Eating Disorders and Obesity: Targeting Two Birds with One Prevention Stone
Buffalo Women’s and Children’s Hospital
Pediatric Grand Rounds
9/19/14
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There are growing concerns that an anti-obesity focus in pediatric public health may result in an increase in Eating Disorders (ED), and future obesity prevention and treatment efforts should track ED cognitions as well as extreme weight control behaviors.
(Pinhas et al., 2013; Sim et al., 2013)

Weight Stigmatization in Youth
• Among boys and girls with the highest level of obesity, about 60% report being victimized by their peers.
• Weight bias can also come from teachers, parents and other adults.
• TV, movies, and magazines reinforce negative attitudes about body weight and perpetuate weight bias.
• All these sources of bias have a major impact on young people’s psychological, social, and physical health.
• Studies show that overweight and obese children who are victimized because of their weight are more vulnerable to depression, low self-esteem, and poor body image.

"STAMPING OUT" OBESITY CAN "USHER IN" EATING DISORDERS AND OTHER PROBLEMS
General emphasis on appearance and weight control can promote eating disordered behaviors.

Research shows that when important agents in children’s social environment (e.g. parents and peers) endorse a preference for thinness and place an importance on weight control, this can contribute to:
• Body dissatisfaction
• Dieting
• Low self-esteem and
• Weight bias among children and adolescents
(Davis & Birch, 2001; Davis & Birch, 2004; Dohnt & Tiggemann, 2000; Neumark-Sztainer, 2005; Smolak, Lester, & Sherman, 2009).

AED Guidelines for Childhood Obesity Prevention Programs (2009)
Sigrid Danielikite, Candi Psych., Deb Burgard, Ph.D., & Wendy Olson-Pyett, M.D.
Obesity and Eating Disorders

• Obesity and eating disorders have been considered distinct, almost “opposite” problems, but this is not the case.

• Overweight (not just underweight or average weight) teens are at risk for engaging in unhealthy weight control behaviors and binge eating behavior.

• Youth can cross over from one condition to the other or have both (Neumark-Sztainer, 2005).

• Adult women with Bulimia Nervosa (BN) or Binge Eating Disorder (BED) were more likely to have been overweight as children than comparison groups. (Fairburn et al., 1997, 1998)

• Exposure to weight-related criticism and teasing increased women’s risk for onset of an eating disorder later in life.

• Obesity AND eating disorders in youth are characterized by difficulties related to weight-control practices, physical activity, eating behaviors, weight status, and body image. While difficulties with the first four factors can contribute to negative body image, negative body image can also contribute to problems with the other factors.

• Changing eating, activity, and weight-control practices may be enough to help a certain sub-group of children avoid developing eating disorders or obesity. However, many children need attention to body image, as this has been shown to be a negative, distorted, or a source of dissatisfaction, for adolescents who are overweight, average weight, or underweight.

Centers for Disease Control and Prevention Youth Risk Behavior Surveys (YRBS)

• Reveal disturbingly high rates of unhealthy weight control practices in adolescents who desire to lose weight or avoid gaining weight (including when the adolescent is actually average or underweight) (Grunbaum et al., 2002).

• Data have shown that Hispanic, white, and black girls all engage in unhealthy weight control practices such as food restriction for at least 24 hours (23.1%, 19.7%, and 15% respectively) and vomiting and laxative use (10.8%, 8.3%, and 4.2% respectively).

• Additionally, dieting has been found to increase the risk of weight gain, not weight loss in teens. Findings show that girls who diet are 12 times more likely to binge eat than girls who don’t diet, and boys who diet frequently are at 7 times greater risk to binge eat than boys who do not diet. (Neumark-Sztainer, 2005).

“So STAMPING OUT” OBESITY CAN CAUSE UNINTENDED HARMFUL CONSEQUENCES

Weight control practices among young people reliably predict greater weight gain, regardless of baseline weight, than that of adolescents who do not engage in such practices (Neumark-Sztainer et al., 2006).

