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Chair

Ms. Hélène LeBlanc

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● (1535)

[*Translation*]

The Chair (Ms. Hélène LeBlanc (LaSalle—Émard, NDP)): Welcome to the twelfth meeting of the Standing Committee on the Status of Women. Today we are talking about eating disorders amongst girls and women.

I would like to let committee members know that we have agreed to change how we organize our meetings with witnesses. Going forward, we will have witnesses from four organizations for a period of two hours, which will give us more time for questions and encourage discussion. It was not possible to implement this change for today's meeting because the videoconference rooms and the witnesses were not available, but we will start doing things this way as of February 24, 2014.

I would also like to update everyone on our witnesses. The invitation process is going well. Only two organizations, the Mental Health Commission of Canada and the Canadian Institute for Health Information, have refused our invitation, and that is because they are not available. Nevertheless, these organizations have chosen to present briefs to the committee, which could contribute to our study.

In our first hour today, we will hear from Noelle Martin, president and professor at Brescia University College, which is affiliated with Western University, and Joanna Anderson, executive director of Sheena's Place.

Thank you for being here today. You each have 10 minutes for your presentation.

We will start with Noelle Martin.

[*English*]

Ms. Noelle Martin (Professor, Brescia University College, Western University, and President, Registered Dietitian Services): Madam Chair and members of the committee, thank you for the invitation to be part of your meeting today. It is truly an honour.

My name is Noelle Martin. I am a private practice dietitian and also a part-time professor at Brescia University College at Western University in London.

In my private practice, I have worked with individuals across the lifespan. However, more recently I have worked solely with university-age clients. I have had an interest in eating disorders for over 20 years, but my direct work as a dietitian with individuals with eating disorders has been done over the past seven years. I feel that I have learned as much from my clients as I have from reading research articles and books, attending conferences, and touring treatment facilities.

In the world of eating disorders, we often talk about “the voice of ED”. ED is the voice that tells a person with anorexia nervosa that they would be a better person if they could just cut their food intake down a little lower or if they could have a flatter stomach. The problem is that ED is never satisfied; it is never enough, to the point of death. Anorexia nervosa has the highest mortality rate of any mental illness. It is estimated that 10% of those diagnosed with anorexia nervosa will die within 10 years of diagnosis.

For a person with bulimia nervosa, ED is the voice that punishes them for giving in to eating after a time of restriction, resulting in a purge that's usually through vomiting or exercise. There are endorphins released when we vomit or when we exercise. For a person with bulimia nervosa, there is a—quote, unquote—stuff-and-release phase. The binge phase is the stuff, and the vomit or the exercise is the release. As endorphins are released in the brain, the individual feels calmer, and for a moment, everything is okay. Eventually, the binge phase may disappear and the purge phase is used over and over again, because the brain needs more and more endorphins released as it is desensitized to the original amounts.

When looking at the prevention of eating disorders, we're looking to never let the voice of ED be heard. In treatment, we try to empower the client to have a stronger voice than ED.

As you may have heard from previous witnesses, the cause of eating disorders is multifactorial. Eating disorders are mental illnesses related to one's relationship with body, food, and others. We know that there's often a genetic link that I think of as a ticking time bomb. Then, we have social, cultural, and environmental factors that may cause the gene to be expressed. For example, it could be a comment from a parent, friend, coach, or teacher that triggers a new thought in one's mind. It could be an article in a magazine, a commercial, or the content of a movie or a show. It can be obvious, or it can be very subtle.

We cannot pinpoint just one thing that is the cause for eating disorders. Because of this, we need to look at prevention strategies that target a variety of areas.

We can use our learning and attitudes about other illnesses when looking at eating disorders, from prevention, to causation, to treatment.

For example, if we only targeted cigarette smoking in cancer prevention, we would only be increasing awareness that smoking may lead to cancer. Instead, we see programs to raise awareness around many possible causations, as well as possible prevention strategies. We need the same for eating disorders. In this light, a diagnosis of cancer cannot always be blamed on the same factor, or on one factor alone, similar to what I have just described with eating disorders.

Thirdly, when a person is diagnosed with cancer, people do not say that "it's all in your head" or to "just get rid of it", as we sometimes hear with the diagnosis of eating disorders. Rather, they're encouraged to pursue treatment and are offered support. We need the same response and attitude for those who are diagnosed with eating disorders.

With respect to treatment, it is a patient's choice for all illnesses—or at least most—as to what route they will take. Eating disorders are included in this.

If one is diagnosed with cancer, one may be given treatment options such as surgery, chemotherapy, radiation, etc. The person is usually motivated to try to beat the disease if possible. For a client with an eating disorder, this choice is hard. It is difficult to realize that the disease is killing them, because at first it gives them such a sense of control. The loss of control that follows can give them a sense of despair, leaving them unsure about where to turn or what they can do.

● (1540)

The voice of ED is so loud at times that it governs all of their decisions, including whether to choose a path that will lead to a longer and healthier life. It is a heartbreaking battle to watch. In light of the analogy mentioned above and the multifactorial causes of eating disorders, when we look at prevention of eating disorders we need the spectrum to be open beyond reaching those who may develop an eating disorder. Educating parents, coaches, and teachers is essential.

For example, education about ways of how to talk to children in a positive manner with respect to normal growth patterns, the normality of differences between all bodies, and the importance of nourishing our bodies respectfully.... Further to this, as a society we need to focus on getting a better relationship with food and with ourselves. Simple things like not looking at food as good or bad, but rather choosing healthy food more often and treats in moderation.... Phrases such as, "I was so bad today, I had a brownie," leave the impression that we are a good or a bad person based on what we eat. This is not a positive message for ourselves or our upcoming generation. Because we have such an extreme focus on the rejection of obesity in Canada we very unfortunately have girls and women of healthy body weights who think they need to lose weight.

We need messages about obesity balanced with messages that support healthy body weights and that eating is a necessity for good health. I would love to see campaigns to eradicate what I call "fat talk". Fat talk would be a statement such as, "I feel fat today." Fat is not in fact a feeling. When one says that they feel fat they are truly saying that they have a negative emotion inside. We should be asking, what is the true feeling? Fear? Sadness? Anger? Frustration? Then we can get at what is underneath. If we are able to get more in touch with our emotions then we can see a reduction in all mental illnesses, including eating disorders.

Finally, we need to target the upcoming generation directly with similar messages that we are asking parents, coaches, and teachers to deliver regarding usual growth patterns and embracing different body sizes as acceptable. In addition we need to deglamorize fad diets. It appears that more young people understand the dangers of smoking and driving after drinking. There are also deadly dangers in fad diets as they can lead to the development of disordered eating and eating disorders. Therefore attention is needed.

I could speak for hours about my thoughts on this topic and I am truly grateful for your time this afternoon. I am also very excited about the attention that is being given to this topic by your committee. It is valuable and life-saving work. I would be pleased to answer any questions you may have about what I have said or offer any clarifications in the area of disordered eating and eating disorders.

Thank you.

The Chair: Thank you, very much.

And now, for 10 minutes, I will ask Mrs. Anderson to speak.

Ms. Joanna Anderson (Executive Director, Sheena's Place): Thanks very much.

Good afternoon. I'm grateful for the opportunity to speak with you about this important issue.

My name is Joanna Anderson. I'm a clinical social worker specializing in the treatment of eating disorders, and the executive director of Sheena's Place, a non-profit organization in Toronto that provides resources and support for individuals impacted by eating disorders. I commend you on acknowledging that eating disorders are an urgent and widespread problem in Canada.

Today I would like to speak to you about the reality of eating disorders, a reality of which I am painfully aware each day. In 2013 Sheena's Place was the first call for hundreds of individuals seeking help, resources, and support services for themselves or their loved ones: students, clients, or patients. A total of 1,100 people registered for one of our free professionally facilitated support groups, and approximately 22,000 unique individuals went to our website for information and resources regarding eating disorders.

Yet we know that this is only a fraction of the population that desperately needs support. Approximately 170,000 women and 75,000 men in Toronto alone will develop anorexia, bulimia, or binge-eating disorder in their lifetimes.

Through my work at specialized eating disorder units at Toronto General Hospital and the Hospital for Sick Children, and as clinical and now executive director of Sheena's Place, this is what I know about eating disorders.

Number one, eating disorders are egregiously misunderstood. Eating disorders are not diets gone wrong, endemic amongst young affluent women. Eating disorders affect women and men, adolescents and the elderly, and can develop at any point across the lifespan. At Sheena's Place, 33% of our clients are over the age of 40, and 36% of our clients have struggled with their eating disorder for more than 20 years. Without early intervention, this is an entrenched, long-standing illness. The research data tells us that 30% of females aged 10 to 14 and 80% of 18-year-olds report dieting to lose weight despite having a healthy body weight. The stigma and widespread misunderstanding associated with eating disorders prevent those who suffer from accessing treatment and support.

Two, the current mainstream approach within our schools, government, and health institutions is profoundly misguided. Individuals with eating disorders do not need to be educated on nutrition. Lifestyle approaches simply do not address the problem at hand.

I'd like to give you an example. When I worked at SickKids hospital, I worked with a young 13-year-old boy who was hospitalized after someone had come into his class to educate them about healthy eating. In that talk it had been said that fat was bad, that fat should be cut out of diets. Within six weeks this child was in a tertiary health care centre on a heart monitor after he had lost so much weight as a result of receiving that message.

