towards enhanced body equity.



3. Privileges and Challenges in the Physical Domain

Physical experiences are powerful in shaping experiences of embodiment by affecting the quality of connection and comfort in the body, embodied agency, experience and expression of desires, engagement in attuned care, and resistance to self-objectification. The DTE highlights four key experiences that affect embodiment in the physical domain, that are, in turn affected by intersecting dimensions of social privilege [1].

3.1. Safety versus violations to the body territory

Violence takes place within the context of inequity of power and privilege, leading to enhanced powerlessness, shame, and multiple disruptions in the body domain among victims. Sexual violations are common among adolescent girls and women, who, most commonly experience rape before age 18, with a lifetime prevalence rate of over 1 in 6 women [4]. This challenge is more severe among specific groups of women, such as women of color and members of indigenous communities in North America [5], women who identify their sexual orientation as lesbian, gay, bisexual, queer, or questioning [6] or their gender identity as transgender [7], and women living with physical disability [8].

3.2. Freedom versus restriction to physical engagement and movement.

Similar to the experience of safety, freedom to physical engagement and movement in the public sphere is granted to privileged members of society, enhancing their embodied agency, joy and well

being. In particular, upon the onset of puberty girls' and women's experiences of active engagement in the physical sphere becomes restricted due to multiple factors, such as: the masculinization of sports and restrictive norms of femininity, confining and exposing clothing, the smaller allocation of resources to girls and women's sports, compromised safety, and inequity in the domestic sphere [1,9]. As Piran describes [1], living in financially challenged circumstances or in unsafe neighborhoods further limits opportunities for engagement in physical activities and the freedom of movement in the public sphere.

3.3 Sanctioning versus Vilification of Desire

Connection, comfort, and agency in the practice of desire enhance positive embodiment [1,10]. However, women go through challenging journeys connecting with their sexual desires and commonly report difficulties in being attuned to their desires and communicating their preferences and boundaries in sexual practices [1,10]. Such challenges relate to the lack of validation, and the common vilification, of female desire [8,10,11], sexual objectification and performance expectations [12,13], the range of sexual violations [10], and the practice of sexuality within the context of inequitable power related to gender, class, ethnicity/race, physical disability and other social variables [14]. The experience and practice of sexual desire among individuals who identify their sexual orientation as lesbian, gay, bisexual, queer, or questioning or their gender identity as transgender is further oppressed along all these lines [8]. Connection to appetite is also commonly disrupted among adolescent girls and women related to the dictate that they restrict the physical space they occupy in terms of size [1]. In homes where food insecurity exists, connection to appetite is further challenged [15].

3.4 The practice of care of the body versus body neglect.

Greater opportunities to practice attuned care of the body are more available to privileged members of society. Adolescent girls and women face multiple challenges in the physical care of their bodies [1]. For example, adolescent girls and women face little societal support in dealing with the spectrum of sexual violations, the vilification of female desire, menstruation, contraception,

domestic inequity, salary gap, and other challenges. These challenges are greater for young women who are poorer, heavier in weight, and whose race/ethnicity, sexual orientation, gender identity, and physical disability exposes them to greater discrimination and fewer resources [1,8].

Enhancing positive embodiment relates to social changes at all levels of the social environment that attend to the physical experiences of diverse girls and women.

4. Privileges and challenges in the mental domain of internalized social stereotypes

Social stereotypes are powerful tools for maintaining social inequities. For example, the strong pressures on adolescent girls and women to stay thin deprives them of the right to take space, inhabit their bodies comfortably, and act with embodied agency in the world [1]; internalizing such pressures relate to negative body image and eating disorders [16]. The DTE emphasizes the importance of scrutinizing and altering multiple social expectations that women face towards enhancing positive embodiment.

4.1 Femininity-related stereotypes

Regarding femininity, the DTE highlights both appearance-related and comportment-related sets of expectations. Appearance-related stereotypes, clustered under the 'woman's body as a deficient object' category [1], privilege men as the holders of the objectifying gaze and compel women to engage incessantly in body repair. Indeed, internalizing an objectified gaze at one's body, or self-objectification, is related to body shame, depression, disordered eating and sexual dysfunction [17, 18, 19, 20]. Comportment-related stereotypes, clustered by the DTE under the 'woman as docile category' [1], involve the expectation that adolescent girls and women act demure, submissive, contained, and be other-attuned. Such disciplining of women leads to the assigning of penalizing labels to those who are perceived as not complying with the 'woman as docile' dictate by being assertive (labelled as 'bitch', 'aggressive'), self-attuned (labelled as 'selfish', 'narcissistic'), angry ('PMS'), or by pursuing sexual engagements ('slut') [1]. Such disciplining constricts women's self-attunement and embodied agency in the world, marks the body as an uncomfortable site to inhabit.

4.2 Ethnicity-related/racial stereotypes

Social stereotypes exist in relation to all dimensions of social location, shaping embodiment. Patricia Hill Collins [21] described constraining stereotypes as "controlling images" that work to limit the possibilities of acting in the world, making "racism, sexism, poverty, and other forms of social justice appear to be natural, normal and inevitable parts of everyday life" (p. 69). In the research program on embodiment [1], the internalization of ethnicity-related/racial stereotypes was an important factor that shaped embodiment. Alice, for example, the only Aboriginal girl in her mostly White school in a middle class neighbourhood of a town with racial-related tensions, felt uncomfortable being tall since she felt "Like I'm a giant and they're afraid of me." Claire, a woman in her 20s of African-Canadian heritage, did not feel comfortable expressing her experienced anger in social situations where she was subjected to prejudicial treatment as she was afraid that such expression would, "reaffirm that we are animals or primitive." Grace, a woman in her 50s of African-Canadian heritage, could not accept her weight, since she feared that being heavier in weight meant embodying a "subservient" role.

A critical lens towards social stereotypes is therefore important to positive embodiment.

5. Privileges and challenges in the social power and relational connections domain

At the intersection of gender, ethnicity/race, sexual orientation, social class, physical disability, and gender identity, social power affects embodiment in three ways: first, directly, through regulating the availability of social resources and, hence, individuals' living conditions; second, through subjecting particular individuals to prejudicial harassment; and, third, through individuals' internalization of inequitable and prejudicial treatment [1]. Inhabiting privileged bodies assures access to resources (e.g., education, employment) and freedom from damaging and, often body-based, harassment, hence facilitating positive embodied worth. Women experience gender inequity in multiple domains of their lives, such as: a gender pay gap, with a greater gap among women of colour, women heavier in weight, women living with disabilities [22]; job segregation and 'glass ceilings' in work sites [22]; and inequity in the home sphere. Poverty rates are consequently higher for

women than for men, and more so among women who are disenfranchised along other varied dimensions of social location [23]. Related to this social inequity, women continue to derive social power from physical appearance, which makes them vulnerable to pressures regarding body shape.

One way to examine the relationship between social power and embodiment involves the study of 'idealized' visual representations of women, since these images comprise a condensed way to reflect and perpetuate cultural values and prejudices. In a prospective study with girls, ages 10-18, we asked them to draw themselves, the ideal girl, and the ideal boy [1]. Ideal girls' drawings reflected the disenfranchisement of girls and women in that ideal girls were both thin and short compared to drawings of the self and the ideal boy, were objectified and sexualized, wore restrictive and exposed clothing, and were often denigrated in the associated narratives (e.g., labelled 'slut', 'dumb blond'). Yet, idealized images were invariably 'White' (blond straight hair, blue eyed, light skin), materially endowed (brand name clothing, expensive gadgets, and thin bodies), hetero-sexualized, and perfect (no allowance for visible differences or disability). Idealized images of appearance exclude most girls and women and support body-based harassment and teasing of girls and women who are heavier, of colour, poorer, lesbian, bisexual, queer, questioning, transgender, or live with physical disabilities [1]. Research indeed suggests that a higher number of different harassment types, increases the adverse impact on self and body image [24,25].

Positive embodiment therefore relates to membership in communities of equity and empowerment, where values of social justice prevail [1].

6. Moving towards equity

The paper suggests that initiatives that aim at positive embodiment among girls and women align with social justice, feminist, anti-oppressive, and human rights perspectives. All domains of social experiences outlined by the Developmental Theory of Embodiment and described in this paper need to be addressed towards enhanced positive embodiment among girls and women (see reference 1 for a detailed discussion). In particular, social transformations need to address the physical lives of diverse girls and women (e.g., safety, sanctioning of desire, greater allocation of resources towards girls and women's physical activities, equity in pay and in

the distribution of domestic chores). Confining stereotypes presentations of girls and women (presented linguistically or visually) should be named and counteracted at all levels of the social environment. Similarly, the prejudicial treatment of diverse girls and women need to be highlighted and contested at the legal, policy, institutional, media, and all social forums. Raising consciousness regarding co-occurring adverse social experiences diverse girls and women face is crucial. Such knowledge could propel readers – including scholars, practitioners, educators, policy makers, and parents—to take transformative action [1]. Ample opportunities exist for such initiatives, addressing physical conditions, social discourses, and access to sources of social power. Readers can engage in creative processes of action enriched by their unique social locations and experiences.

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Booty Shorts and Sexting: A Social Justice Approach to Body Image and Self-Esteem

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Abstract

This paper provides parents, educators, and health care professionals with an overview of how a social justice approach can inform ways to address school issues associated with body image and self-esteem. I present two case studies from my Ph.D. research that focus on healthy body image and diversity acceptance in schools to emphasize (1) the importance of listening to marginalized voices; (2) how a social justice framework can be used to identify social justice issues and barriers to a social justice approach; and (3) how an action plan addresses issues of social justice and helps to engage in advocacy efforts.

1. Introduction

Social justice begins with a nagging feeling that something is 'not quite right'. In the world of body image and self-esteem, there are many bothersome issues that require deeper consideration, such as the policing of appearance and in school clothing policies, food shaming in schools, hypersexualization of girls in media, and fear mongering about children's weight. These issues are clearly bothersome, yet parents, educators, and health care professionals report feeling powerless to create effective change. The increasing awareness of contradictory and biased messages and practices regarding bodies is a call for social justice. Social justice examines deeper societal issues of power, gender, and equality, along with voice and silencing. It is my hope to provide parents, educators, and health care professionals with a social justice framework that gives them the confidence to effectively address issues of social justice in relation to body image and self-esteem.

This paper begins with two case studies about mandatory athletic clothing (booty shorts) and sexting in junior high school [1]. An overview of social justice and its link to body image and self-esteem is provided. I introduce a social justice

framework that emerged from my research that is aimed at (a) highlighting the importance of listening to marginalized voices, (b) identifying social justice issues and (c) creating a plan to address the issues and engage in advocacy efforts. Finally, barriers to social justice, such as avoidance, silencing, and gatekeeping are discussed.

2. Case studies

The following two case studies are from my Ph.D. research in a non-public school for Grades K-12 in Alberta, Canada (see Bardick, 2015 for a complete description of the school and research environment).

Imagine these scenarios:

1. *A group of Junior High girls complain about having to wear "booty shorts" (very short, revealing shorts) as part of their volleyball uniform, when the boys could wear comfortable shorts. When the concern was brought forth to administration, their response was "that's what the Olympic team wears, so that's what the Junior High girls will wear." A number of girls quit the team.*
2. *A group of Junior High girls complain that a number of Junior High boys are "sexting" them (i.e., asking them for topless pictures of themselves). In response to their concerns, a female teacher organizes a noon-hour "Girls Club" where the girls can talk about their feelings. When I asked administration, "Who is talking to the boys?", their response was, "We don't want to raise any prickly issues with the parents, so no one." Further, administration responded that they believed these were developmental issues that were outside of the educational experience, and students should be dealing with it themselves.*

Although these case studies focus on the experiences of Junior High students, they provide a foundation for examining how a social justice perspective can be utilized to identify and address

issues of body image and self-esteem. The next section provides an overview of social justice as a foundation for this framework.

