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# Standing Committee on the Status of Women

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**EVIDENCE**

## Monday, March 3, 2014

## Chair

**Ms. Hélène LeBlanc**

# Standing Committee on the Status of Women

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● (1530)

[*Translation*]

**The Chair (Ms. Hélène LeBlanc (LaSalle—Émard, NDP)):** Welcome to the 15th meeting of the Standing Committee on the Status of Women.

I would like to let committee members know that the Minister for the Status of Women will not be able to appear before the committee on Wednesday, March 5 to discuss the supplementary estimates (C).

Also, the main estimates for 2014-2015 were tabled and referred to the committee on February 27th last. You received an email about that today. If committee members agree, I will ask the clerk to invite the Minister for the Status of Women to appear before the committee for at most one hour between now and May 31 2014 to talk about the main estimates for 2014-2015. After she appears her officials will stay for the second hour, and we hope to have the meeting televised. So that is what we intend to do as far as the main estimates are concerned.

Ms. Truppe, you have the floor.

[*English*]

**Mrs. Susan Truppe (London North Centre, CPC):** Where did we get May 31? I don't know if I missed something. I like having a date in there though.

**The Chair:** Yes.

With the agreement of the committee, we will see about her availability. We certainly wouldn't want it to be May 29, let's say. We'll try to make it so she can come either when we come back in March or at the beginning of April.

**Mrs. Susan Truppe:** Okay, so do we want to say then April 30? We can always change it again later if we have to, I suppose.

**The Chair:** It's just to check with the minister on her availability.

**Mrs. Susan Truppe:** I know it's about her availability, but I'm just thinking that a lot of times with this minister, because she's travelling so much, the date may look okay and then she may have to change it. I'm just saying what if we said April 30, and we can always deal with that at that time and then do May 31 if we have to.

**The Chair:** Madame Truppe, I'm not saying to meet her on May 31, but just to give her up to April—

**Mrs. Susan Truppe:** Let's say April 30, the last day of the month. That gives March and April, two months.

[*Translation*]

**The Chair:** Ms. Ashton, you have the floor.

[*English*]

**Ms. Niki Ashton (Churchill, NDP):** I want to make sure we don't have the minister here before the plans and priorities are tabled in the House, so that we have the information we need to get the right questions.

**Mrs. Susan Truppe:** We should maybe coordinate that with the clerk or something.

[*Translation*]

**The Chair:** That's fine.

[*English*]

**Mrs. Susan Truppe:** So it's based on her availability by April 30, and then we'll coordinate that with what Niki Ashton said.

**The Chair:** That's for the plans and priorities. Okay.

[*Translation*]

So it seems we all agree.

I would like to welcome our witnesses. It is our pleasure to welcome Ms. Patricia Lemoine, who is appearing as an individual, and Ms. Valerie Steeves, associate professor at the University of Ottawa. We are also going to speak via videoconference to Ms. Laura Beattie, vice-president of the Families Empowered and Supporting Treatment of Eating Disorders Canada Task Force.

[*English*]

Also, by video conference from Winnipeg, Manitoba, we have Ms. Elaine Stevenson, who is an administrator for Alyssa Stevenson Eating Disorder Memorial Trust.

Welcome to you all. You will each have 10 minutes for your presentation, starting with Madam Lemoine.

**Ms. Patricia Lemoine (As an Individual):** Good afternoon.

First off, I would like to thank you for having invited me to appear before you today in view of this important study. I also want to emphasize how grateful I am that my employer has not only given me permission to attend this panel in person but also strongly encouraged me to do so. This is the perfect example of how it is important and necessary to have support in the workplace to maintain recovery from an eating disorder. As well, it exemplifies that it is possible, as a woman, to have a great career while being an activist in the field of mental health.

It was an illness born in the corners of my mind. It paralyzed me. It affected every aspect of my life and no, it was no bid for attention. For years, I suffered from a mental illness. It was invisible to the naked eye, but believe me, in my mind, it was very, very real. When I say that my eating disorder was invisible, I mean that since I suffered from bulimia and not anorexia—the most common eating disorder that comes to mind when on that topic—I was able to hide my illness very well since I maintained a normal weight. Yes, my BMI fluctuated greatly and at times was over 25, but mostly I looked normal.