Thus, it is important to evaluate the unintended consequences of “obesity prevention” programs, which may lead to unhealthy behaviors and weight displacements in both directions.

AED Guidelines for Childhood Obesity Prevention Programs (2009) Sigrún Daníelsdóttir, Cand.Psych., Deb Burgard, Ph.D., & Wendy Oliver-Pyatt, M.D.

So Just How Many Teens are We Talking About?
Prevalence of Body Dissatisfaction, Weight Control Behaviors, Obesity, and Eating Disorders

<table>
<thead>
<tr>
<th></th>
<th>Teen Girls</th>
<th>Teen Boys</th>
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</thead>
<tbody>
<tr>
<td>Unhealthy weight control behaviors</td>
<td>57%</td>
<td>33%</td>
</tr>
<tr>
<td>(e.g., skipping meals, eating very little, fasting, or smoking for weight control)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dieting Behaviors</td>
<td>55%</td>
<td>20%</td>
</tr>
<tr>
<td>Body Dissatisfaction</td>
<td>46%</td>
<td>20%</td>
</tr>
<tr>
<td>Extreme Weight Control Behaviors, e.g., (vomiting, laxatives, diet pills)</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Binge Eating Behaviors</td>
<td>17%</td>
<td>9%</td>
</tr>
<tr>
<td>Obesity</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Moderately Overweight/At Risk for Obesity</td>
<td>15-20%</td>
<td>15-20%</td>
</tr>
<tr>
<td>Binge Eating Disorder</td>
<td>2.3%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Bulimia Nervosa</td>
<td>1.3%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Anorexia Nervosa</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Note: Neumark-Sztainer, 2005, p. 10 - From Project EAT and other large studies on teens and young adults including Swanson et al., 2011.

Adolescents Using Unhealthful Weight Control Behaviors – 5 yr F/U

↑ Their BMI by ~ 1 unit more than adolescents not using any weight control behaviors

Were at ~ 3x > risk for being overweight (odds ratio [OR]=2.7 for girls; [OR]=3.2 for boys) AND

↑ Risk for:

Binge eating with loss of control (OR=6.4 for girls; OR=5.9 for boys)

Extreme weight-control behaviors (e.g., self-induced vomiting and use of diet pills, laxatives, and diuretics (OR=2.5 for girls; OR=4.8 for boys) compared with adolescents not using any weight control behaviors.

Neumark-Sztainer et al 2006 Journal of American Dietetics Association
Mismatched Weight, Weight Perceptions, and Depression

- Being overweight (OW) is associated with adolescent girls’ increased depressive symptoms.

- However, interactive models suggest that this finding derives from normal weight girls with OW perceptions having higher probabilities of depressive symptoms than OW girls with OW perceptions.

- Normal weight girls with OW perceptions (pessimists) are more likely to report depressive symptoms than realists who are “doubly disadvantaged” by weight and weight perceptions (OW girls with OW perceptions).

Risk and Protective Factors Predicting Multiple Weight (Wt)–Related Outcomes at 5-Yr F/U

<table>
<thead>
<tr>
<th>Socioenvironmental (Time 1)</th>
<th>Personal Factors (Time 1)</th>
<th>Behavioral Factors (Time 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight-Related Norms:</td>
<td>Body Image and Weight Concerns:</td>
<td></td>
</tr>
<tr>
<td>- Maternal Wt Concerns/behaviors (B, G)</td>
<td>- Weight Dissatisfaction (G)</td>
<td></td>
</tr>
<tr>
<td>- Paternal Wt Concerns/behaviors (G)</td>
<td>- Weight Concern (G**, B***)</td>
<td></td>
</tr>
<tr>
<td>Media Exposure:</td>
<td>Eating Patterns:</td>
<td></td>
</tr>
<tr>
<td>- Magazines on wt loss (G)</td>
<td>- Lunch Frequency (G)</td>
<td></td>
</tr>
<tr>
<td>Home Food Environment:</td>
<td>- Protective</td>
<td></td>
</tr>
<tr>
<td>- Meal Frequency (G)</td>
<td></td>
<td></td>
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<tr>
<td>Family Meal Atmosphere (G)</td>
<td></td>
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<tr>
<td>- Protective</td>
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</table>