The lesson here is that eating disorders are the product of deeply entrenched genetic, biological, psychological, social, and societal determinants. Nutritional education is not the answer.

Three, life with an eating disorder is one full of suffering for the individuals, their families, and their social networks. A woman in one of our support groups described eating disorders as involving relentless pain, self-loathing, isolation, sadness, hunger, disgust, and self-contempt. Our clients tell us that this is the first thing they think about when they wake up in the morning and the last thing they think about before they go to bed.

Eating disorders are debilitating. Many of our clients rely on parents, partners, or disability and employment insurance for income. Many are unable to work, and have been in and out of hospital for years. Eating disorders have profound physical and psychosocial consequences. Only 44% of our clients at Sheena's Place support themselves through income.

Four, Sheena's Place fills a gap in services. Eating disorders are grossly under-resourced, and the Canadian system we currently have is not working. Individuals suffering from this debilitating illness are not able to access appropriate treatment in a timely manner. Individuals, families, teachers, and often physicians are unaware of the diagnostic criteria, treatment options, or resources available to them.

Among our clients, 60% are not currently receiving other treatment or services, and 40% have never previously received any treatment or services. Despite the lack of treatment services accessed by our clients, we know that we serve a highly clinical population. In fact, 17% of our clients have been diagnosed with anorexia, 24% with bulimia nervosa, and 30% with binge-eating disorder. An astonishing 88% of our clients suffer from one or more co-morbid conditions, the most common of which are depression, anxiety, and trauma-related disorders.

● (1545)

For many people, Sheena's Place is the only place offering accessible services. We provide tangible help to individuals for whom resources are scarce to none, yet we fundraise year-round to keep our doors open and maintain an invaluable source of free and immediate help for individuals affected by eating disorders. We know that when we offer treatment modalities that work, groups fill up and have wait lists within hours of registration opening. We know that the only alternatives to this are expensive private treatments, thousands of dollars on individual therapy that many of our clients cannot afford, or waiting many months for one of the few publicly funded spots available.

In the absence of a national strategy, individuals with eating disorders are essentially left to fend for themselves. Of the minority of our clients who are currently receiving other services, 82% are paying for private sector individual therapy. What we know is that early identification and treatment is highly predictive of better prognosis. Waiting times have a significant impact on people's ability to recover. A young woman in Ontario has recently turned to crowd-funding $60,000 to pay for life-saving treatment for her eating disorder. Her story is a stark reminder of the fact that our clients often cannot wait 18 months for treatment.

We help people navigate the patchwork of public and private services available. We frequently hear from our clients that it takes years to learn that landscape of eating disorder treatment. The informal patchwork, of which we are a part, lacks infrastructure, funding, and coordination. Financial support for organizations like ours would help build a centralized database of resources informing people of the treatment and support systems available to them. It would also foster collaborations between organizations working in the field.

A letter from one of our clients speaks to the difficulties and failures of our current eating disorder system. This is a mom of a young 10-year-old boy who attends our mothers' support group. She said:

> My weekly support group is 90 minutes, in seven days, where I feel heard, understood and not alone. I feel the hope of the other mothers and am bolstered by their bravery and inspired by their resourcefulness and intelligence. I get real concrete advice and information about a disease that is a moving target in a healthcare system that is strained and sometimes difficult to navigate.

We are proud of the services we offer, yet we are keenly aware of the harsh reality that our ability to fill the gap in eating disorder services is best likened to a drop in the ocean. It is clear that we need a national registry for eating disorder patients so we can track their outcomes. We need a nationally funded research strategy, adequate training, and knowledge translation. We also need a national awareness campaign.

At Sheena's Place we work to reduce stigma, raise awareness, and educate individuals about the resources and services available to them. We are the first call for media organizations as well as concerned teachers, parents, and social service workers. We are asked on a daily basis to speak to high schools, universities, and publicly funded organizations about eating disorders and weight preoccupation. As a small organization with no public funding, we cannot keep up with these demands. We desperately need a national media campaign to inform the public that eating disorders are a grave mental health issue. We need to change the flawed premise that underlies current coverage of healthy bodies and disordered eating.

We also need financial support for resource and support centres like ours. At Sheena's Place we strive to give meaningful help and information at all stages of recovery. We know that with treatment, our clients can recover. We know that our services are invaluable and save lives, but we lack the necessary resources to expand and build upon our current services. Yet at this point, this is the state of the nation.

Eating disorders are extremely dangerous mental health disorders that are downplayed and misunderstood, and our social and health care services are inadequate at treating them. With secure funding initiatives, Sheena's Place could expand innovative programs that prevent eating disorders before they happen, provide support services to underserved and isolated populations, and help our clients navigate and dismantle the systematic discrimination faced by individuals with eating disorders.

● (1550)

I commend you for beginning this process and I'm grateful to participate in the conversation. I'll happily take any questions you may have.

Thank you.

The Chair: Thank you both very much for your testimony.

Now we'll move to the first round of questioning.

Ms. Truppe, you have seven minutes, please.

Mrs. Susan Truppe (London North Centre, CPC): Thank you, Madam Chair.

Thank you both for your comments and presentation.

Ms. Martin, thank you for being here. I know Brescia very well. I'm very proud to have Canada's only women's university in my riding of London North Centre. I know your principal thinks very highly of the work you've done with eating disorders as well.

Ms. Noelle Martin: Thank you.

Mrs. Susan Truppe: I think you mentioned that you have been interested in eating disorders for about 20 years. In that 20 years, did you learn any best practices?

Ms. Noelle Martin: In the beginning my interest was sparked by the media, specifically through exposure to a TV show when I was young. I remember wondering what was going on? How is this out there?

I immediately talked to my parents about it. I'm an only child, and we talk a lot at home. My parents were great about helping me to start being educated in that area. That is where my interest started to grow. I would say my research in the area really started then.

I think I learned the most in the beginning that there are a lot of stigmas and assumptions. What was interesting to me when I started in the practical area of working with individuals with eating disorders was that my eyes were opened to the reality compared to what the stigma was.

In looking at best practices, I think one of the biggest things is that we cannot put anyone who has an eating disorder or seems at risk for an eating disorder in a box. We have to remember that some of the assumptions we've come up with in society may be true, just like all stereotypes, but we need to treat each person as an individual and be open to their story.

● (1555)

Mrs. Susan Truppe: Thank you.

While you're at Brescia, and since it's all girls there, do you experience eating disorder issues there with any of the girls?

Ms. Noelle Martin: Absolutely. I counsel university students as well as being a professor of university students. Both in the classroom as well as in my counselling area, we see a lot of individuals with eating disorders. It's interesting to note how many of them are enrolled in the food nutrition program because of the interest there in health and in food and in nutrition, to the point of it sometimes being an obsession.

As Ms. Anderson was saying, it's the first thing individuals with eating disorders think of when they wake up in the morning. It's a constant torture, so there is perhaps the idea that if they can learn more about this, maybe that's a way they can break free.

So, yes, when we're working with a school of all women and girls, we do see a high percentage of eating disorders.

Mrs. Susan Truppe: How did you help them then? We've often heard that the family is obviously very involved when there's an issue. A lot of those girls don't have family there because they're from other parts of the country, or even out of country. How would you help them? Did you also maybe develop an awareness campaign within Brescia or Western so the girls who are not experiencing a problem at this point are aware of the seriousness of the disease so they won't have it?

Ms. Noelle Martin: Absolutely.

Mrs. Susan Truppe: Could you tell us a bit about that?

Ms. Noelle Martin: Sure.

There are a few areas. One is one-on-one counselling, paid for by the University Students' Council, for individuals to meet with me as well as my colleague. The access is open, so they can come every week and speak with us for half an hour or an hour about what's been going on. The consistent accountability is a piece that is really helpful, and that's year-round, not just during school. It can be via phone, if they go home in the summer, for example, or we'll put them in touch with a dietitian in their area if they prefer.

In terms of family support, at the right time for the client we definitely encourage mum or dad or sister or brother or spouse or whoever it might be to join us in meetings. As a practitioner, I think of myself as a bit of a facilitator in those situations. Sometimes there are conversations that are really hard to have in the home, so those conversations can be facilitated or started in more of that clinician's environment, but in a safe setting for the client who's working with the eating disorder.

I also work closely with Hope's Garden. We've set up awareness programs as well as group programs right on the university campus, so there's another outlet for students.

Mrs. Susan Truppe: Thanks. I was just going to ask you about Hope's Garden. I think you were executive director for quite a few years.

Ms. Noelle Martin: I was chair of the board, yes.

Mrs. Susan Truppe: Were there any programs there offered to individuals struggling with disorders that you'd like to share with us? What was maybe the best program that you've had that you've found was really helpful?

Ms. Noelle Martin: The program that we have at the university has been very impactful, absolutely, because we're right on campus of the university, and we've had financial partnership with the USC for that. So that's been great.

Two other really come to mind, and one would be art therapy. We had the opportunity to have an art therapist who was one of our strong volunteers, and her program was very strong and still is.