I suffered from bulimia as a teen up until around the age of 25, which means it went undiagnosed and untreated for almost a decade. My condition got out of control in 2006, which I will talk about in a few minutes.

Today, I now consider myself recovered from bulimia, though I sometimes still suffer from anxiety—mostly related to food—especially during stressful times. I strongly believe that eating disorder recovery is possible, but I will add to that, that recovery maintenance is an everyday choice.

As a teen the voice in my head told me that I was lazy and fat, that I was not pretty enough, not good enough, not smart enough. Behind closed doors the bingeing and purging began. Later on, as a young adult, the demands of law school made me feel out of control, so I tried to regain power over my life by controlling food intake.

In the fall of 2006, after years of self-harm, and considering I'd had an especially stressful year living on my own, I hit rock bottom. I had lost 40 pounds within eight months and ended up suffering multiple gallbladder attacks. I eventually found myself in the ER in need of surgery to remove my gallbladder. That's when I knew the self-harm had to stop because I had a feeling my habits had something to do with the attacks I suffered from.

My gastroenterologist didn't ask about my eating patterns, didn't ask specific questions, but said that going for many hours without food, for example, and then eating a lot might be a contributing factor to my conditions. I didn't really comment on it. Also, as previously mentioned, I looked normal. I weighed 140 pounds which was considered, again, a normal weight for my height. The people around me though, my family and my friends, had started to comment on the fact that perhaps I was a bit too thin, that I had lost a lot of weight rather quickly, and that I didn't seem very healthy. But then again, many others congratulated me on my recent weight loss. I remember being mainly disappointed that either way I seemed to be failing one side no matter what I looked like.

I also distinctly remember a moment while I was being brought to the OR for laparoscopic gallbladder removal. I had an internal dialogue with myself and what my inner voice told me. I knew that I was at a crossroad. These few minutes for me were life-changing. I knew I was bulimic—probably, I suspect, the way that an addict knows they have a problem—even though I'd never said out loud I had those issues for fear of being labelled.

What I also knew is that I couldn't continue to live like this, if only for the fact that I might not live at all because, as you might know, bulimics can develop life-threatening complications. Quietly, a few minutes before the surgery, I naively almost prayed that the bully in my mind would also be somehow surgically removed during the process. Of course I knew this wasn't going to happen, but I really wished it could have because I didn't know how I would recover, yet I knew that I had to. To say that I felt helpless to my bulimia is an understatement.

In the following months, I sought help, and in therapy I was glad to speak to a professional who understood me and genuinely seemed to care about my well-being.

● (1535)

After a few sessions, though, I realized I unfortunately didn't meet the requirements for covered sessions in the public system since I'd also run out of sessions covered by my insurance. At $125 an hour in private care, the lack of affordable therapy was now an obstacle. There seemed to be no free help available even though I was willing to get help and admit that I had a problem.

Without therapy, a supportive social network was invaluable, but the stigma and the difficulty of talking about my illness got in the way at the start of what I considered to be my recovery. Although I had been in therapy for only a brief time, it had been very productive because I had learned the basics of how to cope with triggers, and I was able to create plans of action when I found myself triggered. Nonetheless, 2006 to 2008 was a very difficult time and I experienced many episodes of self-harm during that time.

What I decided to focus on in those first few weeks and months of recovery was the reasons I had to get better. I trusted that these reasons would guide me and carry me through onto the right path, and I pictured them as a road map to recovery.

It was simple things at first. I wanted recovery because I knew I'd need to be strong enough to finish my law degree and pack up my apartment after graduation. I knew I needed to recover to be a bridesmaid at my friend's wedding and not disappear during the reception in order to purge throughout the event. I knew I needed to recover because I knew I wanted to be free.

In the end it was a strong will to get better, combined with a lot of support and many expensive therapy sessions, which I was eventually able to afford as my career progressed. I didn't always have private insurance.

All of that allows me today, in 2014, to reach the milestone of six years without having given in to my eating disorder and engaged in self-harm.