Frisco, Houle, & Martin, 2010

Socioenvironmental (Time 1)

- Maternal Wt Concerns/behaviors (B, G)
- Paternal Wt Concerns/behaviors (G)
- Weight Teasing by Family (G)

Media Exposure:
- Magazines on wt loss (G)

Home Food Environment:
- Meal Frequency (G)
- Family Meal Atmosphere (G)

Behavioral Factors (Time 1)

- Weight-Control practices:
  - Dieting (G**, B)
  - Unhealthy Wt Control (G, B*)

Eating Patterns:
- Lunch Frequency (G) Protective

Prospective Risk Factors for Body Dissatisfaction – 5 yr F/U Study*

<table>
<thead>
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</tr>
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<td>• SES</td>
</tr>
<tr>
<td>• ↓Self-esteem</td>
<td>• Weight Teasing</td>
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</table>

Middle Adolescent Girls

- BMI
- SES
- ↓Self-esteem

Middle Adolescent Boys

- BMI
- Ethnicity
- Depression

How Did We Get Here?

- Year before first grade: 48.5% girls want a larger body (Dohnt & Tiggman, 2006).
- 1st – 3rd grade: 42% of girls want to be thinner (Collins, 1991).
- 4th and 5th grade: 20-30% girls are concerned about weighing too much and are trying to get thinner (Go Girls, 1999).
- ages 6-15: 45% girls and boys wanted to be thinner. 37% already tried dieting to lose weight by exercising or restricting calories. 69% reported their mothers had been on diet at least once.
- girls ages 9-11: 50% of 9 year olds and 80% of 10/11 year olds said they were dieting to lose weight.
- by fifth grade approximately 50% of girls have been on a diet.
- by junior year in high school: 90% of girls have been on a diet

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Parental Influences on the Development of Weight Concerns and Frequent Dieting Among Children Ages 9-14*

- Parental concern regarding thinness and parental dieting contribute to a child’s increased concern with weight and dieting behavior.
- Girls who reported that it was important to either parent that they were thin were 2x as likely as their peers to become highly concerned with weight.
- Girls and boys who reported that it was important to their father that they be thin (girls)/not fat (boys) were more likely than their peers to become constant dieters.
- Girls and boys who perceive their mothers are frequently trying to lose weight were more likely to become highly concerned with weight (boys) or constant dieters (girls).

Frisco, Houle, & Martin, 2010

*Frisco, Houle, & Martin, 2010

American Journal of Preventive Medicine.

All Risk Factors predicted two or more weight-related (N=2516) outcomes in the same direction in boys (B) or girls (G) (p<0.05)

(1) Predicted ALL Three Weight-Related Outcomes for marked gender differences over time (Frisco, Houle, & Martin, 2010, American Journal of Preventive Medicine.)
Risk Factors Related to Body Image, Eating, and Weight: Genes and Gender

- **Genes:** (obesity, eating disorders, body image disturbances)
- **Gender:** Body dissatisfaction 2x as high in girls than boys (Neumark-Sztainer, 2006) and the way in which others evaluate body weight/shape was most strongly associated with girls' vs boys' self-esteem (Davison & McCabe, 2006)
  - Internalize the Thin Ideal (promoted by culture)
  - Internalize distress vs externalize
  - Increased sensitivity to relational conflicts/disconnections
  - Greater social pressures on girls to be thin
  - Girls socialized to focus on appearance/weight

Risk Factors Related to Body Image, Eating, and Weight: Development

- Early (11-14) and late adolescence (18-21) involve changes in the body, identity, relationships and responsibilities. Times of transition.
- Increased awareness of one's body and sensitivity to responses of others. Higher risk for body image, eating, and weight-related problems.