The other would be would be the friends and family group, because there's a little bit of a hole there. As we start to see a little bit more of an attention to eating disorders, we're seeing that there's a little bit more access. Certainly we have far to go for those who have eating disorders, but we're not seeing the support for family and friends. A lot of times parents, they don't know what to say. They feel that they have lost their son or daughter and they don't know how to handle it, so there is hope for them in coming and talking with other families and friends.

● (1600)

Mrs. Susan Truppe: Ms. Anderson, just very quickly, I think you said 30% was binge eating and 17% or something was anorexia. Was that right? I found that high.

Ms. Joanna Anderson: Of our clients.

Mrs. Susan Truppe: Sorry?

Ms. Joanna Anderson: No. Those are of our clients at Sheena's Place, not in the general population.

Mrs. Susan Truppe: Right, I understand that. I was just surprised that the binge eating was higher than the anorexia. I haven't really heard that yet.

Is my time up now?

The Chair: Yes.

Mrs. Susan Truppe: Okay. Thank you very much.

The Chair: Thank you very much.

[*Translation*]

Ms. Ashton, you have seven minutes.

[*English*]

Ms. Niki Ashton (Churchill, NDP): Thank you very much, and I'll be splitting my time with my colleague, Madam Sellah.

Thank you very much both to Ms. Anderson and Ms. Martin for joining us today and for sharing your experience and your wisdom on this very important issue.

Ms. Anderson, I want to begin with you. This committee has learned that there is systemic discrimination in our health care system against those suffering from eating disorders. We learn from people like Dr. Blake Woodside that there are often only 10 beds and a six-month waiting list at Toronto General Hospital for eating disorder patients, and you alluded to the waiting list as well.

I'm wondering if you could speak to the systemic nature of the problems you encounter, which is often an element in this discussion that gets missed.

Ms. Joanna Anderson: Absolutely. I think that this is a committee that's being commissioned to talk about women and girls. Eating disorders do affect boys as well, but while we're talking about women and girls, it's been understood that this is an illness of affluent, vain girls, and to understand that it is a severe mental illness is one issue.

I'll tell you a story about one of my clients. She was having chest pain, and I was very nervous for her, and I accompanied her to emergency. I did that because I knew that she was going to be treated terribly in the emergency department. When I mentioned to the ER doctor that she had been a client of mine at SickKids and that she had been struggling with an eating disorder for many years, he said to tell her the waiting list was six months long, and then proceeded to not really treat her with the same kind of respect or care that you would get if you were just having chest pain and someone didn't know that you had an eating disorder.

So I think our clients are discriminated against on the understanding that this is something that people do to themselves, that it's a bad choice that they make, whereas what we're trying to educate the committee and the public about is that this is a mental illness that is very based in genetic and biological functions.

Ms. Niki Ashton: Thank you very much.

I have just one quick follow-up question so that I can leave time for my colleague as well.

Obviously you acknowledged that boys and men struggle with eating disorders as well, but if we bring the focus back to women, I'm wondering if in your work you see women having child care issues and financial issues when they come to seek help.

Ms. Joanna Anderson: I think this is a way that women experience eating disorders differently from men. For sure, if you are an adult women and you have to go to treatment, as Dr. Woodside said, treatment can last nine months to a year to do it properly. What are you supposed to do with your children during that time? Who's going to take care of them? Where is the social and economic support to be able to leave a job or school and go for treatment?

Ms. Niki Ashton: Thank you.

[*Translation*]

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): Thank you, Niki.

I would like to thank the witnesses who are here today for helping us understand more about eating disorders.

I would like to start by saying that, as a health professional, I know a little about eating disorders. However, I would like to call on your experience, Ms. Martin, by asking the following question.

I know that, most of the time, eating disorders result from an imbalance or a relationship between the body and food, but that is not the only factor. As we know, it's fairly complex.

In your field, what do you see as the biggest factor at the root of eating disorders?

● (1605)

[*English*]

Ms. Noelle Martin: That's a very good question. I do think that everyone is different, I really do. If I had to pick one piece I would say it has to be the attitudes and beliefs of society that are then taken and put forward generation after generation.

I think if we take the genetic piece and the biological piece, we all know that genes can be expressed or not expressed, depending on situational factors such as environment and social...and depending on which type of gene we're looking at. So I think if we change our attitudes and beliefs in our culture around many things, we can help with many mental illnesses, including eating disorders.

[*Translation*]

Mrs. Djaouida Sellah: Thank you for your answer.

Do I have any time left, Madam Chair?

The Chair: Yes, you have almost two minutes.

Mrs. Djaouida Sellah: Good.

Setting aside the media and social pressure you just mentioned, what can the federal government do to minimize these disorders?

[*English*]

Ms. Noelle Martin: I think it's anywhere that funding could be given from the federal level in helping those who have eating disorders. In terms of medical...my understanding is that it's more provincial funding. But if there are ways in which federal funding could be offered to places that are maybe even outside of clinical settings, such as Hope's Garden or Sheena's Place, and other places like that across Canada, that would be of huge assistance.

I know at Hope's Garden—and I'm sure Sheena's Place is the same—we relied on volunteers and funding from within our community to help those who were dealing with an eating disorder. I think any funding that can be given then allows places such as Hope's Garden or Sheena's Place to help those within the community and also to provide campaigns for awareness.

[*Translation*]

Mrs. Djaouida Sellah: Thank you.

The Chair: Ms. Anderson, do you have anything to add?

[*English*]

Ms. Joanna Anderson: I'd like to echo what Ms. Martin said. Also, I think one thing that's very important is a national public awareness campaign to help people understand that eating disorders are a severe mental illness that has very high mortality rates, and to understand that this is not just young girls being vain and diets gone bad. We need to educate people around what it is that eating disorders are. I think that would help tie into what Ms. Martin was saying about changing societal attitudes.

We also need research money.

The Chair: Thank you very much.

[*Translation*]

Ms. O'Neill Gordon, you have seven minutes.

[*English*]

Mrs. Tilly O'Neill Gordon (Miramichi, CPC): Thank you, Madam Chair.

Thank you both for being with us this afternoon. We certainly appreciate your time and the fact that you are sharing your experiences with us.

You both mentioned people like parents, teachers, coaches, social workers, and all of us certainly know what an important role these people play in individual lives. I'm wondering, what advice and means of help you would like to see these people receive. Better still, how would you propose to get these messages instilled into the minds and hearts of these important mentors and great friends who are always part of these individuals' lives?

● (1610)

Ms. Noelle Martin: I think one thing that comes to mind in terms of coaches is really helping a coach understand how every single word that comes out of their mouth is very influential in the way that the person who is on their team, or is working towards a goal with them.... Every single word matters.

For example, I have a client who had the potential for an incredible gymnastics career and because of how hard her coach was on her for the way her body looked, she made nutritional choices where she was not given advice from a nutritionist or a dietitian who was of access to the team. She ended up in hospital at the age of nine, and through the age of nine to 19, she was in and out of hospital, had hip fractures, and a lot of negative medical consequences, because of a few phrases early on.

That's just one of many examples, and I think that coaches and teachers need to understand that they either need the proper education before they give advice or to pull in a dietitian or a medical professional who can speak with the team and use the appropriate language so we aren't pushing someone towards an eating disorder or disordered eating, such as Ms. Anderson described when the individual went into that 13-year-old boy's class.

Ms. Joanna Anderson: I think the thing that I find so alarming about this is we at Sheena's Place will go to one school, one coach. Our program manager went to Elizabeth Fry yesterday because they have a woman in prison who is coming out and they don't know how to help her. She has a severe eating disorder.

But that takes a lot of time and resources. We don't have a national campaign to educate people, so Ms. Martin is doing this work, and Dr. Pinhas and Dr. Woodside, whom you've already spoken to.

We're all doing the best we can in our communities, but those are individual approaches and I think we need a national campaign because you can't educate coaches and families and teachers one by one.

Mrs. Tilly O'Neill Gordon: Absolutely, and all of the work that they do they do with good intentions so little would they know that they're saying anything wrong. So they really need to be told and shown because so few people out there are really aware of this disorder and what it really means to the parents and to the patient as well.

I was aware of it, but it's not until we heard presentations from people like you and the other ones that we've had that I began to realize what a serious matter this really is among these young girls.

Among professionals in the field of eating disorders, is there a sufficient sharing of the knowledge and the research data and promising practices out there? What could be done to increase knowledge and sharing so that more people would be aware of these things?

Both of you.

Ms. Noelle Martin: Go ahead.

Ms. Joanna Anderson: I think that there's not, to answer your question quite frankly. Those of us in the field do our best to collaborate and share knowledge.

But conferences are very expensive, conducting research is very expensive. I came to Sheena's Place in 2012 and for the first time we are collecting data on clients and around the illness. When I got there a year and a half ago, no one could tell me who had anorexia and who had bulimia because there just wasn't the money to hire staff to do that kind of data collection.

So it's piecemeal at best.

Ms. Noelle Martin: For myself, I am part.... Sorry, go ahead.

Mrs. Tilly O'Neill Gordon: No, I was just asking if you had something to offer.

Ms. Noelle Martin: I was just going to say, for myself, I am in touch with several practitioners across North America because of opportunities that I've had through attending conferences as well as touring treatment facilities in the U.S.

So I do have the opportunity to communicate with others, but I am sure there could be a greater level of communication, especially within Canada, as the majority of the people who are part of the online community I speak with are from the United States.