3. Why social justice?

Social justice may be defined as a lens through which to examine societal concerns [2]. Social justice considers how unequal power distributions in our social structures impact individuals and groups and helps to identify those with power (i.e. privileged and dominant groups in our society) and those without power (i.e. the oppressed and non-dominant groups in our society) [3]. Foundational understandings of social justice include the consideration of: (a) equal worth and equal rights, (b) equal opportunity and ability to meet basic needs, (c) equal life opportunity, and (d) reduction and possible elimination of inequities [4]. Social justice demands fairness and equity in resources, rights, and treatment [5], and is needed to confront injustice [6]. In school settings, social justice focuses on the overall rights and well-being of children, seeks to remove barriers that inhibit children from reaching their potential, and seeks to build alliances (e.g., family-school-community collaborations) [7]. It involves a commitment to action to speak up for the rights of children, even when it may be challenging to do so [8], and address facets of the school environment that contribute to disrupted experiences of embodiment, helping students develop a critical and social justice perspective [9].

3.1 The link between social justice and body image and self-esteem

A social justice approach calls us to consider how body image and self-esteem issues are manifestations of societal expectations. Social justice has key dimensions of examining physical and psychological security, resource distribution, and power relations, and is an emerging framework for understanding body image and self-esteem. Applying a lens of social justice to body image and self-esteem offers a means to shift the focus away from the individual to broader societal, contextual, and relationship factors [10]. A social justice lens provides insights into gendered, relational, and power experiences that impact people's relationship with their bodies [11]. Along with this description of social justice, an overview of the Developmental Theory of Embodiment (DTE) [12, 13, 14] provides further insight into how to consider body image and self-esteem as social justice issues.

3.2 Developmental theory of embodiment (DTE)

The DTE developed by Piran [12, 13, 14] is based on a 20-year qualitative and quantitative research program with girls and women. It describes multiple social processes that affect the way girls and women feel and live in their bodies. In particular the DTE describes the way in which a range of physical experiences, social stereotypes, and structures of power shape affect embodiment. In this theory, embodiment is defined as "the experience of engagement of the body with the world" [15, p. 177]. The DTE describes a continuum of both positive/connected experiences of embodied agency (e.g., self-care, attunement with the body) and disruptions in embodiment (e.g., self-neglect, restricted agency, and disconnection from the body) [13, 14]. For example, in the case studies above, the DTE would identify the girls' issues with uncomfortable athletic clothing and sexting as disrupted experiences of embodiment. The girls' attempts to express their concerns to administration would be considered an experience of embodied agency, as the girls were attuned to their own needs for safety and self-care. However, not being heard by administration would further contribute to a disrupted experience of embodiment, related to blocked agency and, consequently, embodied disempowerment.

The DTE asserts that adults and educational institutions "should provide girls with multiple opportunities to connect positively with their bodies, including active and joyful engagement in non-objectifying physical activities while wearing comfortable, non-sexualizing uniforms or clothes" [12]. In the DTE, Piran [14] emphasized the importance of (a) encouraging increased connection with the physical environment, (b) a context that supports the right for safety and self-care, (c) guidance regarding bodily changes during puberty, (d) clearly stated policies against body-based harassment, and (e) enhancing critical perspectives on disruptive cultural norms and prejudices [14]. The next section focuses on how a social justice framework can provide a new lens for addressing body image and self-esteem concerns.

4. Social justice framework

I developed the following social justice framework as a decision making model to guide interventions in my clinical practice, with the following key questions:

1. Who are the marginalized and vulnerable groups affected?
2. What is the nature of the initial complaint (i.e., disrupted experience of embodiment)?
3. What is the nature of the “secret wish” (i.e., a desire for a positive/connected experience of embodiment);
4. What is the “problem with the problem”? (i.e., what does the research say about the issue?)
5. What are evidence-based best practices and possible solutions?

I use these guiding questions to examine the case studies from a social justice perspective.

4.1 Listening to marginalized, vulnerable individuals

Marginalized and vulnerable youth may reach out for help by identifying issues that may be a target for intervention from a social justice perspective. Research has consistently shown that youth have a lot to say about their experiences with body-related issues in school settings, and that students can identify practical and creative ways to create a healthier environment for all [e.g., 1, 12, 16, 17, 18]. For example, Piran [9] used a feminist approach to conduct focus groups and provide support to students in a high-risk ballet school to help them transform their school environment by reducing an emphasis on body shape, prohibiting teachers from making evaluative comments about body shapes, and introducing a staff member that students could contact about body shape concerns. McHugh [17] utilized a participatory action research (PAR) approach in an Aboriginal girls school that lead to action initiatives where girls could (a) express themselves (i.e., Girls Club, focus group, and writing group), (b) influence school policy (i.e., development of a school Wellness Policy and hiring of a Wellness Coordinator), and (c) share their experiences with a national audience. Fisette [16] described how accessing girls’ voices can help researchers and PE teachers develop PE programs that are relevant to students by identifying barriers that influenced their participation in and enjoyment of PE classes.

These cases highlight how listening to the voices of marginalized and vulnerable youth is a powerful way to access their actual experiences and give them an opportunity to identify ways to transform their environment. Listening to marginalized voices may provide important information to determine if practices contribute to overall health and well-being or are potentially causing harm [1]. In light of the booty shorts and sexting case studies, it is apparent that the girls were vulnerable, marginalized, and were asking for their concerns to be heard in order to create an environment where they felt safe in their own skin and clothing. A social justice approach focused on listening to marginalized voices and lived experiences is a necessary first step in creating healthy environments.

4.2 The nature of the complaint/secret wish

From a social justice perspective, the above case studies exemplify far more than students “complaining” about things they don’t like. Youth often make initial complaints about an issue, which may overlooked by the adults in charge. Hidden underneath their complaints is a “secret wish” [1], a term I coined to highlight people’s desire for a positive outcome. The “secret wish” highlights a possible avenue for intervention that is driven by student needs and wants. For example, in the booty shorts case, the nature of the complaint was wearing uncomfortable and sexualizing clothing, while their “secret wish” was the desire to wear athletic uniforms that are comfortable and non-sexualizing. By digging deeper than the initial complaint, we can identify a number of underlying social justice issues that impacted the girls in this case: (a) gender issues (i.e., the boys wore long shorts while they were expected to wear booty shorts), (b) power issues (i.e., administrators dictated that these were the uniforms they were required to wear), (c) relational issues (i.e., they did not want their bodies to be objectified by boys, and their concerns were not attended to by administration), and (d) resource issues (i.e., were the booty shorts their ONLY option for a uniform? Who was paying for the uniform?). The secret wish also highlighted a distinct avenue for intervention – identifying ways the girls could wear comfortable uniforms. Further, their body image was initially impacted by wearing revealing booty shorts, and their self-esteem was impacted by attempting to advocate for themselves and being silenced through an administrative “no.”

In the case of sexting, the girls' "secret wish" was to be treated with respect by the boys, and the boys' "secret wish" was to develop relationships with the girls. However, their adolescent relational insecurities combined with an onslaught of social media messaging about attraction and hypersexualization, caused their intentions for relationship to take an ethical and legal turn for the worse. Although teachers and administration did hear the girls' concerns and attempted to create a Girls Group where the girls could process their emotions, important gender, power, relational, and legal issues were not being attended to or resolved. This case highlighted (a) gender issues (i.e., girls were identified as being "emotional" and needing a place to talk about their experiences, while administrators avoided speaking to the boys who were perpetrators), (b) power issues (i.e., the boys had power over the girls by asking for the pictures, and administration had power over all students), (c) relational issues (i.e., adolescent relationships were affected, as were the student-administrator relationships), and (d) legal issues (i.e., the digital permanence of sending topless pictures by phone, and the legal implications of the boys engaging in harassment and potentially redistributing the pictures). What could have been a tremendous learning opportunity for the youth was avoided by administration due to a fear of raising "prickly" issues.

We now turn to the question of "what is the problem with the problem?" in order to provide a foundation for the social justice framework.

5. What is the problem with the problem?

It is important to turn to the research to identify "the problem with the problem" to demonstrate that the concern is valid and problematic within a broader social context, and to provide a rationale for evidence-based interventions. For example, in the booty shorts case, teachers and administration were aware of the girls expressed discomfort with the volleyball uniform. However, they did not appear to be aware of how girls' discomfort with sport uniforms impacted their body image, self-esteem, and enjoyment of sport. Administrator's response of "that's what the professionals wear" minimized how these issues impacted students' body image and reflected how a school sport experience is situated within a larger sociological context of emulating professional sports. The "problem with the problem" in this case is that girls find tight and

exposing clothing problematic, sports' clothing is an important facilitator for identity construction and expression, and fit and comfort are important [19]. Encouraging girls' participation in sport by having comfortable uniforms would return their focus to actual participation in sport, enjoyment, and team building rather than contributing to unnecessary discomfort, possible body comparison, and the potential for dropping out of sport [1].

Examining the research around sexting in adolescence reflects a complex interaction between shared risk factors and adolescent sexual and relationship development. Body-based messages about how girls "should" look and behave and how boys "should" talk about female bodies may have a tremendous impact on students' body image satisfaction, self-esteem, and dieting behaviours [20]. Judge [20] explored the intersection between the legal and clinical ramifications of sexting, and outlined the possible motives (i.e., healthy sexual exploration and self-expression) and harms (i.e., pressure to produce sexual images, self-objectification, boundary violations, sexual harassment, emotional distress) of adolescent sexting. Sexting represents intersections and tensions with gender, identity, relationship, and power dynamics combined with typical adolescent sexual development [20]. Unwanted sexual comments as a form of harassment are disruptive experiences of embodiment that have a negative impact on adolescent self-esteem, and may increase depressive symptoms, body dissatisfaction, substance use, eating behaviours, and self-harm behaviour [9, 12, 21]. The case of sexting moves beyond individual body image and relationship into the legal and human rights realm of harassment and bullying.

With this understanding of the problem, we now turn to a logical approach to identify solutions and overcome barriers.

5.1 Identifying solutions

In both case studies, students clearly identified the problem and their "secret wish" for a more positive experience, which had the potential to lead to logical solutions to their initial concerns. For example, in the case of booty shorts, a logical solution would be for girls to have an option to choose a more comfortable athletic uniform to wear (e.g., wear a matching shirt and comfortable legwear of their choice). This would require administrative

support for the youth to have greater autonomy in the choice of athletic clothing.