Adolescence: Risk Factors Related to Body Image, Eating, and Weight

- Dieting: can go too far in a teen and ↑ risk for an eating disorder, binge eating or obesity.
- Emotional Eating and not Eating per Hunger and fullness Cues
- Poor Emotional Well-Being (e.g., low self-esteem and depression ↑ risk for unhealthy dieting and eating disorders)
- Over/Under-exercise: contributes to weight gain or eating disorders
- For girls, developing earlier and/or being larger than our peers contributes to unhealthy weight control behaviors and body dissatisfaction.
- For boys, developing later than our peers
- Hormonal differences – obesity in girls

Adolescence, Weight, and Our Culture

- Compare themselves to other peers and make adjustments to fit in (or feel like outcasts)
- Undergo large changes in weight (girls may double weight by end of puberty e.g., increase 40 lbs) and have greater fat distribution in hips and breasts.
- Self-esteem in girls decreases starting at age 12 through adolescence at the same time their hormones and bodies are dramatically changing.
- Boys also gain weight but gain less fat. They are more concerned about bulking up by muscularity in our culture.
- Live in a toxic culture that objectifies us, values thinness, and socializes us to value ourselves from the outside in.
  - Are taught to equate thinness with success, control and beauty. Obesity is stigmatized.

The Triple Threat for Girls

If female gender socialization during adolescence includes:
- parental pressure to lose weight
- family criticism regarding weight and
- maternal investment in a daughter’s thinness

These variables can act in concert with other biogenetic, psychological, and relational vulnerabilities to create eating disorders.

(Stice, 2002)

It’s Not Easy Being a Guy Either

- Muscularity now defines masculinity
- The focus on muscularity, combined with dieting and exercise, is more prevalent for subgroups of boys/men:
  - (a) in sports (e.g., wrestling or body building),
  - (b) who are homosexual
  - (c) who have a history of obesity with its associated teasing and shame
  - (d) who want to avoid certain health problems experienced by their parents (Andersen, 1990, 2002).
Boys with Body Dissatisfaction Can Carry this into Adulthood

- Many men suffer from body image dissatisfaction and distortion, with
- 40% of men wanting to lose weight
- 40% wanting to gain weight
- All of them wanting to gain muscle


Risk Factors Related to Body Image, Eating, and Weight: Peers

- Peer influence predicts body dissatisfaction and disordered eating in adolescent girls (Dohnt & Tiggemann, 2005, 2006; McCabe & Ricciardelli, 2005; Paxton et al. 2006, Schroff & Thompson, 2006).
- Perceived friend dieting and school-wide prevalence of dieting are significantly r/t to use of unhealthy weight control behaviors (e.g., purging, diet pill use) for average weight and moderately overweight teen girls (Eisenberg et al. 2005).
- “Girls may equate fitting in with peers to fitting in a pair of jeans,” (p. 49, Neumark-Sztainer, 2005).

Risk Factors Related to Body Image, Eating, and Weight in Adolescence: Weight Teasing

- Weight teasing increases risk of body dissatisfaction, unhealthy weight control practices, binge eating, poor self-esteem, depression, and suicidal thoughts.
- Those teased by peers and family members are at greatest risk

(Neumark-Sztainer, 2006)

Risk Factors Related to Body Image, Eating, and Weight: The Media

Money spent on advertising:
- Federal government’s largest nutrition education program (5 A Day to promote fruits and vegetables) communication budget = $3.6 million
- McDonald's: $1 billion
- M&M's = $68 million
Total annual amount spent by food industry on ads and promotions = $25 billion

Risk Factors Related to Body Image, Eating, and Weight: The Media - TV

Fiji high school females and TV: Increase in vomiting, unhealthy weight control behaviors, and eating pathology. (Becker et al., 2002)

Project EAT
- Teen girls watch 18 hours of TV or videos in a week.
- Teen boys watch 20 hours of TV or videos in a week.

Harrison & Hefner, 2006: Time spent watching TV at baseline predicted ↑ in disordered eating at one-year follow-up for teen girls.