So more attention given to the opportunity for communication within Canada would be wonderful.

● (1615)

Mrs. Tilly O'Neill Gordon: I want to congratulate you on the work that you do. Above and beyond, I was happy to hear you share what you do and how you help the individuals with phone calls and sessions, and meeting with parents.

Can you elaborate on the continuing care of those who have received treatment and how they're followed up?

Ms. Noelle Martin: Absolutely. When I was working in the general community, individuals were able to see me as long as they wished; however, the university clients are able to meet with us for the lifespan of their university career. We have some master's and Ph. D. students who continue to see us throughout their university career.

Beyond that I do make sure that I put them in touch with at least two, if not more, opportunities within their community. So when they find an opportunity for employment or they go home, whatever it might be, I will try to put them in touch with whatever opportunities are available there. The reason I try to find two or more is that not every one is a fit.

The other thing is that in my role as a dietitian, I'm only part of a large team. Psychologists, psychiatrists, and family physicians play a huge role in terms of building a team for healing, really, for the individual.

The Chair: Thank you very much.

[*Translation*]

I will now give the floor to Ms. Duncan for seven minutes.

[*English*]

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair, and thank you to both of you for the work you do and for your comments today.

Ms. Anderson, I just want to make sure that we recognize that you've made three very specific recommendations. One is that we need a national awareness campaign; second, we need a national registry; and third, we need a national research program. Did I reflect that correctly?

Ms. Joanna Anderson: Yes, very correctly, thank you.

Ms. Kirsty Duncan: So there are three recommendations to the committee.

You also raised a fourth point regarding how we share this, not just in terms of best practices but in terms of collecting the research, one place that people can go. You said an essential database or clearing house. Should that be a recommendation to the committee, to have a national clearing house on information regarding eating disorders?

Ms. Joanna Anderson: Yes, I believe that would be a very effective strategy for moving forward.

Ms. Kirsty Duncan: Thank you.

Ms. Anderson, you talked about private treatment and costs. Can you give the committee an idea of what the private treatments are that people need to pay for? Is it seeing psychiatrists, seeing psychologists, seeing registered dietitians? Give us an idea of what the cost of each of those services is, please.

Ms. Joanna Anderson: Sure.

Psychiatrists in Canada are covered by OHIP—if you can find one, and if you can find one to treat eating disorders. I would say that within psychiatry, because this is a long-standing, entrenched illness, a lot of psychiatrists don't want to take eating disorder clients on. They view them as high-risk—their mortality rates are very high—and they view it as a very long commitment.

So that's one thing.

Psychologists charge over $200 per session in Canada. I have a private practice where I've followed clients, and I charge $150 an hour. So that's $600 a month if you're going to treatment only once a week, which I would say is not enough when you are in crisis. One hour of counselling a week is not going to do it.

Our clients often need dietitians. Ms. Martin may be able to speak to the rates they charge a little better than I can. But you need a team, as she said. We know that eating disorders are co-morbid with anxiety and depression, and often trauma. We don't have medication to treat the eating disorder—that's food—but what we can use medication for is to control the co-morbid things.

So you need a psychiatrist, you need a dietitian, and you need a therapist. That's an expensive team if you have to pay for it yourself.

Ms. Kirsty Duncan: This is very helpful. If you could make a recommendation to this committee—you're talking about a team approach—what would that recommendation be regarding treatment?

● (1620)

Ms. Joanna Anderson: As I said, we know that shorter waiting lists are consistent with a better prognosis. Either you have this illness for one or two years, or you have it for many years. That's what the data tell us, and that's what we see at Sheena's Place. So in terms of recommendations, I would say shorter waiting lists, better access to treatment, more treatment options. Not everyone can go to a hospital. You go to a hospital when you've become quite medically unstable. We need treatment in the community that is accessible and paid for.

Ms. Kirsty Duncan: So the recommendation would be treatment in the community that is paid for, acceptable, and with appropriate waiting times, short waiting times. Is that correct, or would you like to modify that?

Ms. Joanna Anderson: No. I think that's absolutely accurate.

Ms. Kirsty Duncan: Okay. Thank you.

The people who come to you, is it one group? How does it break down? Is it people who have tried many different services or is it a combination of, you're the first place they come to? I think you were saying it varies. If they've tried other treatments, what are the average wait times for treatment? How long have they been treated? What is the relapse rate? Could you give us a sense of that, please?

Ms. Joanna Anderson: Sure. I can provide the committee with more numbers. I don't have the numbers exactly off the top of my head, but I can submit them to you.

Many of our clients, I would say about 30%, have had this illness for one to two years. Similarly, another 30% have suffered for more than 20 years. As I said, that is consistent with the literature on eating disorders. That's why we know early intervention and access to treatment is so important. I can't underscore that enough. Our clients have been in and out of hospital for years. They access emergency care because the waiting lists are so long for treatment. They go to the emergency room and that costs the health care system probably millions of dollars.

Ms. Kirsty Duncan: Should another recommendation be early access to treatment?

Ms. Joanna Anderson: Absolutely. Early screening and access to treatment.... When I worked at SickKids we did a family meeting every month where we would talk to parents and introduce them to our program. The theme month after month was, "We went to the doctor, we told them something was wrong with our child, the doctor said it's fine, the doctor didn't know where to send us, the doctor didn't know how to treat us."

Ms. Kirsty Duncan: So is one of the issues that the first person the family is going to go to is the family physician?

Ms. Joanna Anderson: That's right.

Ms. Kirsty Duncan: Is part of this training for physicians to recognize and to screen for eating disorders? Should that be a recommendation?

Ms. Joanna Anderson: Yes. Absolutely.

Ms. Martin noted earlier about children's growth curves. The first thing that we would always do when we got a child into the program was look at the way they had been growing normally until they had this intervention of an eating disorder. The idea is to get kids back on track of their own growth curve, not on some predetermined weight or shape that they want to be, or that they've decided would be best for them.

The Chair: Thank you very much.

[*Translation*]

Ms. Ambler, you have five minutes.

[*English*]

Mrs. Stella Ambler (Mississauga South, CPC): Thank you, Madam Chair.

I'd like to share a bit of my time as well with Mr. Young.

Thank you both for being here today.

Ms. Anderson, I was wondering if I could ask you about the spectrum of severity. We often hear that the disorder starts out a certain way and that only the ones on the most severe end of the spectrum are treated. If the approach is to identify the disorder in its earlier stages, what can be done at that point? We talk about medical treatment, but is there something that parents can do, something that parents can say to make it better, or a change of lifestyle that would help in the early stages?

● (1625)

Ms. Joanna Anderson: Yes. I think that parents aren't educated around what an eating disorder is, or even what the signs are. That's one thing, to have parents understand if suddenly their child is skipping meals, the lunch containers are coming back with food still in them, there is a problem and it needs to be addressed.

I think that kids go out of their way to hide this disorder from their parents, so working with families just to be educated around it is one important step.

Mrs. Stella Ambler: Let's say they figure it out; they see that food is not being eaten, or it's being thrown away. Is there something they can do, or do they have to just immediately go and see a medical professional?

Ms. Joanna Anderson: I don't think they need to immediately go to a medical professional, but you know....

Ms. Martin is a dietitian, so she'll be able to tell you very clearly that the data shows that eating a family meal together is really helpful. Eating with your family, everyone sitting together, has been shown to lower rates of substance abuse, teen pregnancy, eating disorders.

I think it's also about talking to girls about what real women's bodies look like. Women have hips, and they have breasts, and they have curves. We aren't all meant to be stick thin. Respecting your own set point and your genetic makeup is not a message that most young girls are getting. They're getting the message that if they try hard enough, they can have a certain body type, and that's just not true.

Mrs. Stella Ambler: Thank you so much.

Mr. Terence Young (Oakville, CPC): Thank you.

Joanna, could you please tell the committee what should be the minimum standard of care for women and girls with eating disorders?

Ms. Joanna Anderson: Once someone has been identified as being at risk, the minimum standard of care should be that you have access to a doctor who understands eating disorders, who understands the diagnostic criteria and the treatment options.

You should absolutely have access, if needed, to a psychiatrist who can assess for such co-morbid conditions as anxiety, depression, or a trauma-related disorder. You should have access to a therapist to work through some of the cognitive distortions around eating disorders, and have access to a dietitian to help you work through a food plan that will get you to a healthy weight for your body.

Mr. Terence Young: Should an in-patient program be part of that, if necessary?

Ms. Joanna Anderson: Absolutely.

Mr. Terence Young: Dr. Martin, do you have anything to add to that list?

Ms. Noelle Martin: Ms. Anderson has covered the bases, absolutely. When we think about access to care, we have to remember that an individual who has an eating disorder may also have very limited funds to pay for what would be ideal. They may not have the ability to maintain a job because of how preoccupied they are in terms of the eating disorder. They may be suffering from —

Mr. Terence Young: Thank you. I have only 40 seconds, and I'd like to ask Joanna one more question.

Should parents with little children be considering, because of the commercial messages, taking television and magazines right out of their house?

Ms. Joanna Anderson: I don't know that taking TV out of the house is a sustainable long-term solution. I think it's about teaching your children that what they see on TV is not real, it's an image; that images in magazines and on the Internet are tampered with; and that striving to have a body that looks like what you're seeing on TV will send you down the wrong path, because even the models don't look like that.