In the case of sexting, there are several steps required to address the relational, legal and Human Rights issues associated with sexual harassment. It is critical that any issue associated with sexual harassment be taken seriously, as discriminatory harassment is against the law [24]. Each province and school board has different legislation and policies to address issues of sexual harassment, and these need to be known and adhered to. For example, in Alberta, the Section 12(g) of the School Act specifies that “students have a responsibility to ensure their conduct contributes to welcoming, caring, respectful and safe learning environments” [24, p. 12]. In Ontario, a progressive discipline approach clearly outlines “a continuum of prevention programs, interventions, supports, and consequences to address inappropriate student behaviour and to build upon strategies that promote and foster positive behaviours” [25, p. 3]. It is necessary for school administrators to be aware of their provincial policies and legislation to comprehensively address issues of sexual harassment in a manner that is developmentally and situationally appropriate. In this case, an initial step would be to have a frank discussion with both the girls and boys to fully understand the nature of the sexting and the impact of sexting and consent (both requesting and sending pictures and sexual comments) so the students can make a better informed decision about their actions, improve communication and relationship, and understand the potential legal consequences. Further, support to both those impacted by the event as well as the perpetrators needs to be provided. Should the students not follow the recommendations or there be a repeat occurrence despite intervention and redirection, further disciplinary and legal action is necessary to ensure a safe and supportive learning environment.

Although these possible solutions are logical and inspired by the students and provincial policy, there were significant barriers to a social justice approach that addressed both the human and legal issues inherent in each case study.

5.2 Barriers to social justice

In both cases, the actual “problem with the problem” was that the presenting concerns were not fully attended to by those in a power position (i.e., teachers and administration). Barriers to social

justice in these cases include: administrative denial of issues [22]; administrative censorship [1]; avoidance, silencing and powerlessness [1]; lack of training and knowledge [1]; lack of time, resources, school priorities [1]; and not wanting to rock the boat or raise “prickly” issues [1]. Another important barrier to a social justice approach is student reluctance to speak with teachers due to fears of confidentiality, perceived stigma, and inappropriate reactions [23], as well as parents being hesitant to address these issues with administration due to fear of repercussions from “rocking the boat” [1]. In the case of sexting, administration’s lack of knowledge of provincial policy regarding harassment and relevant disciplinary action was an additional barrier to social justice.

Silencing and powerlessness occurred when participants raised an issue that was not in alignment with school mandates, was not considered to be a priority, and administration asserted that neither time nor resources were readily available to address the issues. Sadly, avoidance, silencing, and powerlessness in the school context creates a very unfavourable and disempowering situation for students. In both cases, there were tremendous opportunities for the students to be heard and demonstrate leadership qualities by identifying logical solutions to bothersome problems. Their secret wish to create a healthier, empowered, connected experience of embodiment through a shared understanding of the need for healthy body image and self-esteem, was left ungranted.

6. Conclusion

Body image and self-esteem are often impacted by social justice issues, particularly around gender, power, relationship, avoidance, and silencing. A social justice framework can aid in the quest to listen to marginalized voices, identify areas of concern (i.e., disrupted experiences of embodiment), issues of social justice (i.e., gender, power, relationship), and create logical targets for intervention. It is my hope that the proposed social justice framework and the guiding questions provided can help to: mitigate and repair issues of social justice that impact body image and self-esteem; address the need for legal and Human Rights issues to be seriously considered; and empower individuals faced with these issues to have the courage to create meaningful and impactful change.

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Navigating Differences Within Eating Disorders and “The Other”: What the Professional Brings and What They Leave Behind

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Abstract

Even amongst calls for increased awareness of eating disorders amongst people with diverse identities – people of colour, disabled people, etc. – conversations about eating disorders still carry a number of assumptions that limit our capacity to deeply engage with those who struggle. In this paper, we explore self and other in relation to eating disorder research and treatment. We invite readers to engage in critical self-reflexivity around their own positions, privileges and spaces of belonging as people who research and treat eating disorders. We are all implicated in a system that carries with it potentially problematic relationships with food, weight, shape, exercise, and diverse bodies. We offer examples of barriers to compassionate care for eating disorders and offer a case example with questions. This paper is a starting point for working toward more inclusive ways of engaging with diversely embodied people with eating disorders, opening space for being with difference, rather than trying to “fix” it.

1. Introduction

How often are we, as “professionals” in the eating disorder field, asked to situate ourselves in the work that we do? Who do we imagine as being a part of the “we,” and who do we imagine to be a part of the “them”? Each of us enters into work in the eating disorders field from different spaces of belonging. We, the authors, do too. Andrea is a 29-year-old, white, heterosexual, cis-gender woman in a cohabiting relationship, middle class and upwardly socially mobile, who experiences chronic back pain and identifies as re/covered from an eating disorder. Kaley is a 33-year-old, white, heterosexual, cis-gender, married, lower-middle class woman, who is a mother, disabled, chronically ill, and identifies as a recovered chronic dieter. We offer these opening thoughts not as a way to evaluate how “biased” or

“unbiased” we might be in writing this, but rather as a way of beginning to think differently about self and other in eating disorder research and treatment. Throughout this paper, we will also encourage you to situate yourself in relationship to your clients and/or research participants.

In feminist work, this kind of reflection on your relationship to what you do and who you work with is termed reflexivity, which has been used in research to “dismantle the smokescreen surrounding the canons of [...] impartiality and objectivist neutrality” [1], p. 81). In the therapeutic context, reflexivity has been used across therapeutic paradigms to enhance clinical work—and is about far more than just naming who we are and what labels we use [2]. In this vein of deeper reflexivity, grounded in an understanding of these spaces of belonging—and how we relate to them and work through them in daily life, as well as research and/or therapeutic practice—we use Carla Rice’s [3] critical self-reflexive approach as a frame for understanding how looking at our own “embodied subjectivities” (p. 246). In other words, who we are in our bodies at a particular moment in time impacts how we interpret and relate to the experiences of others. Reflexive practice may come easily to you or may be more challenging; either way, doing this work is important for understanding why we do this work and how we can all do this work in a way that meets the needs and desires of more people and avoids the harms caused by un-reflexive working.

2. Othering and Barriers to Eating Disorder Treatment and Research

We enter into this paper not only with a set of spaces of social belonging, but also with a stake in making systems-level change for eating disorders. Through personal experiences of eating disorders and disordered eating, from the sides of “patient,” “provider,” and “researcher,” we have observed how inaccessible this world—and eating disorder

treatment and research—can be for people in different bodies. Noting these barriers is not a new proposition; reports of barriers to treatment for eating disorders have long revealed disturbing trends, from 86% of ethnically diverse women seeking treatment for an eating disorder not receiving care [4], to physicians not noticing eating disorders in minority [5] disabled [6] and larger-bodied [7] individuals. The world in general, and healthcare spaces in particular, do not make room for the lived experiences of people in bodies deemed different—or “Other”, as we will term it in this paper, following theorists whose work interrogates racism, sexism, ableism, and more (e.g. [8,9,10,11,12,13,14]). We enter into the discussion of Othering in relation to eating disorders, and how to move beyond othering and toward embodied understanding, by asking simply: who is left out of the conversation about eating disorders?

There is not much imagination in eating disorders literature and practice for people who experience food and body related distress and are living with disabilities, queer, trans, non-binary, racialized, fat, poor, older, or any configuration of these identities and/or other marginalized identities [6,15,16]. In order to understand eating disorders, we have to understand the contexts in which they arise—and the ways that heterosexism, ableism, racism, classism, and other “isms” shape this state of affairs [17,18,19,20,21]. We need to grasp that who we assume to be at risk for—and immune to—eating disorders is fundamentally shaped by socio-political forces that arrange people into groups of “normal” and “other” [22,23]. As an example, there is a dominant stereotype that queer women are immune to eating disorders because they are assumed to not be trying to appeal to the male gaze [24,25]. This stereotype is doubly damaging: it simultaneously presumes that eating disorders are all about becoming appealing to men, which has long been shown to be false [22] and leads to queer women’s experiences of eating disorders being disproved or dismissed. Situating this in the larger sociopolitical landscape, such an assumption is consequential in light of continued health disparities for LGBTQ+ individuals, including delayed help seeking and healthcare avoidance [26] linked to stigma and lacking safety in clinics [27]. Another notable example is the way in which Black women’s experiences of eating distress have long been pushed aside and Othered in white Western medical models and strains of research [28]. As Becky Thompson illustrates in *A Hunger So Wide and So*

Deep, this glossing over reflects a lack of nuanced understanding of the complexities of food practices amongst Black women, and how food and food culture might be navigated differently and in the context of coping with daily microaggressions. These are but two examples of how people who experience marginalization along many and often multiple lines are “othered” in both eating disorder research and treatment.

Presumptions of risk and immunity generate Othering in the eating disorders field, which has consequences for whose distress is attended to, and the prescriptions for health offered to people with eating disorders [16]. For example, research articles will attempt to “balance” concerns around the “obesity epidemic” with eating disorder prevention messages, creating a convoluted set of instructions about how to be in one’s body for those experiencing eating disorders of all types at higher weights [29,30,31]. In clinical practice, healthcare professionals dismissing eating disorder symptoms amongst marginalized folks may lead to shame, healthcare avoidance, and feeling “beyond help” [6]). This may culminate in medicalized trauma [32] and isolation for those who are Othered in eating disorders treatment. Socially, this widespread ignoring of the experiences of those who do not fit the expected picture of eating disorders reinforces stereotypes about eating disorders, creating a vicious cycle. In turn, we march on with entrenched models of treatment and modes of research that may not fit the lived realities of those who desire help for eating distress. Models of recovery, too, are painted with a white, thin, able brush, making the status of recovery feel unattainable for those who did not fit the expected picture of “legitimately eating disordered” and thus equally do not fit the expected picture of recovery [33] [16].

3. An Invitation for Change

We paint this bleak picture not as a way of engendering defeat or defensiveness. Instead, we paint this picture as an invitation for change: a moment to pause and reflect upon the relationship between these built and long-entrenched problematics and who we each are as members of the eating disorders field. This is also an important moment to consider how we often unintentionally and despite our best efforts think and act in ways that shore up these stereotypes. One key concept to consider as we engage in reflexivity is implicit bias, or the snap judgments that occur without conscious

thought but that drive our attitudes and behaviours, impacting how we interact in life in general and in healthcare contexts in particular [34]. While completely eliminating implicit bias is not a realistic goal, thinking about how we enact implicit bias and actively working to challenge it can help us to make steps toward greater inclusion and equity in care [35] and in research.

To begin to challenge the biases that pervade the field and to invite you as readers into this paper, we offer a case example with a number of questions to respond to as you explore and assess.

4. Case Example

The following case example is based on a real individual who participated in a study exploring the experiences of marginalized persons with disordered eating [6]. The individual granted permission for this paper. We will use the pseudonym Robin to refer to the participant.

Robin is a 29-year-old single woman who was referred for dietetics services due to issues around constipation. Robin has cerebral palsy (a neurological disorder that impacts movement and processing from birth) and uses an electric wheelchair for mobility. She lives alone in a supportive housing apartment where she receives personal attendant care services for activities of daily living (e.g., bathing, cooking, toileting, etc.). Robin currently receives disability benefits and sometimes struggles with food insecurity. The original referral did not indicate weight or height, stating that Robin is “difficult to weigh due to her disability”. Robin appears underweight and has stated that she needs to take eight laxatives daily to help her “remain regular”. Her food intake is significantly restricted but she reports that her meals are highly influenced by her attendant care services. She further explains that she has limited care hours and sometimes cannot eat the foods that she wants within her allotted time. When asked what her goals were, Robin stated that she wants to learn how she can eat healthier within her personal circumstances, including limited support for food preparation and financial challenges.