(After 1999)
Adolescents who read dieting and weight loss articles vs those who don’t

Girls
- 6x more likely to use unhealthy weight control practices like vomiting, laxatives, diet pills, diuretics
- ↑ depression
- ↓ self-esteem
- ↑ body dissatisfaction

Boys
- 4x more likely to use unhealthy weight control practices like vomiting, laxatives, diet pills, diuretics
- ↑ depression
- ↓ self-esteem,
- associations with ↑ body dissatisfaction but not straightforward

Project EAT, Neumark-Sztainer, 2005

Risk Factors Related to Body Image, Eating, and Weight: Physical Activity

- Decline in physical activity esp. steep for girls (esp. middle school girls)
- From 8 - 18, physical activity ↓ 83% (Kimm et al., 2002) with larger decreases in African-American girls
- Latina and African-American girls cite co-ed PE classes as challenging
  - report ↓ attention from teachers vs boys
  - Concerns about appearance while exercising (sweating, shape/size, makeup)
  - excluded from activities by boys
  - feel uncomfortable doing some activities around boys
  - frustrated by inadequate opportunities to participate

(Neumark-Sztainer, 2005)

Eating Disorders in African American Adolescents and Adults

Compared with Caucasians, Binge Eating Disorder (BED) is shown to be the most common ED among African American adolescents and adults.

(Taylor et al., 2007)

African American Urban Girls’ Risk for Eating Disorders
(N=57, ages 10-15, lower to middle class)
Jones & Cook-Cottone, 2013

Perceptions of American beauty standards and thin ideal may arise similarly as in upper-middle class, suburban minority populations.

As mainstream sociocultural identification increases:
  - Drive for Thinness increases (even after controlling for BMI)
  - Body dissatisfaction increases (even after controlling for BMI)
  - BED symptomatology increases
  - Compensatory behaviors increases

Suggests that thin ideal media exposure in adolescents is associated with body dissatisfaction and eating disorder symptomatology

No significant correlation between mainstream sociocultural identification and solely binge eating behaviors or Bulimia.

No support was found in cultural ethnic identification being associated with less ED behavior in African-American females, contradicting research that suggests that minority girls with less identification with Western culture have lower risk of ED development.

Body Dissatisfaction in Adolescence

- Prevalence does not mean it is benign.
- Closely linked to self-esteem, even more for teens than adults
- Interferes with development of healthy self-concept and identity
- Associated with negative affect as well as disordered eating (Paxton & Heinicke, 2008)
  - Probably strongest risk factor for use of unhealthy weight control behaviors and for binge eating and physical activity (Neumark-Sztainer, 2005, 2006)
  - Is correlated with obesity and other high risk behaviors, i.e., substance abuse, and smoking (Neumark-Sztainer, 2005, Treasure & Treasure, 2004)

Promoting Wellness in Adolescence

One very important factor that can help decrease teens’ development of body image problems, obesity, disordered eating, and eating disorders and body image problems is parent-family connectedness.

Parent-family connectedness, defined as “the adolescent’s experience of being connected to at least one caring, competent adult in a loving, nurturing relationship”, was a consistent and powerful protective factor for emotional distress and suicidality regardless of family composition or demographic factors.

(Resnick et al. 1993: 30,000 adolescents in grades 7-12)
Among adolescents at risk for psychological problems, one supportive relationship with an adult, not necessarily a parent, is associated with later psychological health and can make the difference between a teen experiencing psychological symptoms versus a full-blown disorder. (Farber & Egeland, 1987; Garmezy, 1981; Masten & Coatsworth, 1988; Nevin, 1991; Rutter, 1979; Spencer, 2000; Wang, Hester, & Welberg, 1994; Werner & Smith, 1982)

STOP THE SEPARATE SILO APPROACH:
Expand the vision of “obesity prevention” programs to include the prevention of eating disorders and related issues to ensure that they promote overall health and safety.

Promote:
• Body Esteem
• Self-Esteem
• Moderate/Healthy Lifestyle Behaviors
• Connectedness with self and others

PREVENTING EATING DISORDERS AND OBESITY: WHAT IS A HEALTH CARE PROVIDER TO DO?