So I think media literacy and training are also important. I would make that as a recommendation to this committee, that it would be within the purview of the federal government to add some media literacy and training to a national awareness campaign.

● (1630)

Mr. Terence Young: Thank you.

[*Translation*]

The Chair: Thank you very much for your highly informative presentations and for the recommendations you made to the committee.

Ms. Anderson, you included several statistics in your presentation. You said that this issue affects young people and older people. We have asked you to provide additional information. It would be nice to have more details about this as well as any information you think the committee would find useful.

[*English*]

Ms. Joanna Anderson: I'll happily do that.

[*Translation*]

The Chair: Thank you.

The meeting will be suspended for a few minutes to get the next witnesses on the line.

●

(Pause)

●

● (1635)

The Chair: We will reconvene the meeting.

The witnesses are with us by videoconference. First we will hear from Dr. Monique Jericho, psychiatrist and medical director of the Calgary Eating Disorder Program. We will also hear from two witnesses from Guelph University's Department of Family Relations and Applied Nutrition: Dr. Carla Rice, Canada Research Chair of care, gender and relations, and Andrea LaMarre, a master's of science student.

Welcome. Each organization will have 10 minutes to present.

Dr. Jericho, you may start.

[*English*]

Dr. Monique Jericho (Psychiatrist and Medical Director, Calgary Eating Disorder Program, Alberta Health Services): Thank you.

Thank you, Madam Chair and members of the committee. I very much appreciate this opportunity to speak to you today about the matter of eating disorders. It's a subject that I have devoted the first five years of my professional career to.

I speak to you today principally from the perspective of a clinician. I spend most of my working hours engaged in the treatment of eating disorders. On any given day, I meet with patients of all ages who are suffering with these often severe and complex conditions. I also meet with worried, desperate parents. I meet with exhausted spouses. I meet with the siblings and children of those who are struggling to recover from or simply to cope with eating disorder symptoms. I deal with a lot of fear and anger, as well as confusion and denial.

As you have heard in your inquiry thus far, eating disorders are amongst the most lethal of all mental health conditions. They affect young women, significantly distorting what could otherwise be a normal developmental trajectory through adolescence, thereby establishing the conditions for further mental illness throughout their lives. These conditions are almost never present without significant co-morbid symptoms, principally those of depression and anxiety, but self-harm, substance abuse, and other impulse control problems are also often present.

What is less measurable here, and by far more meaningful to the individual, is the extent of the suffering these diseases exact on patients and their families—the broader toll on society. From my unique, and I would say, privileged vantage point, I can tell you that the suffering created by eating disorders is immense.

Through my affiliation with the University of Calgary, I provide education and mentorship to medical students and resident physicians at various levels of training. In my lectures, I generally begin by explaining what eating disorders are not. They are not the result of personal choice, they are not glamorous, they are not minor, they are not phases, and they are not the result of bad parenting, etc.

I often feel like I'm starting at a deficit. I'm working against a powerful media force, and in some cases, an already rigid set of societal beliefs about what eating disorders are and what people with eating disorders are like. Without excessive digression, I will point out what is obvious.

We live in a time and place where female beauty is often equated to power. Sadly, the belief is that to be beautiful is to be thin, so to the fresh eager ears of medical students, it's often difficult for them to truly appreciate what is so bad about the pursuit or attainment of thinness.

I believe that this is where some of the issues in treatment begin, at the beginning. All stakeholders, and in particular, all physicians need to understand what eating disorders are. They need to be taught how to diagnose these conditions and generally how to manage them until people can access comprehensive specialized treatment centres.

Beyond this, they need to be prepared to deliver a diagnosis that the patient may not like or may deny. In other words, they need to be prepared for the discomfort that is often required in treating a patient who is often unable to be compliant or who may not have the investment in the diagnosis. They need also some preparation in how to talk to parents and partners about the condition, because without this alliance a physician's power is reduced to the few moments they spend with a patient in their office.

Knowledge of eating disorder management must extend beyond the realm of family physicians, pediatricians, and psychiatrists. Almost all practising physicians will encounter individuals with eating disorders. Making the diagnosis and taking timely, appropriate next steps is crucial and can be life-saving.

To strengthen my argument about the need for better management of eating disorder patients by all physicians, regardless of specialty, I will provide you with the following vignette, which literally took place only yesterday.

I received a call from an experienced internist who was concerned about a patient she had recently seen. It was an 18-year-old woman who had experienced unexplained weight loss over the preceding two years. Her medical status was so severe that she had a BMI of 13 and was in renal failure. After a comprehensive assessment, the internist felt confident that the individual had a diagnosis of anorexia nervosa. When she attempted to share her views with the patient and her mother, both rejected the diagnosis and became angry at the mere suggestion of it.

Worried and conflicted about what to do next, the internist placed a call to the two other specialists who had seen the patient and to the GP who made the referral. None of these individuals had considered the diagnosis of anorexia. Instead, multiple expensive and invasive tests had been done to find the elusive cause of her weight loss.

● (1640)

She spoke to one of her colleagues whose response was not to be too hasty in making the diagnosis of anorexia. Instead, the plan was to pursue rare and highly unlikely malabsorption syndromes, what we call “zebras" in the medical world. The physician's response to the possibility that the condition was anorexia nervosa was revealing. He said, "Let's give her a chance. It still might be something else".

The internist was calling me because she had no idea how to proceed. She knew what the diagnosis was, but no one—not the patient, not the parent, not the other physicians involved—wanted to call it what it was, not the rare zebra, but the unfortunately common horse, anorexia nervosa, with a prevalence in young woman of between 5% and 10%. This exemplifies how physicians may deny or fail to see eating disorder diagnoses and thereby significantly impact a young person's chances of recovery. In this case, this young person had been ill for two years, had dropped out of school and sports, which she had previously excelled at, and was walking around the city of Calgary at a dangerously low BMI and at risk of further decline and sudden death.

I hope the committee can appreciate with this story the challenges that physicians face and the complexity of providing doctors with necessary support and information at critical junctures during their training.

I will leave this topic with a sobering fact: exposure to eating disorder treatment programs is optional even in psychiatric residency training programs.

With regard to treatment, I have been the medical director of the Calgary eating disorder program for two years. In this capacity, I have had a twofold focus. First, our program needs to provide evidence-based treatment to those who suffer from eating disorders. Second, we need to provide service in such a way as to meet the needs of southern Albertans. In short, we are not providing adequate services if patients must navigate a long wait list to access our care, because every day that goes by before a patient is comprehensively and effectively treated is another day in which their disorder can grow stronger and another day in which patients become more removed from who they were before the eating disorder entered their lives. It is a time when suffering expands.

Timely, appropriate access to good-quality care is imperative in the treatment of eating disorders, and in most parts of the country we are failing.

In my view, there are some ways we can make the situation better.

First, there should be mandatory comprehensive education of all medical students and resident physicians on the subject of eating disorders.

Next, there should be a mandatory requirement that publicly funded programs practise evidence-based treatment, not just whatever the flavour of the month is, not just what individual clinicians would like to do. Funding for infrastructure and training must be driven with the goal of delivering evidence-based care, and the resources must match the scale of the problem and what is required to deliver that care. Better mechanisms must be put in place to support physicians treating individuals in the community and for those working in remote and rural areas.

Finally, mechanisms through which programs can interact, share data, and collaborate on research to accelerate understanding must be established and supported.

With that, I'll say thank you so very much for this opportunity to contribute to this important work.

● (1645)

[*Translation*]

The Chair: Thank you very much, Dr. Jericho.

I will now give the floor to Dr. Rice and Ms. LaMarre for 10 minutes.

[*English*]

Dr. Carla Rice (Canada Research Chair in Care, Gender and Relationships, Department of Family Relations & Applied Nutrition, University of Guelph): Thank you very much for inviting us to speak here today.

My name is Dr. Carla Rice. I'm a Canada research chair at the University of Guelph where I research problems of embodiment, including eating disorders and obesity.

Ms. Andrea LaMarre (MSc Candidate, Department of Family Relations & Applied Nutrition, University of Guelph): My name is Andrea LaMarre, and I'm completing my graduate studies with Dr. Rice at the University of Guelph. My research deals with individuals in recovery from eating disorders.

Dr. Carla Rice: In my 20 plus years of experience working in this area—formerly as the manager of the National Eating Disorder Information Centre in the late eighties and early nineties; later as a clinician at Women's College Hospital, where I worked with women who were struggling with a full range of food, weight, and body-image issues; and now as a researcher—I have been in contact with hundreds of individuals, family members, and health providers dealing with these problems.

While I've witnessed many changes in the delivery of services over this period—more changes in service delivery than in treatment modalities—one thing has remained constant and that is the "revolving door" scenario in which many individuals cycle in and out of treatment without finding solutions. Many families and friends still feel helpless in the face of these complex concerns. Caregiver burden is high even though caregivers are resilient and desire the best for their loved ones.

As the existence of this study shows, there's a growing interest in developing federal policy in support of eating disorder prevention and treatment in Canada and we fully support this development. We are here today to advocate for a strategy that acknowledges, honours, and welcomes in individuals' complex lived experiences of eating disorders. We want a case for centring those experiences in any strategy.