In order to examine our inherent biases, it is important to try and answer the following questions honestly and quickly, remembering that we are all products of a culture that values certain bodies over others. In that spirit, what gut assumptions did you initially have about Robin? Often, disability is viewed as a medical problem as opposed to a distinct

marginalized group of people [36]. As a result, professionals committed to diversity and challenging cultural biases can often overlook disability [37]. But, in one study of therapists in training, 95% of participants viewed disability as a personal tragedy and responded to disabled clients with feelings of pity [38]. Certainly, this occurred for Robin. She explained how she felt many healthcare professionals working with her simply could not understand why she would intentionally restrict her food given that she had so many other health problems presumed to be associated with her physical disability. She further explained that there was a feeling amongst healthcare professionals that she should not be concerned with her appearance or size because she, as a disabled woman, was so far from ever achieving the Westernized beauty “ideal”. Other gut assumptions that people often associate with physical disability include feeling sad or sorry for the individual (Robin recalled feeling like she was granted “special” permissions out of pity such as being excused for being late), treating them like a child (Robin frequently had to remind her care team to talk to her, not her mother), assumptions around sexuality (Robin was recently divorced but people often assumed she was single and asexual), and assumptions around poverty and social mobility (Robin was college educated from an upper-middle class family). Consider which, if any, assumptions you may have had about Robin. How would these have impacted your treatment, care or approach with her?

Next, we would like you to consider what personal aspects of your identity (e.g., social location, power and privilege, training experiences, life experiences) may be at play? For instance, if you yourself do not have any disability, how might your privilege as an able-bodied person impact your interactions? How accessible is your space for individuals with disabilities? Or, consider typical solutions recommended to combat restrictive eating: 1) a food diary (Robin is unable to write independently), 2) finding meaningful movement (Robin has significant barriers to physical exercise), 3) psychotherapy (Robin has difficulties navigating inaccessible transportation and office locations), 4) finding enjoyable food (Robin needs attendant care services for all of her food preparation), and 5) reducing/eliminating laxatives and other purging methods (Robin requires laxatives as part of her disability symptoms). Perhaps not surprisingly, Robin spoke about how previous solutions presented to her by dietitians and physicians often felt out of her

reach, which contributed to further feelings of disempowerment and hopelessness. Next, consider your training. How was disability discussed? In traditional healthcare professional programs, disability is usually only discussed as a problem to be fixed/rehabilitated [39]. For Robin, doctors had difficulty seeing beyond their typical understanding of a person with cerebral palsy to understand her struggles with disordered eating. They offered her solutions, such as prescription laxatives and pain management, rather than addressing her eating and her restriction. Robin recalled that she was never asked why she wasn't eating, but rather it was always assumed to be disability-related. These are just a few examples of how not checking your own position and privilege can result in unintended negative consequences for individuals who experience marginalization.

Based on your own reflections and previous experience, what would most likely happen to Robin if she had sought support for her eating disorder in your facility or practice? What potential barriers or challenges might exist? Although Robin was brought to doctors by her mother on several occasions due to issues surrounding poor appetite and low weight, she was not identified as having an eating disorder for fifteen years! Each time that her low weight was noted by healthcare professionals, it was explained away by the fact that many individuals with cerebral palsy exhibit low body mass indexes. Once identified, Robin found support of a private psychotherapist who recommended inpatient treatment. However, inpatient treatment was grossly inaccessible for her. She would not have access to her attendant care services and was uncertain about how she would use the toilet or transfer in-and-out of bed. Robin also knew that use of laxatives would not be permitted on an inpatient unit and she worried about these consequences. She further reported not wanting to "feel so different" from all the other individuals receiving treatment because she needed help with writing and other tasks. Lastly, consider what needs to be in place in your facility/practice that could better to assist Robin. Examples may include disability-affirmative therapists, policies on accommodation and more accessible treatment practices. When treatment guidelines are exclusively developed with nondisabled individuals in mind, adapting the treatment later can be difficult and, sadly, oftentimes impossible. This results in a withdrawal from services and promotes a self-perpetuating cycle in which institutions inaccurately believe that they do not have to adapt their facility

and/or treatment given that marginalized persons never seek it out.

We hope that this case example provided some useful content and ideas for reflection. However, practicing self-reflection and critical reflexivity is an ongoing, lifelong activity that is only as useful as it can be regularly implemented. There are a number of practices that can assist in maintaining the practice of reflexivity and thereby, encourage systemic changes in the lives of marginalized persons. The first, and most important, is to continually seek out feedback from members of marginalized groups. This requires active efforts to remove power differences and barriers that prevent marginalized persons from participating in systems of treatment, prevention and research of eating disorders. It also requires humility to hear feedback and accept responsibility, particularly for negative critique. Second, seeking out regular supervision and/or spaces that allow for vulnerability and personal exploration can provide space for reflexivity. This may include seeing a psychotherapist or finding a mentor, or perhaps inviting other colleagues to start a reflexivity supervision group. The structure of said group is less important than the active engagement in discussion and exploration of thoughts, feelings, beliefs and behaviours, particularly those that center discussions around privilege, systems of oppression, inherent biases and relational patterns/impacts. A final suggestion is to engage in regular self-reflection through journaling or memoing, if it is an accessible option for you. Although the specific method of self-reflection is not important, many find the act of regular writing a helpful tool to put words to their thoughts and feelings that are often out of active consciousness (e.g. [40]). Becoming more aware of those automatic thoughts and feelings are key to breaking inherent biases related to our work and our lives that we can acknowledge formed within a toxic (i.e., fatphobic, ableist, white supremacist [41], heteronormative) culture.

5. Conclusion

Working through this case example may have brought up feelings of powerlessness or excitement for you; there is often a sense of both opening to new ways of working and an awareness of the structures that constrain this work that enters into the room when reflecting on this work. Social justice work is desperately needed, but very challenging to practice. Barriers to acting in ways that meet our

values include, but are not limited to, funding limitations, diagnostic requirements, training demands, ableist work demands, calls for evidence-based treatment only—and the difficulty of funding the research required to claim “evidence based.” Further, we are often constrained by white supremacist culture, which is characterized by: perfectionism, sense of urgency, defensiveness, quantity over quality, worship of the written word, paternalism, either/or thinking, power hoarding, fear of open conflict, individualism, progress is bigger, more, objectivity, and a sense of the right to comfort [41]. We are not powerless, however. In committing to this work—to exploring how we other, how we are othered, and how we might use work on ourselves and with others to challenge the taken for granted in the eating disorder field, we commit to challenging white supremacist culture. We can work to understand how privilege infuses the systems in which we prevent, treat & research eating disorders. We can consider how the ways we talk about eating disorders reinforce dominant power structures and continue to marginalize many. Once we have taken these steps, we are on our way to actively challenging stereotypes & acknowledge privilege, creating space for being with difference.

Reflexivity is not in and of itself enough to change the pervasive stereotypes and profound othering in the eating disorders field. To challenge systemic exclusions, we must also engage marginalized communities in understanding what ways of working work for them. As we learn—and learn how we have and continue to fail, we must also work to avoid defensiveness. There is a balancing act to be found between tackling systemic issues, while providing clients with more immediate assistance. At its heart, this work entails listening to and believing—and deeply honouring—various lived experiences, even when they do not fit our preconceived ideas about what they might be like. Challenging systemic exclusions and our own internal biases is not a “one off”—it is a lifelong, collaborative, and communal effort. We invite you to continue this work, and to use this article as a jumping off point. We offer as concluding thoughts a number of people who have inspired us in this journey, whose work you might find helpful in dismantling systems of oppression: Desirée Adaway, Sonya Renée Taylor, Virgie Tovar, Be Nourished, Nalgona Positivity Pride, Marcella Raimondo, Carmen Cool, Karin Hitselberger and Corbett O’Toole.

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A Weight Neutral Approach to Health and Wellness

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Abstract

Ann McConkey is a Registered Dietitian and Lisa Naylor is a counsellor in the Provincial Eating Disorder Prevention and Recovery Program, a community based program that serves all genders at an inclusive feminist community health clinic. This paper provides an overview of the workshop we delivered at the 2017 National Eating Disorder Conference. We present a model of care and practice that addresses physical and mental wellness for everyone, regardless of body size or current health status, called Health At Every Size®. As HAES® practitioners, we are committed to respect, acceptance and the provision of appropriate care for people of all shapes and sizes with an emphasis on health-promoting behaviours and changes to improve quality of life. We do this with consideration for emotional, mental, spiritual and physical wellbeing. This interactive workshop was intended to share what we have learned about weight neutral approaches to health and was designed for educators, counsellors, dietitians, and other medical care providers to challenge their own assumptions about weight and health and to learn practical skills to provide weight neutral health promotion, education and care.

1. Introduction: Weight neutrality at Women's Health Clinic

Women's Health Clinic (WHC) opened in 1983 in Winnipeg, MB, Canada. In 1985, Catrina Brown developed a program at WHC that she later wrote about with Robyn Zimberg in Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders. This program called, Getting Beyond Weight, was the first in Canada to recognize weight preoccupation as a feminist issue, acknowledge body image and dieting as part of an eating disorder continuum, and use non-pathologizing approaches to address eating disorders [1].

In the 33 years since the initiation of this trailblazing program, WHC has continued to develop and deliver numerous programs and educational initiatives that promote body peace and body equity. WHC also launched the first community based treatment program in Manitoba for eating disorders, which is unique in our weight neutral approach to recovery. In addition to our eating disorder program, WHC delivers a wide variety of services (i.e. counselling, medical, abortion, midwifery, health education, parenting, etc.) which allows our weight neutral approach to impact on the health and wellbeing of thousands of Manitobans.

The Board policy at WHC first reflected weight-neutral values in 1991. Eventually we adopted the language and principles of the Health At Every Size® movement culminating in the current WHC Health At Every Size® Values Statement. To summarize the values statement: Health at Every Size (HAES)® is an evidence-based approach to reduce the risk for and to treat chronic disease. HAES® encompasses physical, mental, emotional, and spiritual health while challenging the assumptions about the relationship between weight and physical health [2].

As HAES® practitioners we commit to promoting:

1. Body Inclusivity
2. Respectful Care
3. Eating for Wellbeing
4. Life-enhancing movement
5. Health enhancement, and
6. Advocacy [2]

These six commitments for our practice provided the structure for our workshop at the NEDIC Conference in 2017 and provide the framework for this paper. This paper outlines our rationale for utilizing a weight neutral approach, and our method of implementation. To further explore, we offer clinical observations from our practice. In addition, this paper includes reflection questions that were explored during the workshop to encourage self-reflection of the reader. Self-reflection is key to understanding how one's practice has been shaped

by dominant views about weight and health and instrumental in shifting to a more weight neutral and weight inclusive approach to practice.

2. Context

2.1 Focusing on weight causes adverse health outcomes

The medical community and every other industry related to food and body promote the belief that a higher body mass index (BMI) is the cause of poor health; however a growing number of research studies do not support this viewpoint. A review of the research by Tylka and colleagues (2014) puts forward a great deal of evidence that weight control practices may cause far more adverse health outcomes than a person's actual weight. For instance, Tylka et al (2014) cite studies saying that when the treatment focused on weight, there was an increase in weight cycling, binge eating and a decrease in physical activity [3]. Dieting or focusing on weight loss has also been found to be a significant risk factor for developing an eating disorder [4].

2.2 Failure of weight loss interventions

Mann and colleagues (2007) find that dieting is not effective because there is no known, safe way for people to lose weight and maintain that loss; dieting also often leads to weight gain; and most people tend to end up heavier than they were before the diet [5].