My diagnosis with a mental illness did not define me. Eating disorders have the highest mortality rate of any psychiatric diagnosis. I am alive in front of you today. I am 32 years old and I am recovered.

When I graduated from law school in 2008 I decided not to write the Quebec bar exam, not to become an attorney, but rather I wanted to become recovered. I didn't see myself pursuing a legal career while recovering. I felt that recovering might be a lifelong process and these two realities seemed incompatible to me.

As many leaders have now said in public in the last few years, I believe there is no health without mental health, and that breaking the silence and opening a dialogue is critical when living with a mental illness—more specifically, an eating disorder in my case.

As part of my ongoing healing and recovery process, I became more active over time in promoting mental health initiatives and eating disorder awareness locally, nationally, and beyond. My goal as an activist with lived experience as an eating disorder survivor is to encourage dialogue to end stigma surrounding mental illness.

As one of my favourite authors Kurt Vonnegut famously once wrote, "You were sick, but now you're well, and there's work to do."

Thank you.

● (1540)

**The Chair:** Thank you very much.

[*Translation*]

I will now give Ms. Steeves the floor for 10 minutes.

[*English*]

**Dr. Valerie Steeves (Associate Professor, University of Ottawa):** Thank you very much.

First I'd like to start by commending the committee for undertaking this study, I think it's incredibly important. I'd also like to commend Ms. Lemoine for her really important testimony before this committee and I really appreciate that you came and shared that with us.

Rather than looking at the individual level effects and consequences for people, I came to this issue from a different angle. I'd like to take some time and look at some of the structural issues that exist in the environment that position girls to be particularly vulnerable to eating disorders and problems with body image. I'm drawing on the findings from a research project that I co-lead with my colleague, professor Jane Bailey at the University of Ottawa, called the eGirls Project. We started the eGirls Project because we wanted to get a sense of how girls perform gender in online spaces.

When we went into this project we expected to find a diversity of different kinds of girl, where online media—because it does remove us one step from the physical world—would create opportunities for greater equality and greater freedom to express girls' authentic sense of self. Our very first foray into this field was stunning. We looked at over 1,500 social media profiles of girls who reported to be between the ages of 15 years old and 22 years old in Ottawa. And we found one monolithic performance of girl. It was a girl who was very ultra thin, very heteronormative, very white, very sexualized, that kind of thing. And we were fascinated by this because we thought that this was perhaps a reflection of the fact that we were looking at publicly available profiles.

So we got funding to sit down and talk with young women from Ontario, from both urban and rural areas, about their experiences online and what they thought of this particular performance of girl. And what we were told is that it is a normal girl online, that they are under an incredible amount of pressure to conform to this hyper thin ideal of feminine beauty that's so unattainable. And as we've thought through the reasons for this, we've come to the conclusion that there's an unintentional consequence that's built right into this combination of online architecture and the commercial agenda behind the sites that girls live on in online spaces. These sites are built around the seamless collection of personal information from the children who inhabit these sites. But it's not just their name and their address, that type of thing. Everything they do, everything they say, everything about their relationships with each other is collected. And all of that information is fed into an algorithm that sorts them for commercial purposes so they can be targeted, not just with ads, but targeted with a new environment to encourage certain kinds of behaviour. And there is research out there—and ours supports this conclusion as well—that suggests that the algorithm is not neutral. That when we are sorting these people, we're sorting them along the same "-isms", the same discriminatory patterns that you see in offline spaces.

I want to give you two quick examples of how this works for the girls we talked to—both were my experiences online actually. Many years ago when I was on a very common early social networking site, I had been on the site reading all of their legal policies. I'd been there for about two weeks, I lived on this site. They knew my IP address as well as I knew their legal terms of use. And then I wanted to register on this site to see what it would be like to be a 16-year-old girl who lives in Vancouver. And I had been on this site and every time I went to the homepage I was surrounded with world news. It was a particular kind of world news, yes, but world news. You know, politics, the issues of the day. I registered as a 16-year-old girl and instantly that news disappeared and I was surrounded with celebrity news, talk of celebrity relationships, and celebrity tips on how to get skinny, ads for surgery so I could become more beautiful. So the algorithm sort just doesn't target young women with advertising, it chains the social environment that they live in to promote certain kinds of being girl.