Ms. Andrea LaMarre: Obtaining specific information about programs, including the number of beds available, reliable estimates on wait times, and specific types of therapy offered, remains extremely difficult, despite strong efforts to devise online service directories for eating disorder care. Individuals and families may also struggle to obtain information about services that are available across Canada.

This difficulty can be exacerbated while seeking services in a province other than one's home province, for example while attending university. Patients and families may be left trying to navigate a difficult system of referrals and waiting. There is certainly a dearth of available and affordable services for those whose health may be at serious risk, if appropriate and timely treatment is not provided.

Dr. Carla Rice: I do not think it is about changing the entire system or about reinventing the wheel. Rather than overhauling a system that may be helping many individuals and that is evidence-based, we recommend the development of an alternate system of community-based treatment and support. This system would focus on prevention and on counseling people before they develop chronic conditions. As well, alternative approaches to care may be more appropriate for individuals for whom mainstream approaches have not worked.

While we have accurate statistics about individuals who obtain a diagnosis, our research shows that there are many others who remain undiagnosed. These unnamed and unheard others may face stigma or be dismissed by community, family, medical providers, and others on the basis of their body size or on the basis of their race or ethnicity or their gender, among other factors. To better match services to complex needs, we envision a system with multiple points of entry and multiple approaches to care and support tailored to the needs of these different groups.

A number of barriers may prevent individuals from seeking needed care, not the least of which is how we talk about eating disorders. Though we are starting to see some shifts, a number of stereotypes persist in the popular imagination. Among these, we may still expect eating disorders to be a problem of young, white, middle- to upper-class heterosexual women with hyper-emaciated bodies.

Those who don't fit this stereotype may feel that their disorder is not legitimate in the face of this single story or single representation. This perception may be magnified if people confront negative experiences with health professionals, family members, and others.

Let me give you an example. Individuals from minority groups in particular may face a system that disbelieves in their disordered eating, while also feeling that to seek treatment is to broach and also to breach their ethnic or racial identity.

For example, in researching body image and eating concerns among diverse groups of Canadian women, I spoke with a number of racialized women—Asian women, South Asian, as well as African Caribbean Canadian women—whose eating disorders were misdiagnosed or dismissed by health care providers, an experience that complicated their recovery and that they attributed to race. In other words, they attributed it to health providers' not being able to imagine, because of this dominant mythology, someone of their racial group struggling with an eating disorder. Andrea has heard similar stories from her research participants.

● (1650)

Ms. Andrea LaMarre: In my research, I've spoken to young women who have faced strong familial and cultural norms around problems in the family. These things were not to be spoken about outside of the family for fear of bringing shame and embarrassment upon the family unit. For individuals faced with such cultural and familial discourses, asking for help can be extraordinarily difficult. There is still a great deal of stigma that surrounds help-seeking among individuals with eating disorders from both minority and non-minority groups.

Dr. Carla Rice: For those whose bodies do not fit neatly into the stereotypes, help-seeking can be met with confusion and assumptions. Taking the example of the women involved in our studies, significant struggles went unrecognized as providers read their bodies as "normal". This suggests that behaviours considered extreme—for example, multiple workouts a day or extreme restricted eating—may only be read or seen as disordered once one's body crosses the line into extreme emaciated thinness. Those whose bodies were classified as overweight or obese too were sometimes advised to restrict their diets and to increase their exercise, even though these recommendations triggered or exacerbated their disordered eating.

These practices are prescribed in doctors' offices and prescribed in gyms across the country as we fight against an apparent obesity epidemic. Yet fat-shaming tactics offer few solutions and may even perpetuate behaviours detrimental to women's health.

In my own research, for example, every single woman I interviewed who experienced themselves as fat in childhood developed an eating disorder in childhood or in adolescence that was due to people's attempts to regulate their weight.

Ms. Andrea LaMarre: Not occupying a body that is easily understood to be suffering from an eating disorder may also complicate the process of recovery. Weight restoration and normalized eating are generally considered pillars of eating disorder treatment programs. When new instructions are given to individuals to develop new patterns of behaviour around food and exercise, these are often in direct opposition to the prescriptions for health that are offered to the general population. Recovery in such a context can be extraordinarily difficult. To borrow one of my participant's words, "For people who already feel so alone and want to belong, to ask them to do something countercultural can be really scary."

Recovery itself is poorly understood. While individuals may see recovery as a process rather than an outcome, clinicians require biomedical criteria through which to gauge recovery.

More funding for research in this area would help to explore individuals' and families' understandings of recovery and the resources they require to achieve it.

Although we can see the evidence base growing around mainstream approaches such as cognitive behavioural therapy, currently existing models may not resonate for all individuals. One size does not fit all in eating disorder treatment. Our knowledge based around treatment primarily stems from studies conducted at programs that are currently funded, which are often generally in hospital contexts. It could be that other forms of treatment, for example, narrative therapy, which is often employed in fee-for-service community practice could be highly effective as well.

"Evidence-based" may mean that someone has been able to gather a large enough sample size to conduct a randomized controlled trial of the approach. Strong quantitative studies that test and compare various forms of treatment are still lacking.

● (1655)

Dr. Carla Rice: This suggests that we need to develop stronger relationships with individuals with lived experience to truly understand what is working and not working. Centring the experiences of people who have and have not received treatment, in a wide variety of settings, would entail deeply engaging with those individuals, and this requires good qualitative research. So we need qualitative research on top of quantitative research. Greater dialogue between individuals, families, and providers would also help to bridge significant divides between those who deliver and those who receive care.

We cannot abstract individuals from the social context especially in the case of eating disorders, where context is deeply implicated in girls' and women's disordered eating. Developing an effective supportive system depends on acknowledging that neither individuals nor systems need fixing in isolation. We need to work at the interface of individuals and systems to better understand individuals' complex needs as well as to expand possibilities for treatment within the system and care in communities as well.

Our solutions must be grounded in a strong understanding of the social-situatedness and the lived, embodied experiences of diverse individuals with eating disorders.

We thank you and welcome questions from the committee.

[*Translation*]

The Chair: Thank you for your presentations.

Mr. Young, you have seven minutes.

[*English*]

Mr. Terence Young: Thank you, Madam. Perhaps the clerk can wave at me when I hit five minutes so I can share my time with my colleague. Thank you.

Dr. Rice, I would like you to please comment on what causes eating disorders, with specific reference to objectivizing women and their bodies.

Dr. Carla Rice: Thank you very much for the question. I think that's a very good question.

I think that one of the reasons that eating disorders are so disproportionately experienced by girls and women is because of the objectification of women, where women are positioned as the object of the collective gaze and the public gaze in our society. This kind of positioning happens at a really young age as girls learn to take up their femininity. Being seen as the object of other people's looks is a primary criteria for femininity for women in this society. I think that objectification does play a role. But I also think we have to see these disorders as complicated, multidimensional problems where the social and the cultural play a really foundational role. There are other factors operating that relate to one's biology interacting and intersecting with psyche and the broader society.

Yes, go ahead.

Mr. Terence Young: So parents who have little children—say they have two children under four years of age—would it be a good idea for them to keep magazines and television right out of the house?

Dr. Carla Rice: I think that's a start. I think that as a broader culture though, that child is going to be socialized and acclimatized to what kind of gender role is expected of them when they go to day care, and when they go to school later on. Keeping magazines out of the house and turning off the TV set is great, but children are going to encounter these values as soon as they enter public school and other spaces where they meet up with other children.

Children themselves learn what kind of gender identity is expected of somebody, of them as a girl or as a boy, and they learn how to perform that because they want to fit into the social order, the social world. So we have to be thinking about prevention in a much broader way, not just targeting individual families.

● (1700)

Mr. Terence Young: Are girls and women with eating disorders being discriminated against in our health system?

Dr. Carla Rice: I don't feel one hundred per cent prepared to answer that question.

Mr. Terence Young: Okay, I don't want to put you on the spot

Perhaps I can ask Dr. Jericho.

Dr. Monique Jericho: Okay, you can put me on the spot.

Some hon. members: Oh, oh!

Dr. Monique Jericho: I can really only speak to my experience, so I want to be cautious, but I can tell you that I have had this conversation with folks from across the country. To say somebody is being discriminated against, I think, implies a deliberate type of neglect or a deliberate type of harm. I would suggest that's not happening. But I do think that the issue is that there is a lack of recognition for the severity of these conditions, period. Because of that, we just simply don't have the resources that we might need, and in particular the resources we need for the most gravely ill.

Mr. Terence Young: Dr. Jericho, what should be the minimum standard of care for women and girls with eating disorders? The minimum standard of care....

Dr. Monique Jericho: I think it ties in to what I was saying before. These people deserve to have their diagnoses or their problems acknowledged. They deserve to have that problem be given a voice. If that happens, if there is that acknowledgement, then the next step is that they are then able to access some form of care. So the minimum is the acknowledgement that it's actually a problem and that it's real, and then the next step is that they get treatment or support for the problem.

Mr. Terence Young: Thank you.

My colleague's going to ask some questions.

Mrs. Stella Ambler: Thank you very much.

Dr. Jericho, I'm wondering what pharmacological treatments are designed or used for individuals with eating disorders, and how and if they're regulated by the Food and Drugs Act.