Weight loss interventions have consistently shown to fail in the long term, as within 1-5 years almost all people restore to their original weight and often gain even more weight [3], [5], [6]. In fact, a person categorized as having an "obese" BMI has less than a 1% chance of reaching the "normal" weight BMI category [6]. The failure of diets is not due to a lack of individual will power or effort but is, at least in part, a biological pull to maintain a consistent body weight [7].

2.3 Why diets don't work

Our clinical experience finds that restrained eating creates a sense of deprivation that leads people to think constantly about food, particularly foods perceived to be forbidden, such as desserts, snack foods or fast foods. Many studies have demonstrated that restriction leads to both overeating and eating in the absence of hunger and have shown that binge eating is a natural response to restrictive eating [3]. This was first demonstrated in Ancel Keys' famous 1950 starvation study that

revealed that dietary restriction leads to a heightened preoccupation with food and eating and an increase in overeating behaviours [8]. Food restriction and weight loss negatively impacted mood and led to an increase in anxiety symptoms and obsessive thinking [8].

We know that dieting encourages rigid and controlled behaviour; promotes unhealthy self-esteem, guilt, shame, depression, and isolation; and encourages obsessive thoughts and behaviours regarding food and eating. It further promotes all-or-nothing thinking, slows metabolism, and interferes with the body's natural hunger and satiety signals. It triggers binge eating and ensures that the dieter will fail, which often triggers more rigid and harmful dieting and disordered eating practices.

In summary, depriving one's body of food and nutrients by not eating enough causes food cravings and can lead to binge eating as a natural reaction to undereating. Subsequent weight gain is due to metabolic changes, a changed relationship to food, and the powerful drive of the body to return to its genetic set point [8].

2.4 Health risks of weight cycling

The failure of dieting often results in repeated cycles of weight loss and weight gain, known as weight cycling. A 2005 Finnish epidemiological study indicated that weight cycling is a risk factor for cardiovascular diseases. Prevalence of hypertension, insulin resistance and high cholesterol were found to be elevated among weight cyclers within the "normal" BMI category. The study indicated that even those with a low BMI who weight cycled due to sport or career (for example: cyclists or ballerinas) were at risk for chronic diseases commonly associated with a higher weight [9]. Tylka et al. state that, "Overall, research conducted around the world for the past 25 years has repeatedly shown that weight cycling is inextricably linked to adverse physical health and psychological well-being" [3], p.4.

2.5 Dieting on the eating disorder continuum

Regardless of the specific eating disorder diagnosis, one factor that we have observed almost universally with clients in the eating disorder treatment program is a history of dieting. Multiple studies have established a causal link between dieting and binge eating with and without purging. In a large study of 14–15 year old adolescent girls

dieting was the most important predictor of developing an eating disorder [4]. Those who engaged in strict dieting practices were eighteen times more likely to develop an eating disorder within six months as compared to non-dieters. Girls who were more moderate dieters were five times more likely to develop an eating disorder within six months compared to non-dieters [4]. In another long-term study with adolescents, some dieters engaged in more extreme food restriction and purging or laxative use, while others engaged in binge eating; additionally, the persistent dieters showed an increase in body mass index when compared to the non-dieters [10].

At WHC, all behaviours intended to pursue weight loss (dieting, over exercising, purging, restrictive eating, laxative use, and weight loss surgery) are recognized to exist along a continuum of disordered eating behaviours. Each behaviour is associated with different risks that can contribute to disconnection from the body.

2.6 Weight bias and stigma

Another rationale for weight neutral health care centres around the reduction of weight bias and stigma. We know that a focus on weight increases bias and stigma towards people perceived to be fat. This may include negative assumptions that are made about people based on the size of their bodies; it may include verbal abuse and discriminatory behaviours. Individuals may experience barriers in day-to-day life such as undersized chairs in public locations or a lack of appropriate sized medical equipment such as blood pressure cuffs or patient gowns.

Puhl and Heuer (2010) cite multiple studies that have shown that people are stigmatized because weight is perceived to be caused by factors within one's personal control (11). This serves to justify stigma as an acceptable societal response [11]. Research on weight bias has found that fat individuals are less likely to access healthcare and are less likely to receive evidence-based and bias-free healthcare when they do access care [12]. Weight bias has also been associated with adverse health outcomes including anxiety, stress, depression, and low self-esteem and body image issues [13]. In addition, the stigma associated with weight has been further shown to contribute to social inequities, health disparities and stress induced illness [11].

Furthermore, specific research on the impact of weight bias among adolescents indicates that 40-50% of teens who were teased about their weight reported feeling depressed and sad [14]. Adolescents also reported coping with weight based teasing by avoiding activities such as gym class, increasing food consumption, and binge eating. Incidents of skipping school and grades dropping increased along with subsequent experiences of weight based victimization [14].

Utilizing the framework of weight-neutral care helps to reduce the weight bias and stigma that is one of the adverse effects of a focus on weight.

Here are some key questions for personal reflection. How weight neutral are you? How often do you...

- *Compliment someone on their weight loss?*
- *Assume someone is doing well because they have lost weight?*
- *Talk about your weight? Make negative comments about your size or shape?*
- *Disapprove of body fatness in general?*
- *Equate being fat to being unhealthy?*
- *Say something that assumes others around you are "watching their weight?"*

3. Six Values for Health Promotion

3.1 Body inclusivity

Body inclusivity includes respect for, acceptance of and provision of appropriate care for people of all shapes and sizes [2].

Care providers at WHC actively embrace and appreciate body diversity and strive to respect the bodies of LGBTQ people, people with disabilities, disabled bodies, people of colour and Indigenous people. These inclusive, social justice oriented, and client centered values are reflected in WHC's Principles of Service [15]. Our recommendations for practicing body inclusivity include:

- Respond in a neutral way when someone reports weight changes but validate positive health behaviour changes.
- Make only positive or neutral comments about your own body and refrain from commenting on other's body shape or size.
- Examine your own biases or assumptions about weight.
- Adopt a premise that all bodies are good bodies and that everyone benefits from feeling peaceful about their body.

For reflection:

- *What would a body inclusive environment look like or feel like?*
- *What would be different at your workplace, classroom, gym, at home or in the community?*
- *How would you deliver service differently?*

3.2 Respectful care

The next tenet is respectful care. This means that all staff have the opportunity to learn about weight bias, risks of dieting and HAES® principles. The clinic environment includes chairs and medical equipment that meet the needs of a wide range of body sizes. Health education, promotional materials and other communications use inclusive, diverse images and non-stigmatizing language when discussing weight or health [2].

At WHC, we pay attention to the details. For example, if there are magazines in our waiting room they will not include messages that are contrary to our values (i.e. nothing that promotes diets or weight loss). Another way we practice respectful care is to avoid stigmatizing language such as “overweight” or “obese”. These are medical terms with arbitrarily shifting definitions. In 2013, the American Medical Association defined “obesity” as a disease, going against the recommendations of its own Public Health and Science Committee [16]. The Canadian Medical Association followed suit in 2015 [17].

At WHC people simply have a weight which is not used as a measure of their current health status or a future health goal or expectation. Even with clients who may be at an artificially low weight due to an eating disorder, their body shape or size is not identified as the problem nor as a proxy for the illness itself. Weight change, in itself, is not seen as an indicator of restored health and wellbeing.

WHC clients are rarely weighed as this is unnecessary for most general community health clinic visits. Weighing may be necessary in diagnosing specific conditions such as malnutrition or to prescribe certain medications. We have observed the adverse effects of weighing which can include embarrassment, anxiety, and clients reporting that they avoid seeking medical care.

If weighing cannot be avoided in your practice, then we suggest you adopt the recommendations from the Rudd Centre’s on line Tool Kit: *Preventing Weight Bias: Helping Without Harming*. This includes asking for permission to weigh, offering to

have the person face away from the scale and ensuring that weighing takes place in a private location and is recorded without comment or judgement [18].

3.3 Eating for wellbeing

Another important tenant at WHC is to encourage eating for wellbeing. Healthy eating includes eating for energy, nutritional needs and pleasure. We encourage regular eating that is balanced as well as flexible. Dieting for weight loss is not recommended [2].

WHC dietitians and other care providers use a variety of strategies to encourage eating for wellbeing. We encourage families to share food together and attempt to make meal times pleasant and an opportunity for positive connection. Adults are encouraged to model a balanced relationship with food, which includes eating regularly and enjoying all types of foods from all food groups. We discourage diet talk and labeling food as “good” or “bad”. In school or community settings, we discourage food shaming and teaching about food as “healthy/unhealthy” or “good/bad”. We encourage educators to teach about nutrition as eating for energy and pleasure and without connecting it to weight. In classrooms, children can make soups, visit a greenhouse, plant and harvest a garden, try new foods or share traditional dishes made at home. These activities help children enjoy food and learn about nutrition without fear of judgment about what is in their lunch box.

We recognize an important part of eating for wellbeing includes learning how to nourish the body adequately and, at the same time, avoid treating food choice as a moral issue.

People of all shapes and sizes deserve to eat and be nourished. We encourage clients to eat at regular intervals and eat enough throughout the day. We emphasize how this fuels the brain as well as the body. We use an *add in* approach when clients are missing basic nutrients. Even when client goals include reducing their intake of pop or low-nutrition snacks, we start with adding in other fluids or the missing elements such as protein or complex carbohydrates. Typically, clients begin to make the desired changes themselves as they notice that they crave the pop or low-nutrition food less often. No food is labeled “good” or “bad” as we are also working towards moving away from all-or-nothing thinking. Nutritious foods are promoted because they help to reduce the risk of chronic disease (high

blood pressure, diabetes etc.), help with recovery from discordant eating, improve mood and emotion regulation, and increase energy levels. Eating foods that are pleasurable is also encouraged.

Today, food is frequently labeled with a variety of value-laden words like “clean”, “ethical”, “super” or “sustainable” which creates a moral divide between those who strive to eat in a virtuous way versus those who just eat food. Food that has been processed in some way prior to consumption is often perceived as nutritionally inferior and therefore morally inferior to food prepared at home. The media and the diet industry reinforce the idea of “good” and “bad” foods, which even the American Dietetic Association has stated this may foster unhealthful eating behaviours [19]. We are aware that these categories also reinforce other social distinctions, such as ethnicity, socio-economic status and education level. We work to decrease shame about food choices and try to be aware of any food security issues facing our clients. We normalize eating and teach that food is more than fuel; it is also about culture, traditions, experience, pleasure, and taste.

Clients are encouraged to give themselves permission to eat all foods. This is done through education about the futility and risks of dieting, challenging beliefs that food is an issue of morality, and providing emotion regulation skills with the goal of feeling calm. Language around food is neutral. For example, we may say to a client: You require regular fueling through the day. You can tune into your body to notice which type of carbohydrates, whole grain or white, help you feel more satisfied. Often people find whole grains more satisfying because of the fibre.

When people can feel calmer and more relaxed about eating, and are not labelling their food as ‘good’ or ‘bad’, they are able to eat enough food regularly through the day and can feel comfortable integrating a wider variety of foods including treats and snack foods.

3.4 Life enhancing movement

People of all shapes and sizes are encouraged to move their bodies in pleasurable ways in order to enhance their health within the range of their individual abilities, limitations and interest [2]. At our clinic, physical activity is promoted for the mental and physical health benefits, the potential to reduce the risk of chronic disease, for increased social connections and for pleasure. Clients are supported

to explore the idea of joyful movement, which we define as something that gives us pleasure, feels good in our bodies, and is not punishing or inflexible. For those with eating disorders, there is considerable attention paid to what is safe within the context of recovery.