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BODY WEIGHT IS NOT A RELIABLE PROXY FOR EATING BEHAVIORS AND PHYSICAL ACTIVITY
Although statistical associations exist between body weight and risk for morbidity and mortality, being heavy or slender is not by definition pathological.

Correlation does not imply causation and the middle of the weight spectrum can cloak a multitude of unhealthy practices.

Since healthy living is important for children of all sizes, interventions should focus on lifestyle rather than weight.

AED Guidelines for Childhood Obesity Prevention Programs (2009)
Sigrún Daníelsdóttir, Cand.Psych.; Deb Burgard, Ph.D.; & Wendy Oliver-Pyatt, M.D.

WHAT’S A HEALTH CARE PROVIDER TO DO?
The few studies that have examined the effects of “obesity prevention” efforts on risk-factors for eating disorders, suggest that focusing on health, NOT weight, may be key to avoiding harm to body image and eating behaviors.

For example, Austin, Field, Wiecha, Peterson & Gortmaker (2005) found lowered rates of disordered eating in a school-based intervention that focused on promoting healthy eating and activity patterns, rather than on weight per se.

GOAL: Simultaneously promoting body esteem and healthy lifestyle behaviors in youth (Neumark-Sztainer, 2005).
### Academy for Eating Disorders Guidelines for School-and Community-Based Interventions Addressing Rising Weights in Youth

1. Interventions should focus on **health, not weight**, to avoid overvaluation of weight/shape and negative attitudes about fatness.

2. The WHO defines health as a *state of complete physical, mental and social well-being* and not merely the absence of disease or infirmity. Interventions should be constructed with consideration for a child’s social, emotional, and physical health. Promote the “Middleground” and Wellness.

3. Interventions should focus on physical activity and healthy eating **AND** on promoting self-esteem, body satisfaction, and respect for body size diversity.

4. Construct a social environment where all children are supported in feeling good about their bodies.

5. Focus only on **modifiable behaviors** (e.g. physical activity, intake of sugar-sweetened beverages, teasing, time spent watching television), where there is **evidence** that such modification will improve children’s health.

6. Weight is **NOT** a behavior and therefore not an appropriate target for behavior modification.

7. Interventions should be **weight-neutral**, i.e. not have specific goals for weight change but aim to increase healthy living at any size.

8. It is unrealistic to expect all children to fit into the “normal weight” category. Interventions should be referred to as “health promotion,” **NOT** “obesity prevention,” as the ultimate goal is the health and well-being of all children, and health encompasses many factors besides weight.

9. School-based interventions should **avoid** the language of “overweight” and “obesity” since these terms may promote weight-based stigma.

10. Focus on creating, **healthier environments** for children vs. focusing solely on “personal responsibility.”

11. **Avoid Anti-Fat messaging:** Fat is bad, Fat people eat too much.

12. Do **NOT** target heavier children specifically with segregated programs aimed at lowering weights.

13. Childhood overweight should be defined as an upward weight divergences that is abnormal for an individual child, which can be determined only by comparing the child to him- or herself over time (vs an arbitrary BMI cut-off).

### Feeling Good about Our Bodies and Ourselves

**Processes that Contribute to Negative Body Image in Middle School Students:**

- Conforming to Fit in**S**
- Assuming Difference Means Deficiency and Disconnection**S**
- Chronic Anticipation, Witnessing, or Experiencing of Peer Criticism and Teasing**S**
- Believing Appearance Heavily Informs Initial Impressions and Peer Acceptance**S**
- Engaging in Frequent Negative Self-Comparisons**HSC**
- Linking Thinness and Expensive Clothing with Popularity and Privilege**HSC**
- Feeling the Pressure to look Perfect**HSC**
- Perceiving and Responding in Extreme Ways**HSC**
- Experiencing Emotional Vulnerability**C**
- Feeling the Futility of Being Fat**I**
- Feeling Confident about Being Yourself**I**
- Being Able to Express and Embrace Difference**I**
- Believing No One is Perfect**C**
- Feeling the Pressure to be Good for Parents**I**
- Feeling Good about Our Bodies and Ourselves