Another interesting example from my own experience is this. At the same time, I was also on a lot of the anorexia sites online. I had been talking to a number of people about educational initiatives helping girls deal with these kinds of messages and recover from anorexia and bulimia. And one of the best educational sites was supported by ads powered by Google.

● (1545)

When you went to this educational site to learn about your illness and to be given information to help you deal with your illness, it was powered—I kid you not—by ads for plastic surgery and dieting aids. That's the first point.

This environment is changed to privilege and promote a certain kind of femininity that is highly dangerous for young women because it promotes a completely unrealistic expectation around body size and body image. This also has serious consequences for young women, and we have spent the last two or three years talking to a number of them. What we were told over and over again is that this is a highly stressful environment. They're under an incredible amount of pressure to conform. They have to be really skinny. They have to be made up with make up. They have to be sexy—not too sexy, but certainly sexy. All of the girls either said, “Yes, I do the duck face”, which is the sideways shot when you suck in your cheeks and you look like Angelina Jolie, or they laughed about doing it when they were younger. They were very self-reflexive about the fact that this wasn't necessarily very healthy or very pro-social, but at the same time they said, “Hey, it's a good way to look skinny online”. These young women were under incredible pressure to conform to unrealistic images of body size.

There are three stories I want to leave you with.

Here is the first one. Lingerie shots were big with 15-year-olds in the past year. Young girls would put on lingerie; they'd diet like crazy beforehand so they'd be good and skinny; and they'd post these on the Internet. I'd say, “Hey, what's up with that?”, and they'd say, “Well, those girls are confident”. I said, “Okay, what does that mean? What does confidence mean?” They said, “Well, you're confident enough to take off your clothes and pose on the Internet in a lingerie shot. As soon as you post it, you watch that picture like a hawk, and if you don't get 30 “likes” within the first 10 minutes—you know how when you're on Facebook and other social media, you press the “like” button—then you take it off, and it's a disaster, and you're humiliated.” So confidence was displaying a thin, highly sexualized body in online spaces and being “liked” by others. They didn't even see that it was a failure of confidence, because if you're not “liked” by others, you're shamed for it, so you have to get the picture down right away.

When we talked to all these young women, as I said, they told us stories about the stressfulness of this environment, and how difficult it is to be a young girl in today's environment when all these messages around them are telling them to be ultra-thin and to act in particular ways and to perform a very narrow kind of femininity. I do want to stress that this intersects not just with misogyny but also with racism and homophobia and other concerns for equality-seeking groups. When we said, “Where do you think this is coming from?”, many of them would say, “Well, hey, it's media. It's all around us. We are surrounded by it.”

In the second story I wanted to tell you, I was talking to a 15-year-old girl in an urban area in Ontario. We were having this conversation and we were talking about these issues, and I asked her what she does on Facebook. She said, “Girls are under so much pressure on media”. I said, “Okay, so you post pictures on Facebook?”, and she said, “No, I never put pictures of myself on Facebook”. I thought, “I found one. I found a girl who doesn't buy into it. She rejects the whole thing and says, 'I'm not going to do that because it's stupid'”, so I said, “Hey, why don't you put pictures of yourself on Facebook?” She said, “Because I'm fat and I'm ugly and I know it, and I'm not going to let any of those terrible people, those —expletive deleted—kids that I go to school with, tell me I'm fat and ugly. So I say I'm ugly and I don't put my picture up.”

First of all, she is underweight if anything. She's 15. In all the interviews I did, with one exception.... I, at one point, had to reach over to a girl who was crying and say, “But you are beautiful”. She was a beautiful girl, and she was trying so hard to conform to this, and it created so much tension, that instead she just rejected herself completely.

The last story I wanted to tell you—and I'll make it very short because my 10 minutes is just about up—I was talking to a 22-year-old woman, and again I thought this was great, because she was talking about how she uses media to promote a company she had started. She does a lot of crafts so she takes pictures of her crafts and sticks them up on Pinterest. Again I thought, “This is terrific. I've found a kid who has navigated this well”, but she said, “Oh, no, it wasn't always like that. I actually had a lot of trouble with body image”. She began cutting when she was in high school, so I asked her what happened.