For personal reflection:

- *What comes to mind when you think of joyful movement?*
- *When you are active, are you able to notice if the activity helps you feel more connected with your body and your emotions or do you use activity as a form of disconnection?*

3.5 Health enhancement

At WHC, the emphasis is on health-promoting behaviour changes that improve quality of life and with consideration for emotional, mental, spiritual, and physical wellbeing [2].

Rather than focusing on weight, WHC practitioners discuss health behaviours that may reduce the risk of chronic diseases [20]. This may include specific recommendations to: increase energy, improve blood sugars, and lower blood pressure and cholesterol etc. In the case of eating disorders, this includes specific tools for addressing food and body behaviours. Throughout the treatment program, clients build skills to ground themselves, regulate emotions, and practice mindfulness and self-compassion. In our observations and client self-assessments, there is evidence that the practice of these skills, together with weight neutral messaging, can lead to a significant reduction in disordered thoughts and behaviours as well as support long term recovery.

When it comes to health promotion, WHC addresses messaging to people of all body shapes and sizes, rather than presume that people with certain bodies require more health education than others.

3.6 Advocacy

We promote HAES® principles to our clients, other health care providers, and the wider health care system and the community. We promote critical thought around the damage done due to weight bias in the fitness, nutrition, healthcare, fashion, pharmaceutical and diet industries [2]. Advocacy at WHC extends beyond our weight neutral approach to other important social issues that impact health. Poverty, food insecurity, inadequate housing,

discrimination based on gender, disability, race or Indigenous status, along with other social determinants, such as isolation, are shown to have significant impact on physiological and psychological health and wellbeing [21]. WHC attempts to increase social connection and supports through support groups, programs that address issues such as poverty, and/or through prioritizing services to marginalized communities.

For personal reflection:

- *What is something you can do to advocate for inclusion of all shapes and sizes in your workplace?*
- *If you experience privileges or are awarded respect based on the size of your body, how can you use that privilege to support those who are oppressed or stigmatized based on the size of their body?*
- *How would the health status of your patients or clients improve if the social determinants of health are addressed?*

4. Conclusion: Focus on wellness, not weight

WHC's decision to focus on wellness not weight in all aspects of our health care and service delivery is supported by Tylka et al (2014) [3] and Bacon & Aphramor's (2011) [22] review of the empirical research. Body size is to a large degree genetically determined [23], [24] and weight is not modifiable on a sustained basis for most people. Therefore, it is ethical, responsible, and compassionate to provide weight neutral care that can actually promote health behavior change to reduce the risk and treat chronic diseases.

Specifically within the eating disorder treatment program, we have observed the therapeutic benefits that come with our focus on helping clients change their thoughts, feeling, and behaviours instead of their weight. This requires preparing clients for the possibility of body changes during recovery and acknowledging the grief they may have about weight change or lack of change in a culture that stigmatizes bodies that do not conform to societal ideals. Through cognitive behavioural restructuring and dialectical behavioural skills such as emotion regulation, distress tolerance, radical acceptance and mindfulness, recovery is possible without a focus on weight change as a measure of success.

In our clinical experience, as clients move through the eating disorder treatment program, we have found that clients show a decrease in the following: disordered food and exercise behaviour: all or nothing thinking, negative self-talk, isolation, shame, self-blame, weight preoccupation and symptoms of anxiety and depression. Many clients also make improvements to symptoms related to chronic disease such as lowering their blood pressure or blood sugar levels. There is also a measurable increase in self-care and wellness-promoting behaviours, body acceptance, self-advocacy skills, confidence, and self-worth and self-compassion.

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Adolescent girls use power tools: A critical media health literacy program

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Abstract

This paper reports on a media literacy program, “The Body Positive Program” which was created to promote protective factors for adolescent girls in the context of growing concerns around the intersections of media and health. A critical media health literacy (CMHL) framework was designed to help explain how media literacy and health literacy intersect in important ways for critical studies. The framework was also used to examine the digital artifacts made by 26 adolescent girls who attended one four-week, body-positive program. Participants were encouraged to think critically about their health and media for several hours each week. The 26 girls in the study also participated in a different physical activity component each week designed to promote movement and fun rather than emphasize weight or ability. We anticipated that this emphasis on body-positive activities, health, and media literacy would be reflected in the girls’ designs of their digital artifacts at the end of the program. We also interviewed the girls about their artifacts. This paper reports on one portion of a larger study on this program. It took place in the fall of 2015 in Ontario with the cooperation of a non-profit agency that supports girls in Ontario, Canada.

1. Introduction: Health concerns for adolescent girls

Many researchers have raised increasing concerns around adolescent health through a decline in physical activity e.g., [1], [2] [3]; an increase in mental health challenges [4]; and a growth in negative body image issues [5], [6]. Additionally, a recent House of Commons report [7] suggests that Canadian adolescents are immersed in a culture that connects acceptance to appearance and the result is that adolescents may harm themselves and their health due to body image concerns. Further, the report also finds that, although there are biological risks for eating disorders, the environment can trigger at-risk outcomes. This trigger can be something such as the

constant monitoring and tracking of food consumption, measurements of BMI, calorie counting, or even a compliment directed toward an aspect of the body. Viewing and internalizing media messages can also prompt body surveillance and dissatisfaction. The report suggests that more research is needed on how to build resilience for adolescents against this messaging [7].

Societal pressures to look a certain way, reinforced through media and social media, can prompt self-esteem issues and increase the likelihood of mental health challenges, disordered eating, and poor self-concept based on a body image ideal that may be unrealistic or impossible for most adolescent females [8]. Further, there is growing research that emphasizes that the social determinants of health play a large role in the health outcomes for adolescents and their families; these factors include, for example, household income, race, ethnicity and gender [9],[10].

2. Adolescent lives

2.1 Media usage

It is undeniable that adolescents are being exposed to an increasing amount of potentially harmful media [11],[12]. The media, friends, and family are the main reasons that adolescent girls become motivated to change and modify their bodies [13]. Many adolescent girls misunderstand body-based media messages and see the messaging as an encouragement to be thinner, which can entice them to practice disordered eating such as purging, restricting food, and using pills and smoking rather than eating [14].

According to Tiggeman and Slater (2013) internet exposure and social media are also associated with the internalization of the thin ideal, body surveillance, and the drive for thinness even more so than watching television or looking at fashion magazines. Additionally, Facebook is also associated with having a negative body image; Facebook users scored much higher on every indicator of body image concerns [15].

2.2 Lack of prevention programs

Much of the existing research and health programming has focused on the idea that *individual choice determines health*; this focus ignores the complexities in our current society [12]. Secondly, the focus on programs that emphasize exercise and food as a simple solution is insufficient, not helpful, could be harmful, and is too narrow of a focus when a holistic view of health is more supportive. In fact the Health of Commons (2014) report emphasizes that the obsession on obesity and its subsequent policy and societal response supports this limited direction. Finally, health education may continue to fail to meet the growing needs of adolescents. Many interventions blame the individual and further marginalize people as determined by socioeconomic status factors [14] which measure a family's social and economic position in comparison to others, based on education, occupation, and income levels [11], [14]. The definition of health is more closely tied to poverty and issues of marginalization than whether or not someone made a bad food choice [10].

The focus of the teaching should not be on the shape and weight of the student, but rather on promoting a model of wellness, health, and resilience along with weight neutral goals [16]. The House of Commons Report also states that there are no health and body image prevention programs geared toward Canadian adolescents; this gap, they assert, occurs during the riskiest period of development [7]. The World Health Organization proposed more holistic approaches to health (mental, social, and physical) seventy years ago [17].

Currently more than 20 percent of Canadian adolescents are diagnosed with mental health issues and media is a factor [4]. Harmful media can negatively influence self-esteem and body image [12] and can be more influential than family and peers [7].

2.2 Potential Protective Factors

Although there are links between media and several body-image related concerns, there is another side to media. Using media and technological tools to combat negative messaging gives adolescents the platform to fight back by using their own voices, and is an area that is largely unexplored [12]. Critical media literacy can give adolescents the skills to break down media messages and understand how the idea that acceptance is related to appearance is a mediated message [18].

The literature surrounding critical media literacy is only just emerging [17] and very little has been written about adolescent girls and critical health literacy. In fact, there is an absolute gap when the search is critical, health, media and literacy [18]. There is also an absolute gap with respect to the girls' voices to deconstruct and reconstruct critical health literacy messages with the use of media [12].

Building protective factors such as critical media literacy skills that incorporate ideas around health and allow adolescents to create body positive messages can lessen outcomes such as reduced body dissatisfaction while building resilience [19]. Protective factors such as critical media literacy [18], critical health literacy [20] and physical activity [21] can be provided in a prevention program.

By focusing on prevention and protective factors through the teaching of critical media literacy and critical health literacy (CMHL) and encouraging advocacy, this research attempts to fill a gap by showing that adolescents can build resiliency through activism [12],[14] [22] and resist unhealthy media messaging [23].

3. The critical media health literacy framework

To date media teaching [24] and health teaching in general [20] have not been at the critical level. Because these teachings can build protective factors, this research sought to contribute to the small amount of literature available on the topic. Nutbeam theorizes that there are ways to teach students about health. Programs geared toward health education and communications have largely failed and are not adequate, especially within various social and economic groups within society. At lower levels of criticality, students are *told* how to be healthy. At higher levels, students consider the evidence and think and act for themselves [20].

This research study set out to explore what happens when adolescent girls in a course on self-esteem and body image are encouraged to think critically about media and their health. We wondered if this would be reflected in their media productions. Other questions emerged such as how their discourse would reflect health understandings.

4. Methodology

The methodology used for the "Body Positive Program" was qualitative. Elements of data that were analyzed for the larger study included observations, interviews with the girls regarding the

construction of their media artifacts, and field notes. This study was conducted over 4 weeks (2 1/2 hours per week) and included 26 adolescent female participants ages 12-17. They were invited to participate through Girls Inc. who were running programs in the community.

During the last session, the girls were encouraged to create digital artifacts that could be used to combat media messaging around body image. The girls were told that their artifacts would be on the website www.teachbodyimage.com.

4.1 Critical media health literacy

A framework was developed to measure the criticality and health levels in the artifacts that the girls produced. This framework incorporates the work of several other researchers: Nutbeam's levels of health literacy [20], Kellner and Share's levels of media literacy [24] and a framework used to examine the level of criticality in preservice teacher lessons [25]. It made sense to combine critical media literacy with health because of the number of health messages provided in the media, and the implications of receiving media messages [26]. The framework used to evaluate the artifacts designed by the girls in this study is presented in Table 1.

Table 1. Health Literacy/Media Literacy framework (HL/ML) for artifact evaluation

Levels	Description
Basic media health literacy	Media that articulates basic understandings about health.
Media health arts	Aesthetically pleasing media about a health issue that demonstrates basic understandings of health.
Media health literacy	Media uses media conventions to create a health artifact that demonstrates the ability to question basic understandings of personal health.
Interactive media health literacy	Media questions basic understandings of personal and social health in way that communicates more than telling.
Approaching critical media health literacy	Media questions health information from a political or social or consumer lens, then reconstructs and shares the health message as a way of taking social or political action.
Critical media	Media questions health

health literacy	information deeply from a political, social and consumer lens, then reconstructs and share the health message as a way of taking social and political action.
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Source: Scheidler-Benns, 2016 [19]

5. Findings

In general, the girls took the topics introduced in the workshop seriously. They were eager to share their thoughts and listen attentively to each other. Often their conversations had to be interrupted in order to move to the next activity. The discussions often became lively and many times several girls were raising their hands at once to share their ideas. They appeared to feel safe and secure despite the research team being present, taking notes, observing, and recording. The girls created six artifacts during the fourth and final session. Although all girls were involved in creating the artifacts, 17 out of the 26 produced artifacts to share on the website.