I'll tell you why I'm asking specifically. I'm wondering how often eating disorders are treated with antidepressants, and if there are other drugs that are used, if they work. What are the adverse effects and risks of treating eating disorders in this way?

Dr. Monique Jericho: Okay. I think I can start off saying that there are no drugs. There is no medication that will cure an eating disorder. There is no medication you can give somebody that will cure or treat their eating disorder.

There are arguably some indications that bulimia nervosa can be effectively treated in the short term with the use of some antidepressant agents. But this is the minority of individuals, and this is generally not considered to be a lasting effect.

The treatment for eating disordered individuals is generally food. So I guess when you ask me what happens clinically, it is that many individuals are treated with a variety of different medications that would broadly be grouped under the classification of antidepressants, mood stabilizers, and antipsychotics. But those medications are prescribed for the treatment of symptoms. For instance I mentioned co-morbidities when I spoke earlier. Many individuals would come into a treatment program with co-morbid depression or depressive symptoms, and the clinician like myself may try to alleviate some of those symptoms using a medication. Similarly I might try to treat core symptoms of an eating disorder, such as maybe the experience of the body, through the use of a medication. So potentially I would try an antipsychotic to see if that would be helpful.

There are very few guidelines about the uses of medications in the treatment of these individuals. Clinically I'd say it's across the board. Some of my colleagues would use a lot of medications. I tend to not practise that way. But the point is that the standard really isn't established and there's no evidence to suggest that the use of these medications is necessary or effective.

● (1705)

The Chair: Thank you very much.

[*Translation*]

Ms. Ashton, you have seven minutes.

[*English*]

Ms. Niki Ashton: Thank you very much and thank you to all of our witnesses today, Dr. Rice, Ms. LaMarre, and Dr. Jericho, for your very compelling testimony and for sharing your experience with us.

I do have a few questions for the three of you, I guess. Beginning with you, Dr. Rice, it was very interesting to hear about your work, about Ms. LaMarre's work. It is an aspect of this discussion around eating disorders, stereotypes, and images, that we've only begun to touch on, I believe. But it is an issue.

Certainly, the portrayal of women in our society is something that's related to so many issues that we tackle in this committee. I'm wondering if you could give us an idea—if you are familiar with this information—if there is a trend in terms of the way women have been portrayed over the recent decades and the influence of media. Obviously, media has taken various different forms, including social media in this day and age, that impacts the pressures young women and girls may face with respect to body image.

Dr. Carla Rice: Absolutely. We live in an increasingly image-oriented, visual culture where our identities in many ways get reduced to our physical identity, especially when we're in adolescence where looks and appearance become something that's of primary importance.

We actively work to construct our identities through Facebook and through posting images of ourselves. So living in this extremely visual society where people construct their identities around how they look and how they appear.... Added on to that is the fact that girls and young women are positioned as the objects of the gaze, and that we're meant to focus on our image and to see that as a primarily important aspect of who we are. That has exacerbated the problem.

There are studies showing that models have become thinner and thinner. There are famous studies demonstrating that over the past 30 or 40 years. Girls and women are also confronted with more and more emaciated images of beauty.

Even beyond objectification, psychologists are now talking about sexualization, which is a kind of hyper-objectification of girls and young women, where girls and young women are now meant to create a very sexy image. It's not only one that should be attractive and thin but now has to be one that's overtly sexual.

Ms. Niki Ashton: It's very interesting and we've heard from witnesses in other discussions as well about how important it is to start working with girls at home and conveying the right kind of message to them. This is clearly a societal issue as well.

One of the things that's very clear in our work here—not just on this issue, but on others—is that there are fewer and fewer voices that speak out on behalf of women's issues. I'm aware of campaigns years ago that addressed, on a much larger scale, degrading images of women in advertising. Spokespeople would come out and speak to these things.

There is no question there are a number of bloggers and there are sites where these discussions happen, but unfortunately there are fewer and fewer voices with funding and with capacity to be able to keep track of some of these things. Perhaps actually, the last vestige is your work within academia and in the context of research.

According to you, is it important to have advocacy on these issues to support parents, to support teachers and educators but also at a broader societal level as well?

● (1710)

Dr. Carla Rice: Absolutely. We saw sort of the death knell of a few organizations like MediaWatch and other similar organizations. I'm not sure when those organizations folded, but it happened in recent years. We desperately need watchdog organizations attending to the kinds of images that are circulating.

You know, I think we also need to think about how eating disorders themselves are represented in society, in mainstream society. We need to think about that critically. In my remarks I alluded to this idea of the single story or a singular representation of who is the woman who develops an eating disorder. In Canada's multiracial and multicultural society I think that image no longer fits the reality of who is actually developing eating problems in this country.

Certainly when I was doing clinical work in Toronto I worked with a broad range of women from every racial group and cultural group. That notion that an eating disorder is sort of a purview of the white young woman who's upper-class or middle-class no longer holds true.

I think we also have to be thinking about the representation of eating disorders in the broader culture. I think Andrea also has something to say about that.

Ms. Niki Ashton: I was just going to say, actually, that I was hoping to leave some time for Dr. Jericho.

Andrea, perhaps if you want to just make a quick comment....

Ms. Andrea LaMarre: Yes. I was going to comment on how true this holds in my own research and my participants. I mean, women of some minority groups are saying that they had never seen any sort of representation of someone like them who had developed an eating disorder. They were feeling lost and confused, and do they even have a problem? That kind of feeling, feeling very lost in the system and unable to ask for help because of that.

Ms. Niki Ashton: Thank you so much.

Quickly, Dr. Jericho, as a follow-up, you work with, I'm sure, people from the LGBT community, as well as indigenous people. I'm wondering how you approached the work with diverse women.

Dr. Monique Jericho: It's a good question and you're absolutely right, we work with individuals from those communities. I have to say that we don't feel, or I certainly can speak for myself and say I don't feel like I approach those women in a vastly different way. I meet with every individual as an individual.

As was said earlier, there's no one-size-fits-all treatment. We take every single individual as an individual who has had their unique set of experiences and their unique experience of their body in this world.

I would say that I don't necessarily treat those individuals differently, but I am perhaps more sensitive to inquiry around the particular struggles they may face.

The Chair: Thank you.

[*Translation*]

Ms. Crockatt, you have seven minutes.

[*English*]

Ms. Joan Crockatt (Calgary Centre, CPC): Thank you very much.

Dr. Jericho, if I could just pick up where the discussion has sort of been going.... Maybe I'm taking a little bit of a different direction.

If I could just get you to explore for a minute what your thoughts are on whether or not getting someone to eat, to move away from seeing weight as bad, is the solution we're looking for, like getting an alcoholic not to drink. Or is the lack of eating a symptom of an underlying problem that you need to work to get at?

Dr. Monique Jericho: Would you like me to answer that?

● (1715)

Ms. Joan Crockatt: Dr. Jericho, yes. Thank you.

Dr. Monique Jericho: Thank you. Sorry. I didn't want to step on toes.

I think the underlying problem is the cognitive and emotional issues that compel a person to stop eating. Thereafter it becomes a reciprocal process because the more a person engages in restricted eating, the more cognitively impaired they become. The more cognitively impaired they become, the more rigid their thinking becomes, the more preoccupied with issues related to body, food, shape, and weight they become. Then the cycle continues. It's kind of a snowball effect.

It's this combination and reciprocity that's difficult to actually halt. But when we talk about using food as treatment, what I'm speaking to there specifically is that in many cases it's about desensitizing someone to something that they need as a life-sustaining treatment. You're desensitizing somebody to something they actually need to survive and that's where the food comes in, almost a behavioural type of approach when folks are truly unable to recover in any other way and perhaps a more autonomous way.

It's a desensitization for those who are gravely ill. We really need to work hard with folks who have been quite sick and who have been eating in these distorted restrictive ways to get back into a normalized pattern, because the whole body adjusts to malnutrition. They no longer feel hunger cues. They don't have the relationship with food that you or I might take for granted. We really have to retrain folks.

Ms. Joan Crockatt: Does that solve the problem? I mean, we know now that the rates of recovery are much, much better with treatment. That's part of what we've been doing here, finding out how to get people to that point, but I'm still interested in knowing whether or not it solves the problem if we can get them to start eating.

So you've essentially desensitized them to thinking about food as being bad. You want them to think of food as being necessary to survive. But do they then move to cutting or some other behaviour?

Dr. Monique Jericho: I think you've really hit the nail on the head there.

I think we have to be really careful about looking at these illnesses as being about food. The restriction of food is a symptom of some underlying, more complex, as I said, kind of cognitive or emotional problem or dilemma. Now we get into really grey areas, where we start talking about the individual and what is the core, the root, of the conflict that has led to them needing to manifest that conflict or that struggle in these ways.

That's where the richness comes in—the social and cultural influences, the genetics, the biology, the early role-modelling. All of these factors will feed into some sort of need or conflict that will be played out or experienced as an eating disorder.

But you're quite right that if we just focus on food, if we cut off that branch of the tree without looking at the deeper issues and without helping a person to understand themselves, their narrative, their emotional experiences, or how to regulate them, then the problem will invariably resurface as abuse of alcohol or drugs, or cutting, or...in a quieter way, let's put it that way.