● (1550)

She said, “Well, I hit grade 9 and I was desperate to be popular. I did everything: I dieted, I did the makeup, I did the clothes. I did everything I could to fit in with the cool group. One day when I was at school I checked in on Facebook. I was friends with one of the popular girls at school, and she had posted a picture of her and me on her Facebook page.”

Another girl within their group of friends had posted, “We all know why you posted that picture”. She looked at it, and she didn't know, so she went up to the girl who was in the picture with her and asked what this was about. The girl said, “Surely you know”. She responded with, “No, I don't know. What is she talking about and what is everybody on Facebook now seeing about me?” The girl said, “Well, you're fat and you're ugly. You make me look good. That's why I'm friends with you. That's why I put pictures of you up on my Facebook page."

So not only are we making it incredibly difficult for young women to navigate through the social space, we are allowing the commercial mining of the social world that these young women live in. We're also making it really difficult for them to have healthy relationships with each other, where they can support each other as they try to push back against this.

I'll end my comments with that. Thank you very much.

**The Chair:** Thank you very much for a fascinating presentation.

Now, Ms. Beattie, for 10 minutes, please. Thank you.

**Ms. Laura Beattie (Co-chair, Families Empowered and Supporting Treatment of Eating Disorders Canada Task Force):** Good afternoon. Thank you for giving me the opportunity to speak today.

First, I want to acknowledge that families with sons get eating disorders as well. We must not forget our sons. I feel if we make this just about girls and women, we are only perpetuating the stigma and myths attached to this illness.

I can give you my family's story to give you an idea of what happens with successful interventions for anorexia, but I urge you to hear from other families who have children who have had to transition into the adult system, who have sons, who have children younger than 10 when diagnosed, who have been on wait-lists and have been in-patients, and who have children with binge-eating disorder or bulimia.

My daughter is 17 years old this month. She has been in recovery for almost four years. She is a happy, healthy, beautiful teenager, full of life and spark. Her father and I keep an eye out for signs and symptoms that we have educated ourselves to be aware of. We store in the back of our minds that recovery is precious and that relapses can occur. So we watch, ready to step in if necessary and put recovery back on track. We know there are parents of young adults who have successfully helped their children to maintain recovery, and that there are steps we can take to help support our daughter once she is of legal age.

My daughter was 13 when diagnosed with restrictive anorexia nervosa. She was 12 when she fell off her growth trajectory. During her well-child visit her height and weight were plugged into a formula and the result was considered a normal BMI for her age. Research shows that eating disorder signs and symptoms first begin to appear at least two years before diagnosis, when height and weight are plotted on a growth chart. There was also discussion around age-relevant stages of development, but nothing about signs and symptoms of eating disorders.

She never had body image issues. There was no talk of diets or dieting in our house.

We had a series of medical misadventures in our search to find out what to do to help our daughter. I was asked to call the eating disorders clinic intake. A parent would never have to make a self-referral to an oncology clinic if cancer were a suspected diagnosis. We were triaged by an intake worker who asked me questions through the lens of adult eating disorders. Children and adolescents are not small adults.

We were referred back to our family health team to meet with a mental health counsellor. In the meantime, I watched my daughter's health deteriorate...anxious, cold, weak, socially withdrawn, running back and forth through the woods, skating laps for hours on the pond, running up and down the stairs, unable to sit for any length of time, and eating very little. Internally, her brain was shrinking, puberty stalled, growth stopped, her bones were thinning, and her heart rate slowed.

I found the online organization F.E.A.S.T., Families Empowered and Supporting Treatment of Eating Disorders, and its online parent forum, Around the Dinner Table, and discovered that there was evidence-based treatment for adolescents. Most importantly, I learned that our family could help my daughter recover from her eating disorder, and that there was an evidence-based treatment called family-based treatment, or FBT, that was the best shot at recovery for adolescents.