**Processes that Contribute to Positive Body Image in Middle School Students:**

- Feeling Confident about Being Yourself
- Feeling Validated For Who You Are
- Understanding the Source and Impact of Peer Criticism and Teasing
- Believing No One is Perfect
- Being Able to Express and Embrace Difference
- Having a Balanced Mindset

**Note:** = the process is active **before and during** puberty/middle school; **= the process is active during puberty/middle school; **= the process is active during middle school; **= the process is active during puberty/middle school; **= the process is active during middle school; **= the process is active during puberty/middle school; **= the process is active during middle school. These processes are presented in a linear way, but are interactive, as are the subsystems in which they operate. Each set of processes is listed in order of frequency with which the process was mentioned in the text and/or their saliency across the text.
Prevention Programs for Eating Disorders and Obesity

Encourage integrated universal – selective prevention approaches based on an ecological understanding of shared risk and protective factors for obesity, eating disorders, and their associated co-morbid behavioral health problems.

Begin at middle school or possibly earlier.

(Levine & Smolak, 2007; Neumark-Sztainer, 2005).

Future Prevention Efforts Should Consider Drug Prevention Literature

Drug prevention research indicates that long-term prevention is facilitated by multidimensional programs aimed at changing student norms, engaging the school as a system of adults and students, and at linking positive changes in the school with changes in the community, including mass media (Levine & Smolak, 2006).

Four Cornerstones to Promote Positive Body Image and Healthy Weight and in Your Teen

1. Model healthy behaviors
   • Avoid dieting or at least unhealthy dieting behaviors.
   • Avoid making-weight related comments as much as possible.
   • Engage in regular physical activity that you enjoy.
   • Model healthy (but not perfect) eating patterns and food choices.

(Neumark-Sztainer, 2005)

Four Cornerstones to Promote Positive Body Image and Healthy Weight and in Your Teen

2. Provide an environment that makes it easy for Teens to make healthy choices:
   • Make healthy food choices readily available.
   • Establish family meal norms that work for your family.
   • Make physical activity the norm in your family and limit TV watching.
   • Support your teen’s efforts to get involved in physical activity.

(Neumark-Sztainer, 2005)

Four Cornerstones to Promote Positive Body Image and Healthy Weight and in Your Teen

3. Focus less on weight; instead focus on behaviors and overall health:
   • Encourage your teen to adopt healthy behaviors without focusing on weight loss.
   • Help your teen develop an identity that goes beyond physical appearance.
   • Establish a no-tolerance policy for weight teasing in your home/school.

(Neumark-Sztainer, 2005)

Four Cornerstones to Promote Positive Body Image and Healthy Weight and in Your Teen

4. Provide a supportive environment with lots of talking and even more listening:
   • Be there to listen and provide support when your teen discusses weight concerns.
   • When your teen talks about fat, find out what’s really going on.
   • Keep the lines of communication open – no matter what.
   • Provide unconditional love, not based on weight, and let your teen know how you feel.

(Neumark-Sztainer, 2005)
**BE A POSITIVE ROLE MODEL: WALK THE WELLNESS/MIDDLEGROUND TALK!**

- Normalize what happens during puberty and adolescence. For eg., a girl can double her weight by end of puberty.
- Normalize that you may like you body some days and not like it others. Encourage the teen to “wait it out” because change is sure to happen.
- Decode the meaning of “fat.”
- Encourage movement that is fun and social.
- Encourage positive affirmations about body and self.
- Avoid all/nothing interpretations of your messages. Check out what you said. Kids can be concrete and eating disorders involve problems with information processing.