Ms. Joan Crockatt: I want to jump in with another question here, if I can, because I'm still hoping to get a question in to Dr. Rice.

We've asked a little bit about banning images and about whether we think society should start to move down a path of saying that we don't want certain images to be accessible to our kids in their formative ages, because they might be triggers. Having come from the media world myself, I know that we're somewhat genetically programmed to be highly attracted to certain body images. I'm not sure if we can train society away from that, even if we wanted to completely ban certain types of images.

I'm just wondering what your thoughts are on that.

Dr. Monique Jericho: I'm certainly not an expert in this, and I'm not an expert in the research in this field, but I think when we overemphasize the role of media, we miss the bigger picture.

Obviously I'm in support of not progressing towards increasingly severe emaciation and the other things we talked about in terms of the representation of women. But I think it's really important that we train our children, our youth, early care providers, and our parents to help support children in understanding these images; to provide them with resilience, both emotionally and cognitively, to understand these images; to see themselves as unique and distinct and capable of making choices.

You can't live in a bubble. I think we need to also look at that big picture of what breeds resilience in children. I think the same things that breed resilience in children around eating disorders are the same things that breed resilience around addictions, other mental health concerns, and so on.

I'm talking about early childhood stuff here.

Ms. Joan Crockatt: Thank you for that lovely answer. I wish I could hear more.

Dr. Rice, can I just ask you a question here? If you feel compelled to answer what I've already asked Dr. Jericho, feel free, but I'm also interested in knowing whether or not you've seen any countries that have models that we should be using in Canada, or taking more cues from.

You can choose what you wish to speak about.

Dr. Carla Rice: Wow, that is such a great question in terms of both prevention and treatment.

I can't give you a good answer to that question right now. I don't know that there is. I really don't know that there is.

To come back to this question about banning certain kinds of images, such as banning emaciated models from walking on the runway, which I think was attempted in 2006 in Spain, there was an attempt to—

● (1720)

The Chair: Very briefly, Dr. Rice.

Dr. Carla Rice: Okay. Sorry.

I'm not certain that's a good solution, because it just continues to put the female body as sort of the object of our surveillance and of our regulation. We need to be thinking at a very basic level about how we socialize girls to have another relationship with their bodies.

Ms. Joan Crockatt: That's a wonderful answer. Thank you very much.

The Chair: Thank you very much.

[*Translation*]

Ms. Duncan, you have seven minutes.

[*English*]

Ms. Kirsty Duncan: Thank you, Madam Chair.

I'd like to thank you all for your testimony today and thank you for the work you do.

Dr. Jericho, I believe you said that resources must match the scale of the problem. If you could make very specific recommendations that you would like to see in this committee's report, what would you want the resources for?

Dr. Monique Jericho: There's a variety of different things that come to mind as soon as you say that, and of course, because I'm a clinician I think immediately of the clinical context. I think about the fact that we have anywhere up to 10 individuals at any given time who are severely ill and at risk not being able to access appropriate hospital beds. That's the first thing I think about, because folks with eating disorders don't fit into the traditional psychiatric paradigm, and they don't fit into the traditional medical paradigm, so there's this gap. That's an acute need, and I think it's a need that is pervasive across the country.

But when I think about the application of resources in other ways, I do feel it would be nice to have some resources devoted to developing mechanisms where there can be more collaboration between programs, a better networking and greater understanding of what each of us is doing. I feel that within pockets we're all doing good things, right? In our program, say, we provide a consultation service to providers in the community. They can call us, they can ask us questions. I know many providers do teleconferencing and therapy that way for folks in the rural communities. But we need to talk to each other and have that facilitated.

Ms. Kirsty Duncan: So if you could take those two ideas and make them a recommendation.... You've talked about closing the gap between the traditional paradigm and the mental health paradigm. Would that be a recommendation?

Dr. Monique Jericho: Yes.

Ms. Kirsty Duncan: And you've gotten to one of the major issues, which is the range of treatment, the continuum of treatment, particularly for those who are gravely ill. So...closing the gap, real treatment for those who are gravely ill.

Do you want to specify more?

Dr. Monique Jericho: Yes. By real treatment I mean hospital-based capacity, designated beds.

Ms. Kirsty Duncan: That's what I was looking for, thanks.

Then on collaboration, are you looking for funding and sharing of best practices based on evidence-based medicine?

Dr. Monique Jericho: What I'm looking for here...and I'm really pleased, Dr. Rice, that you spoke the way you did, because I agree with you wholeheartedly that we don't have a lock on how to treat these conditions.

When I say evidence-based what I'm talking about is applying a standard that we can all discuss, and starting from that standard to build on and innovate from there. If we're all collaborating, then we can share in our discoveries around these innovations and move the field forward. But right now things are so compartmentalized that we just don't have enough to really build strong research. We end up doing great things in pockets, but we don't always know what each other is doing. Then we are stuck with evidence that comes only from randomized controlled trials.

Ms. Kirsty Duncan: I have that, okay.

You talked about funding for training, so a recommendation to this committee is that there should be funding for training. I believe Ontario has a good model that you may want to elaborate on. You also said that eating disorder training is optional in psychiatry, if I remember correctly.

Would you like to make some very specific recommendations to this committee that you would like to see in the report?

● (1725)

Dr. Monique Jericho: I'm not able to comment on the training specific to Ontario. I will say that the reason I emphasized the piece around psychiatrists and psychiatry training is that at a bare minimum, I would suggest that all psychiatric residents be required to spend a portion of their training time in the treatment specifically of those who have eating disorders.

Ms. Kirsty Duncan: Thank you. I appreciate that.

Dr. Monique Jericho: That's the bare minimum.

Ms. Kirsty Duncan: The bare minimum, I've underlined it. Thank you.

We hear repeatedly that people land on a different planet. They land in this world they don't know anything about. Families try desperately to navigate the system. Would navigators help?

Dr. Monique Jericho: Do you mean navigators who exist to point people in the right direction? Meaning someone that would be affiliated with primary care—

Ms. Kirsty Duncan: Yes.

Dr. Monique Jericho: —who could then direct folks? We have a system presently here called Access Mental Health and they are a centralized triaging resource. So my experience with them is that they have been quite helpful because they are a resource that physicians can access by telephone and they're also a resource that individuals can access without the need for the interface through a physician.

Ms. Kirsty Duncan: Does that exist across the country?

Dr. Monique Jericho: I don't believe it does across the board.

Ms. Kirsty Duncan: Thank you.

I have two last questions. We hear over and over about timely, appropriate treatment and we've also heard people talk about a national research program, but we haven't had that elaborated on. What are the appropriate wait times, and what research program are you looking for?

Dr. Monique Jericho: I can speak to the treatment piece and say that appropriate treatment, again, starts with the diagnosis. Once you get a diagnosis then what we can do is to start providing at least the bare minimum of maintaining medical stability and preventing further deterioration.

The question you're asking me is difficult because once we get into these specialized treatment centres...and I can say the bare minimum ought to be family-based approaches for young people, cognitive behavioural therapy plus DBT for folks with bulimia. Then it starts to piece out, because again, not one size fits all. But these are the evidence-based themes that we need to continue to keep moving forward with along with the interventions that are more behavioural in nature around providing food, providing meals, and doing the important nutritional work that needs to happen. So this to me is the bare minimum of an eating disorder program.

But I also have to acknowledge that most people with eating disorders aren't in those programs. So the bare minimum there is they —

The Chair: Thank you.

We may have time for one question from Ms. Young. But one very short question with a brief response because of lack of time.

Thank you.

Ms. Wai Young (Vancouver South, CPC): Thank you very much.

Thank you very much for your insightful testimony.

Since I have a very brief time, I wanted to say that I'm a sociologist. What I wanted to ask all of you is if you can send into us —because this is such a critical issue obviously—anything that you were not able to speak about today because of timing issues. But also I'd be particularly interested in you going a bit deeper, because we talked about ED being a symptom, that it's not the root cause, that there are some psychological issues there.

I'd like you to also give us some context for this in terms of if it's 1.5% of the population—we heard figures the other day of 525,000 people across Canada—these are significant numbers with significant mortality rates as we discussed.

Therefore are these incidents increasing over time? If so what could be some of the broader societal or cultural reasons for this, because you've studied this and you work with it daily? How can we address it? Or what are some recommendations you have on that broader basis so that we're not just treating or addressing the symptoms, but we're also trying to look at the root cause to see if we can address some of that?

● (1730)

The Chair: Thank you very much, Ms. Young.

I would ask the witness to send in the information via the clerk of the committee.

Again, I want to thank you very much for your testimonies. Everybody—

Ms. Joan Crockatt: I wonder if Ms. Young could just add something, just another small comment?

The Chair: It's because the bell is ringing. Maybe you could make your request—

Mr. Terence Young: I have a point of order.

I'd like to move for Ms. Young to finish her time. We have lots of time to get to the vote.

[*Translation*]

The Chair: Do we have unanimous consent?

[*English*]

Mr. Terence Young: She's been sitting patiently for two hours.

Some hon. members: No.

Mr. Terence Young: Okay, we'll remember this. Thank you.

[*Translation*]

The Chair: Ms. Young, you can send your request to the clerk.

Thank you very much for your presentations.

The next meeting will take place here at 3:30 p.m. on Monday, February 24.

The meeting is adjourned.

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