Unsure of where this treatment was available, my husband and I began to re-feed our daughter using the Maudsley method, and I read everything I could get my hands on. I felt supported and encouraged by other parents who were also experiencing the isolation, the blaming, and the lack of adequate and timely treatment and support for families.

I'd like to walk you through re-feeding, what it looks like, and what it takes to work. We did this for five months until my daughter was weight-restored, which is a moving target in someone so young, due to puberty and adolescent growth. Our family focused our life around getting our daughter nutritionally weight-restored. It's a 24/7 job. I resigned from my job, and we made our house into an in-patient unit. My goal was to feed my daughter one bite at a time.

First, I'd like you to imagine your worst fear. You can probably avoid this fear and the anxiety that it creates. We were exposing our daughter to her worst fear, but she could not avoid food or she would die. Our daughter would cry, scream, spit, hit, punch, scratch, and yell that it was too much food, that her stomach hurt, that she wanted to die. Plates of food were thrown. My daughter would fall into a catatonic state. It was like a scene from *The Exorcist*.

Meals could take hours, but food is medicine. We learned to separate the eating disorder from our daughter. Intuitively, you do not want to see your child upset and in pain, but when we're re-feeding, there is no choice. There is no rationalizing with an eating disorder.

This was not forced feeding, and it was not punitive. It was a requirement, using whatever leverage we had. Life stops until you eat. There is no option: food is your medicine. If meals are refused, then plan B is put in place: a trip to emergency for an NG tube feed, or a call to the mobile crisis unit.

● (1555)

I was lucky that I never had to do this. We weathered through the emotional dysregulation, anxiety, and lengthy meal times. From my reading I understood what was happening in the brain. This made it easier for me to exhibit patience. My daughter was exhibiting a typical fight-or-flight response to an anxious situation. From a neurobiological standpoint it made sense.

My son, who is two years older than his sister, would try to offer her distractions of stories and singing at meals. Many times dinner would run until 11 p.m. He would study and sleep with earplugs in. After meals we would sit with her to prevent her from compulsively exercising and standing and distracting her from the physical discomfort she felt. We needed to close the loopholes around the illness. I slept in my daughter's room for five months because she was frightened and I had to monitor for any nighttime compulsive exercising. I monitored her computer use to make sure she was not accessing pro-ana sites and that she was not discussing suicide. We listened outside the bathroom to make sure she didn't purge or exercise. We barricaded our loft so that it wasn't a safety risk, we hid the knives and medications. We turned the TV off to avoid content that could be triggering and upsetting to all of us. When she would run out into the snow in her bare feet to avoid a meal my husband, son, and I would have to chase her, bringing her back kicking and screaming. In early days, I shadowed her 24/7 and she hated it.

Due to exercise restriction I drove my daughter to and from school, and then I drove back to the school twice a day to sit with her during two nutrition breaks. She was not allowed to be in gym class or participate in any of the extracurricular sports that she loved. I looked through the course curriculum for her grade to make sure there was no information within the curriculum that could be triggering, and that she could not participate in. Ironically, she had just finished the unit on eating disorders.

● (1600)

A few weeks into re-feeding, our GP referred us to a pediatrician and adolescent psychiatrist. Neither knew much about the Maudsley method of re-feeding or family-based treatment and how it worked. Our pediatrician told me it was too hard, that I should return to work and give my daughter age-appropriate independence around food preparation and eating. This was fundamentally inaccurate and dangerous advice.

The pediatrician referred us to a child psychologist to make our daughter feel better about herself. The psychologist said that she would always have anorexia, but was unaware of family-based treatment and that eating disorders are fully treatable. What a waste of time and money, and how crushing for my 13-year-old daughter to hear.

We finally entered the FBT adolescent eating disorders program in my hometown three weeks after re-feeding began. We had already begun to see results. Our daughter was smiling and less withdrawn at school. She began to sing again. Over the next five months, with support from FBT, and then participating in a year-long, multi-family treatment program, we managed to get my daughter's weight restored and into recovery.

With food and time, the exercise compulsion stopped. The OCD-like movements decreased. She socialized and she began to enjoy food again. I almost cried when she told me how good a meal tasted. Family mealtimes were no longer violent or unenjoyable.