5.1 Description of the artifacts

The girls created six artifacts during the fourth and final session. The choice of media was left up to the girls and they were free to present their voices in whatever medium they chose. We asked them to create something for the website to share.

The first artifact created was a picture of Soundwave. The toy looks like a robot and contains many accessories including a photographic memory from data storage capabilities, shoulder-mounted rockets, radio wave sensors, and a tape deck. In her words, the girl described it as a comparison between a Transformer Soundwave and an average man. Soundwave is 13 feet, 5 inches and an average guy is only 5 foot 10 inches. Soundwave's top speed is Mach 4.1 and the average guy can move at 14 miles per hour. She explained that this toy presents a stereotype that boys have to be tall and strong. She said that she always thought that girls' toys were stereotypical but she had come to realize that boys' toys were as well. The girl's interview revealed that she had chosen this character because she was concerned that boys were worried about body image too. She felt that the toy may pressure boys to want to be a certain size and strength, rather than embracing their uniqueness. Her message to boys and girls alike was to not let toys set a guideline for what size you have to be because there is no toy that

matches the unique person you are. She was passionate about the topic.

The second artifact was the audio of the two girls singing *Try*. When asked why they chose the song, they explained that the song was about accepting flaws because everyone has them. Words from the song itself state, “You don’t have to change a single thing.” They recorded their song publicly in the main room in an impassioned and powerful way. They were proud to sing openly in front of the other girls and this acknowledges their feelings of acceptance.

The third artifact was a six-page PowerPoint created by five girls entitled *Positive Body Image*. They said that it was motivated by a “real” girl who has had a lot of surgery done to her to look like Barbie. They were impressed also by the report about a man who started a foundation for a more natural doll. The girls said that their slide deck showed women of different sizes and shapes who were comparing themselves, and everyone is different. The slides begin with an image of a distorted and thin Barbie, a regular Barbie, and the new Barbie, which is not as tall and thin, showing uniqueness. The girls said that people think of body image as a negative idea but that it should be positive. Their main message was to “Stay positive and be yourself.”

The fourth group created a 10 slide PowerPoint entitled, *Love Yourself, Accept Yourself*. The girls shared their thoughts about their project by saying that a person’s own opinion matters the most and that people should be proud of who they are. People should not be ashamed of how other people see them. The girls explained that they wanted to send the following message to other girls: “Stop the negative talk about your body. Our differences make us beautiful. Embrace your unique bodies and love who you are.” On slide #8 they wrote “Everyone has a Perfect Body” using pictures of women of many shapes, sizes and ethnicities. On slide #9 the girls wrote, “It doesn’t matter; we are all beautiful.”

The fifth group created a video using the song lyrics and music *Words* by Hawk Williams. The words from the song explained the pressures they feel which are like being a prisoner that needs to be set free. The girls explained that they chose this song because, “We’re too hard on ourselves and it’s very hard to draw confidence and you have to do that from the people around you.”

The sixth artifact was a dance video that three of the older girls created to the song, *Fight Song* by Rachel Platten, and was recorded on an iPad. The pressures this older group felt were explained in the

lyrics from the song itself. (This is my fight song – take back my life song.) Their message was that everyone has different perspectives but all bodies are beautiful. Another explained that she saw that no one is built the same and size does not matter.

The artifacts showed that the girls needed very little support to define their pressures around body image. They were able to deconstruct and reconstruct media to change the message. In a very short amount of the time, all 17 out of the 26 girls were able produce a media artifact to share on the website. Although some girls chose to watch other girls create an artifact, all of the girls participated in the creation of an artifact during the final evening.

These findings indicate that, when adolescent girls are encouraged to think critically about their health and body image, they can do it. The participants in this study were comfortable and empowered to use technology to express themselves using digital tools. They showed strong facility with technology – almost effortlessly creating their artifacts using different devices unassisted. One group used their phone, one group used the iPad, and the others used laptops or desk computers, seamlessly moving from discourse to artifact creation. They were clearly empowered with the idea of using technology to express themselves.

Their media was socially-focused. They wanted to use their voices to encourage other girls to not worry about how they look, to love themselves, to focus on health not their size, and to continue to share these messages. Their media showed a sense of their future audience: other girls who would see these artifacts on the website. Through their choices of songs, poems, memes, and images they acknowledged the pressures and they encouraged other girls to continue sharing positive messages.

These findings indicate that the media deconstruction and reconstruction elements combined in this program are a model that can be drawn upon for future interventions. Incorporating these ideas into other prevention methods are shown here to take very little time to do.

5.2 Findings about health

The participant girls were able to recognize the potential harm to their health in the media messages. In listening to their discourse, we found that the girls saw health through a social lens (being happy, feeling good). They were powerful encouragers of each other. They resisted size comparisons and sought to be comfortable in their

own skins. The girls were also very concerned with mental health, and saw that being supportive, active and feeling good in general was important. Food was not discussed.

Within the context of this program, when the girls talked about health they said it was different from the way that health is typically taught in schools. Based on observations, the combination of health and media literacy teaching provided positive outcomes. Their enjoyment of the physical activity and the possible benefits that can be derived from it during these sessions invites the continuation of research that combines, rather than separates physical education, media and health (as is the case presently in many Ontario schools).

The girls discussed freely and worked on building community, which may be challenging to do in a typical school setting, because the girls had much to say but indicated that they needed safe spaces to do this. Significantly, the participants indicated that they sense what is happening in the media but they needed support with the words and concepts to help them explain what they were experiencing. They also relied on strong role models from media to voice their messages.

6. Conclusions

These findings add to the existing literature in that the study showed that critical media literacy combined with critical health literacy can lead to indications of empowerment and resilience in adolescent girls. The participants expressed themselves in a way that showed understanding of the social construction of beauty and its consumer links. They felt compelled to share their message with other girls. This has implication for education policies to consider adding critical health literacy to the curriculum as well as more holistic approaches to health that include social and mental health.

One limitation of this study is that many of the girls who participated in this program had attended other aspects of Girls Inc. programs. This is an organization that inspires girls to be strong, smart, and bold. They may have had more experience with positive messaging, thus they may have been more open to creating strong messaging to share with other girls. Also, follow up sessions with the girls would have helped to measure the program benefits more clearly over time.

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Learning about Real: Critical Media Literacy and Body Equity

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Abstract

This paper is based on a Critical Media Literacy workshop presented at the 2017 NEDIC conference held in Toronto, Canada. The workshop aligned with the conference themes: awareness, equity and acceptance. The goals of the workshop were to promote awareness of the impact of media culture on children and adolescents; encourage acceptance of all bodies; and promote body equity. Research indicates that the school curriculum misses key opportunities to teach critical media literacy and body acceptance. With exposure to more critical forms of literacy, students can learn to recognize and respond to multiple social media sources showing stigma and stereotypes, as well as mediated messages about food and body perfection. The curriculum should, but does not, address key health implications of trying to change one's size and shape. Through critical media literacy, K-12 students can learn to ask key questions and remake online content to counter these hegemonic messages about the ideal body. They can seek and re-post body-positive messages and create their own messages to promote awareness, acceptance and body equity.

1. Introduction

Schools are part of Canadian society, grappling with both new media and a struggling social conscience. Critical media literacy is a pedagogy that brings together new literacy skills and social awareness. Today's Canadians have many new ways to consume and to create media using technology but they have fewer opportunities to think critically. They are accustomed to using technology to communicate. When you hand a smart phone to a child, invariably they respond by trying to get the screen to react to their touch. Many privileged young Canadians who were born by the turn of the 21st century have never known a world without colour screens, portable phones, and media that are social, personalized and responsive. Whether or not students have opportunities to think critically about new media is not as apparent, however.

The last 50 years have seen other important, national changes. A growing form of Canadian social consciousness is evident in the Charter of Rights and Freedoms [1]. The Charter prohibits discrimination based on protected areas such as race, national or ethnic origin, sex, age or mental or physical ability. More recently, there has been recognition of the discriminatory aspects of heteronormativity and the gender binary; the Canadian Human Rights Act [2] prohibits discrimination based on the previous protected areas and adds sexual orientation, gender identity or expression, marital status, family status, genetic characteristics, disability, or a pardoned conviction. Discrimination based on size or shape is not a protected area under either policy.

The prevention of eating disorders was identified as a serious health concern by a parliamentary committee [3] who heard that there is social pressure on Canadians to conform to an ideal shape and size. This imperative to look a certain way holds the individual accountable to make the effort to achieve an improved body. This narrow focus holds individuals largely responsible for their health and ignores the social determinants of health [4], broader systems of global food provision [5], and other factors such as genetics that factor into body size and shape [6] [7]. A focus on individual responsibility/morality supports a culture of body shaming. One Canadian psychiatrist reports that schools can be toxic environments for judging weight and appearance for girls [3]. There are similar findings about boys and school [8].

Body equity is a concept that recognizes the natural diversity of bodies and encourages schools to acknowledge diverse bodies in its curriculum and policies [9]. The school curriculum should address bias based on body size and acknowledge media pressure to look a certain way. Schools should consider carefully if they are equating weight and health, because people can be healthy at many sizes; slimness is not necessarily an indicator of health. The curriculum should also introduce students to the broader health determinants such as differences in opportunity and access to water, food, and safe

spaces to be physically active for Canadians regardless of their geographic or social location.

2. Canadian Curriculum

It would be very good news, indeed, if we could report that the curriculum in Canadian schools has been responsive toward addressing social conscience and helping students navigate the information age with a critical stance. Instead, we find that the Canadian curriculum has been slow to respond in critical ways. The curriculum has changed little; it reflects many aspects of the same dominant culture, class, gender and heteronormativity that has existed for centuries (See for example [6], [7], [10]).

Herein lies a call to action. We need to update curriculum policies such as physical education curricula that reflect long-standing traditions of military, sport, and the gender binary without recognition of the natural diversity of bodies, and different ways to be active, irrespective of ability.

Rather than examining new media for its visual techniques, which the curriculum presently promotes, there is a very real need to examine media in critical ways. One issue might be considerations surrounding the media diet of Canadian children. Other issues might include the commercialization of children's online spaces. Canadian students in a wired world need media studies [11] to understand how sources mediate the information that students may take for granted as "truth." Students need to learn how to ask key questions to evaluate information and respond through a more critical lens.

Emergent, ubiquitous technology (new media) can either perpetuate unhelpful stereotypes, or it can be used to challenge media representations. The school curriculum has gaps or is absent in addressing issues related to the harm perpetuated by media stereotypes. Talking about these mediated messages supports the prevention of eating disorders. Body image and self-esteem curriculum requires a critical stance. One way to respond to curriculum gaps is to teach students how to recognize body positive messages, resist "ideal body" messages, and construct their own new media to promote the acceptance of body diversity.

2.1 New literacies, new pedagogies

Students need to participate in selecting, viewing, and responding to media in ways that allow them to be more informed and participating citizens. For this to happen, students need to learn how to

question what is happening in their world and become critical, reflective kinds of learners. Today's issues and politics have significant life or death implications for certain populations. Globally, there are shifting changes in populations due to wars and climate change. Faced with the aftermath of colonialization, finding peace and reconciliation are important challenges. There is a growing disparity of life outcomes for the wealthy and the poor. These are only some of the challenges facing global citizens. In order to understand, students will need to examine why the outcomes of life are different for different groups and how injustice plays a role in unequal treatment.