**NEW YORK STATE COMPREHENSIVE CARE CENTERS FOR EATING DISORDERS (NYSCCEDS)**

New York State Department of Health, Division of Chronic Disease Prevention and Adult Health Bureau of Health Risk Reduction

**Guidelines for NYSCCEDs**

- Comprehensive and integrated services are provided to all individuals with diagnosed eating disorders.
- CCCEDs provide/arrange for all levels of care appropriate for individuals with eating disorders.
- CCCEDs will have the capacity to provide or arrange for the full range of services appropriate for the care of individuals with eating disorders.
- CCCEDs shall provide case management services for all individuals served by the Center.
- Within the selected service area, the CCCED will sponsor programs that increase the awareness, early identification and treatment of eating disorders.
- CCCEDs will conduct and participate in research programs to identify and address gaps in evidence based prevention and treatment methods.

**NYSCCED Core Sites**

**Western - Rochester**
- University of Rochester Medical Center
  - University of Rochester School of Nursing
  - Golisano Children’s Hospital

**Northeast – Albany**
- Albany Medical College
- Four Winds Hospital, Saratoga Springs

**Metro – New York City/Long Island**
- NY Psychiatric Institute/Columbia University
- NY Presbyterian Hospital
- Schneider’s Children’s Hospital

**Western New York CCCED (WNYCCEED)**

**Local Organizational Partners**

- University of Rochester Medical Center: (core center)
- School of Nursing and Golisano Children’s Hospital
- The Healing Connection, Inc. (affiliate)
- Eating Disorders Community Advisory Board
- Mental Health Association (central phone line)

Website: www.nyeatingdisorders.org
WNYCCCED Programming

- Interdisciplinary
- Comprehensive
- Coordinated
- Individualized
- Developmentally-appropriate
- Health-focused
- Family-centered
- Community-based
- Consumer-oriented
- Multi-modal
- Cost-effective
- Evidence-driven

The Healing Connection, Inc.
Eating Disorders Partial Hospitalization Program (PHP)
Fairport Office Centre, Fairport, NY

- 7 hour/day, Mon-Fri, 11:30 am to 6:30/7:00 pm (35hr/wk).
- Multimodal, multidisciplinary comprehensive treatment to adolescents and adults (> 12 years old).
- Normalization of eating, stabilization of weight, and improvement in other psychological or behavioral symptoms.
- Step up from outpatient or step down from inpatient or residential treatment. Can obviate inpatient admission.
- Developmentally-informed, family-based, consumer-driven
- Multi-family Therapy, Family Therapy, Parenting Group, Group Therapy, Individual Therapy

Contacts at WNYCCED Core Sites

University of Rochester
School of Nursing
WNYCCED Director
Mary Tantillo PhD PMHCNS-BC FAED
585-703-3403

WNYCCED Case Manager
Jennifer DeSanto MD Ed
585-276-6022
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Golisano Children’s Hospital
Child & Adolescent Eating Disorders Program
WNYCCED Medical Director
Richard Kreipe MD
585-275-7944

Intake Contact Number:
Intake Coordinator
585-275-2964

Contacts at Affiliate Sites

Rochester
The Healing Connection, Inc.
Tammie Hills
Office Manager
585-641-0281

Websites for Eating Disorders Info

- Metro Comprehensive Care Center for Eating Disorders
  www.eatingdisordercenterofexcellence.org
- Northeast Comprehensive Care Center for Eating Disorders
  www.urmc.rochester.edu/patient/services/necced
- Western Ed Comprehensive Care Center for Eating Disorders
  www.wnyeatingdisorders.org
- National Eating Disorders Association NEDA
  www.nationaleatingdisorders.org
- Academy for Eating Disorders
  www.aedweb.org
- Bulimia Resource Guide for Family and Friends
  www.bulimia.org
- Families Empowered and Supporting Treatment of Eating Disorders (F.E.A.S.T.)
  www.feast-ed.org
- Maudsley Parents
  www.info@maudsleyparents.org
- The National Association for Males with Eating Disorders, Inc.
  www.namedinc.org
- NIMH booklet Eating Disorders
- Gurze Books
  www.bulimia.com/fac/eatingdisorder.html
  www.bulimia.com