But this is not a sprint; it's a marathon of vigilance. It takes days and months and years of chasing growth through puberty and adolescence. It's about the dance of figuring out when and how much control over food choices to slowly give back to your child. It's about not letting your child sleep in like other teens because they must eat regularly. It's about figuring out what courses your child cannot take in school, such as personal fitness, nutrition, or physical education, if they are still at a vulnerable stage in their recovery.

It's about educating teachers to make sure your child is allowed to eat in class to maintain regular nutrition. It's about figuring out whether your child is at a stage in recovery where he or she can participate in class trips and summer camp, and educating these institutions to see if modifications can be put in place to support recovery and give your child a sense of normalcy and accomplishment at the same time.

Imagine trying to do all this as a single, self-employed parent; if your other children are very young or have their own special needs; if you have to provide eldercare as well; or if you have your own health concerns. What if your child is physically larger than you?

Comorbid conditions like ADHD, OCD, depression, or substance abuse must be addressed as well.

Imagine reading about FBT in Saskatchewan or P.E.I. or Quebec, and realizing that you have no way of accessing this therapy that has the best treatment outcomes. What if your child has had to be hospitalized, and then after discharge you are placed on a wait-list for a program and you helplessly watch your child begin to slip back into the illness because you need support? Or what if you have a child who is over 18 and your family wants to use FBT, but the centre where you live will only see your child individually as an adult? What about those families for whom FBT doesn't work?

I suffered from depression and post-traumatic stress after re-feeding our daughter. Our now 19-year-old son became depressed due to the stress and trauma of his family putting all their energy and attention into dealing with the eating disorder. My daughter felt shame and guilt for putting her family through this ordeal despite our reassurances that nobody was to blame. She will sometimes have flashbacks of the trauma of re-feeding. They are not accurate, but they are there.

This has not been an easy road and we are not finished. We need to make sure that when our daughter leaves home she has a tool kit for recovery and resilience. When your child becomes ill with an eating disorder at a young age and you have been the safety net to prevent relapse, it is very easy to be lulled into thinking that a child has recovered and there won't be a relapse. We must be cautiously vigilant yet allow our children to live in the real, unfiltered world.

Thank you.

● (1605)

[*Translation*]

**The Chair:** Thank you very much.

I will now give the floor to Ms. Stevenson for 10 minutes.

[*English*]

**Ms. Elaine Stevenson (Co-Administrator, Alyssa Stevenson Eating Disorder Memorial Trust):** Madam Chair and committee members, thank you for the opportunity to present to you on eating disorders. I feel fortunate to have worked in partnership with many of the people who have previously presented to this committee on Canadian eating disorder services advocacy.

I would like to share with you my personal observations on the harmful effects that eating disorders can have on your child, your entire family, and society in general.

I will provide a list of recommendations concerning a number of urgently needed eating disorder services. This list has been formed over the 24 years that I have been involved as an advocate for those suffering from eating disorders. I have had the privilege of meeting many family members and their children suffering from eating disorders from across Canada. I have met many of them at conferences where I have spoken, provincially, nationally, and internationally, and at community forums for clinicians, and I have often lectured to fourth-year mental health nurses.

Eating disorders are cloaked in the three S's: shame, secrecy, and silence. This condition is made worse by its debilitating, deteriorating, and potentially deadly effect on those who suffer. Eating disorders affect those from many cultures and socio-economic backgrounds. I am alarmed, but sadly not surprised, by the intensive research results here in Canada by Dr. Leora Pinhas that indicate that children as young as five years of age are developing eating disorders.

Anorexia has the highest mortality rate of any psychiatric illness. It is estimated that 10% of the individuals with anorexia will die within 10 years of the onset of the eating disorder.

On August 27—I have a picture of our daughter Alyssa—our family's lives changed forever. Our daughter Alyssa passed away at 24 years of age after a 12-year battle with her eating disorder. Alyssa's eating disorder and her death continue today to have serious consequences for our family. Countless other families all across Canada also continue to feel the effects of losing a family member to an eating disorder.