The New London Group designed a pedagogy of multiple literacies for this new digital era. One aspect of this pedagogy is the need for overt instruction on equity concepts [12]. Students need to understand a meta language that supports the interrogation and critique of media texts including negative terms such as oppression, prejudice, stigma, and discrimination. They also need the words that will help them to design the future such as voice, advocacy, fairness and reconciliation. Sometimes this process involves seeing media through an historical lens, such as understanding the impact of the deregulation of children's television. In other words, students need to examine issues that they have previously accepted and taken for granted, such as explanations about colonialism and difficult truths about its legacies such as residential schools. Students also need the skills to examine advertising that directs them to look a certain way or media that privileges certain body types. Parents and teachers can help them to "name" the issues.

2.2 Keeping the "critical" in critical media literacy

Schools teach media literacy but the curriculum couches these lessons in neutral tones. For example, the ministry of education in Ontario says that critical literacy includes asking students to consider whose views are represented and whose are omitted [13]. This is promoted without also teaching the broader social context that there has been a dominant (white, male, European) influence in school texts that has presented a mostly singular view of the world for centuries. Luke describes this as *sidestepping the analysis of social, cultural and economic power relations* [14]. An epistemological stance of neutrality in education does not acknowledge the complexity of life and a diversity of

views. Teachers who are leaders of inquiry encourage students to explore multiple perspectives.

The media literacy curriculum informs students that most media texts are created for profit or persuasion, but once again, the curriculum fails to acknowledge that mass media can affect their overall health choices. Students need the skills to recognize that media can influence them to change their bodies and compromise their health in order to fit into an ideal that is promoted by a cosmetics company or as fodder for gossip on a talk show. Rather, the opposite is happening in Canadian curriculum policy; students are given the message that they should be working to change and improve their bodies [7],[10].

The Canadian Women's Health Network directly connects media with body dissatisfaction, finding that media's perpetuation of the thin ideal leads to unhealthy dieting, taking drugs to lose weight, disordered eating, depression, and unnecessary surgeries such as breast implants. We argue that students today need age-appropriate lessons that will help them understand how to investigate and consider these messages. Students need information on the broader social contexts in order to understand the more complex power relations at work to influence them.

In searching for the best media literacy approach for a democracy, Kellner and Share examine curriculum and find four general approaches to media literacy. The first is the *protectionist model*, which cautions against too much screen time or excessive exposure to media violence. This approach can be helpful as long as teachers do not oversimplify it to become anti-media in general. The second approach is *media as art*, which examines the aesthetic elements of media. This can be helpful if students can use these lessons to create their own media and find their own voices. The third approach, *media literacy* helps students to examine multiple forms of media but it generally follows the approach that media are neutral and it does not challenge taken-for-granted assumptions. A fourth, more democratic approach, combines elements of the first three but also involves students in media production so that they can take action against the social practices they critique [15].

When combined with critical pedagogy, critical media literacy requires teachers to 1) examine their own assumptions; 2) move away from the neutral space; 3) help students name injustices such as assumptions of heteronormativity, racism, and religious intolerance etc.; and 4) encourage the re-

construction of media and the creation of new media.

The next section examines how notions of looking a certain way have resulted in media perfection codes that coalesce along gender binaries. Schools can approach these topics using age-appropriate materials. The body image and critical media literacy lessons provided at www.teachbodyimage.com for example, have been designed with child and adolescent development at the forefront. These and other well-researched resources can fill gaps left by curriculum policies that "sidestep" or take a neutral stance on some of these issues.

Critical media literacy can help students understand the broader systems at play impacting on food choice and food availability. Food choice and choosing to exercise are not solely the responsibility of the individual. For example, concepts such as walkable cities and shorter commutes also contribute to health. "Choosing" to exercise may be within the purview of the individual with the means, the opportunity and the unburdened ability to make those choices. In this way, the teaching of critical digital literacies is as important for students' health as for its contribution to an informed citizenry.

4. Eating disorder prevention and critical media literacy

According to multiple leading experts [16], eating disorders affect an estimated 600,000 to 990,000 Canadians of all ages, with children as young as seven years old entering eating disorder programs. More recently, evidence indicates that Canadian males increasingly experience body dissatisfaction and disordered eating, along with an unhealthy focus on gaining muscle. For women aged 15 to 29, one in four to one in five show symptoms of body dissatisfaction and disordered eating. As there are insufficient means to treat all of these individuals, expert researchers identify that the answer instead lies in working concertedly on prevention as well as intervention and treatment [16].

One risk factor for eating disorders that exists in media is the over-representation of the young, thin or muscular body shape as the ideal. The prevalence of this perfect body type can lead someone viewing media or participating in social media uncritically to see this body size as the norm, although this body size occurs naturally in only a small percentage of the population. Given that most people are younger, older, taller, shorter, fatter or thinner than this

segment of the population, constant comparison with a mediated ideal contributes to body dissatisfaction.

Another risk associated with media is the objectification and sexualization of female bodies to a large degree but also male bodies. The issue that needs to be raised is whether or not these media norms can be accepted uncritically or if they should be challenged. For example, close-ups focus on a part of someone's body, rather than the person and their message. As Canadians, we have to examine carefully how comfortable we are with presenting girls and women so frequently as objects of desire. There is also the issue of realism, as real life cannot compete with Photoshop and hours of endless preparation designed to sell dresses on the red carpet. Beyond the sale of dresses, these practices promote what is valued culturally and socially. These looks are unattainable for the general population. Presently there is an advertisement on Canadian television that shows a woman exercising, running a board meeting and coaching her daughter's team – all before breakfast. These types of media messages subtly tell women how to “be” in the world.

Other media such as gossip shows (talk shows and entertainment shows) participate blatantly in social comparison, judging people by their looks and clothing choices, and assigning popularity. Acceptance is related to appearance which results in choices that are risky for health. The results are profits for those corporate entities focused on selling weight and appearance management.

One need only look to popular magazines at the grocery checkout counter to see the inherent contradictions in the corporate media messages. While the overall message is to sell, many of the magazines offer quick weight loss advice as well as recipes. Commercials sell under the guise that a person needs to improve their looks to stand up to social comparison. Many of these ads are aimed at women and girls (for fuller hair, shinier lips etc.). Missing from these media messages in general are realistic body sizes and proportions. Even models who are selected to represent aging women often do not have the typical features and proportions of the women they supposedly represent. Naturally, this helps to promote the sale of a product to make someone look younger than their age. These are only some of the issues.

A key question emerges: *Do we want to teach adolescents to focus on the media techniques and the audience, or do we want to challenge adolescents to connect the dots, understand the*

powerful forces at work, and participate to create counter narratives in their (social) media?

The purpose of a critical media literacy program is to intervene early by reducing the risk factors and simultaneously building the protective factors such as peer norms for resilience against harmful messages. Awareness of eating disorders can help educators to think about and challenge common cultural practices that promote body dissatisfaction such as body shaming or size shaming. One example of a broader social issue that can be discussed in a critical media literacy program is the tendency of people to comment on other people's size and draw implications from this about their character. Other socio-cultural factors include weight-related teasing and discrimination.

Media are complicit in contributing to body dissatisfaction by over-representing bodies that do not reflect average Canadians. Asking students to think about how bodies are represented in media can help students see how broader social contexts shape our views of health and self. Teachers can also help students see that broader issues such as geography impact health. This helps to shift the focus away from health approaches that assign credit or blame to the individual without considering the broader social determinants.

The proliferation of new media and the ability of young people to harness new forms of communication present a new frontier for eating disorder prevention, but insufficient attention has been given to the potential of these new technologies to advocate for social change [17]. Some of the recommended elements of such a media literacy program would include awareness of advertising techniques; naming and countering gender stereotypes; understanding objectification and sexualization; considerations of the implicit and explicit messages of media, and advocating for more realistic representations of bodies [18].

5. More critical future students

There are some cautions about critical media literacy and body image intervention programs. One of the exercises in the critical media literacy workshop asks participants to compare different critical media literacy programs and reference materials for schools. We examine “off the shelf” lessons for schools that are marketed as critical media literacy. Participants also assess well-researched lessons from the National Eating Disorders Information Center (NEDIC) curriculum

“Beyond Images” which is available free of charge @ <http://nedic.ca/beyond-images>. According to the description on the website, *Beyond Images* is a body image curriculum created for Grades four through eight where students explore how and why media messages are constructed and then learn to construct their own messages.

Significantly, the workshop participants are not told the sources of the media lessons up front. Neither are they given the *criteria* on which they should judge the lessons. When they report their comparisons of these lessons to the full group, participants’ comments consistently report what they need in critical media literacy lessons.

First, it is essential that the materials provided are age-appropriate. Children who are five or six years old may not grasp some of the messages from media, but they are old enough to understand, for example, that advertisements for toys on television can misrepresent what the toys can do. Children may not understand the significance of being the target audience for processed breakfast foods, but they can learn to use a digital camera and find their voice in describing the images that they take. Critical media literacy lessons found at sites such as NEDIC and www.teachbodyimage.com have been vetted so that they are age-appropriate and matched to child development levels.

Workshop participants also examine books that are available in school libraries that encourage adolescents to diet or manage their weight in order to be a certain size. One book talks about the dangers of being size zero, yet some of the participants in the workshop *are* a size zero and they were born that way. This same book encourages adolescents to talk to their doctor before they diet rather than telling students not to diet. Counting calories and labelling foods as good or bad should also be discouraged. As health and education professionals, we have real concerns about the issues that some of these off-the-shelf curriculum materials raise. We do not recommend reading materials for students that equate health with weight. Instead, we affirm principles of natural diversity, body acceptance, and equity. In addition, educators who are concerned that students may have an eating disorder should refer the student immediately to a health care professional and should not address eating disorders with school-based counselling.

Participants from parent groups, health workers and others in our workshops have affirmed these and other central messages that should be apparent

in critical media lessons. Here are some of our conclusions, posted as key messages on the www.teachbodyimage.com website.

1. Children and adolescents can understand that media are not neutral and influence us for different purposes such as politics and profit. Advertising uses our insecurities in order to convince us that we need a product.
2. Teachers/parents can teach and model how to take apart media messages to examine their intent and perspective.
3. The ideal body is culturally, socially and historically defined and media influenced.
4. Media / social media show us only limited views of the world. Gender stereotypes can contribute to narrow, sexist ideas and beliefs. Students can learn that stereotypes limit people from reaching their potential.
5. Media can misrepresent bodies and accent gender binaries presenting hyper-sexualized or hyper-masculinized bodies as the norm. This can contribute to body dissatisfaction and harassment.
6. The media can exaggerate health issues and promote simple solutions for complex issues.
7. Social pressure to be a certain size can be resisted by empowering students through critical media literacy studies.
8. We need to discourage social comparison, especially in light of the present drive to present perfect images and perfect lives on social media.
9. Everyone can model size and shape acceptance.
10. Teachers and parents can also help by avoiding linking acceptance to appearance. Source: www.teachbodyimage.com

Our research has shown that teachers also need to examine their own biases about shape, size and dieting [19]. We all need critical media literacy in what has been called a “post-truth” era. It also contributes toward eating disorder prevention when we help students investigate what is “real.”

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