I am very saddened that today, after 24 years as an advocate, we still have many families desperately searching for timely, specialized eating disorder programming for their children. Long waiting lists exist from as much as six months to a year and a half for many who suffer. As you have already heard from Dr. Woodside, early specialized eating disorder treatment intervention, as with many other illnesses, is often one of the most important keys to a successful recovery.

The situation is often worse for many who live in rural and northern communities. Mental health workers in these areas service several communities spread out over a wide area and often do not have expertise in treating eating disorders. Critical eating disorder services are often only offered in large urban cities. It is extremely difficult for many to leave their homes and family for intensive eating disorder treatment in a city where they know nobody and often feel isolated and depressed. Parents often can't leave their jobs to provide emotional support during their child's treatment. Some clients leave treatment early due to loneliness and isolation from their families.

Many times families know instinctively that their child is in extreme physical, mental, and emotional danger. Their child can't wait for treatment, and they will search frantically for specialized private eating disorder therapists or programs, or will send their child out of province and even out of country for treatment. Many parents also have to pick up living expenses for their children, as many who suffer from eating disorders are unable to work.

As parents, we had no choice but to seek private therapy for Alyssa. At $120 an hour—now this is back in the 1990s; it's up to about $150 or $160 now—three times a week for three-hour sessions for almost 12 years, therapy financially impacted our whole family.

I am outraged that the issue of long waiting lists for urgently needed eating disorder treatment still occurs across our country. To me, there is something inherently wrong with a public health care system that often only becomes available when someone is on death's door.

● (1610)

We would never think of making patients suffering from cancer, diabetes, or heart disease wait that long for urgent treatment. Yet, eating disorders can be just as deadly, as many suffer continually from electrolyte imbalances that can lead to cardiac arrest, kidney failure, and even death. We're talking about saving people's lives here, improving their quality of life, and helping them to begin treatment to feel well again.

Under Canada's Health Act, two of the five principles, universality and accessibility, indicate that all insured residents are entitled to the same level of health care and all insured persons have reasonable access to health care facilities. These principles do not exist for many suffering from eating disorders all across Canada.

In addition, many eating disorder clients also have co-occurring illnesses, such as obsessive compulsive disorder, anxiety disorder, severe depression, early onset of osteoporosis, severe dental problems, and drug addiction. They often engage in self-harm, such as burning, cutting, and even attempting or succeeding at suicide.

In the case of drug addiction, sometimes as parents we feel caught in the middle as many service providers will not take your child into treatment until the drug addiction or eating disorder is cured first. Both are dangerous health issues and I feel strongly that more programs need to be created that can treat concurrent illnesses at the same time.

As a society we also need to take a critical look at negative media messaging, often fuelled by the very powerful multi-billion dollar diet industry that consistently bombards us with the promise that being thin will bring you great health, happiness, sexiness, and acceptance by society. The pursuit of perfection and unachievable societal standards of beauty are causing irreparable physical, mental, emotional, spiritual damage, and even death.

As a parent and advocate I am often troubled by the fact that many doctors do not know or do not have much training in the treatment of eating disorders. I ask myself, “Why are many doctors often assessing only a person's body mass index to determine their overall health and whether there is a presence of an eating disorder?” Especially when the World Health Organization, in 1946, defined health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.

Consistent with this definition, interventions aimed at addressing any health concerns should be constructed from a holistic perspective, where equal consideration is given to social, mental, emotional, and physical aspects of health. To me one of the most serious omissions is that, provincially and federally, governments across our country are not tracking the incidence with which this deadly illness occurs. Experts that have already testified before you estimate that over a half a million Canadians suffer from eating disorders.

I believe that death statistics from eating disorders are not properly recorded. Often, the cause of death is listed as cardiac or kidney failure, and the contributing cause of death is listed as bulimia, anorexia, or often it's not even filled out. I know without a doubt that Alyssa's 12-year battle with an eating disorder was the cause of her death and the contributing cause to her death was cardiac pulmonary embolism, brought on directly by her eating disorder.

Dr. Blake Woodside testified that:

> About 60% of my patients have chronic complex post-traumatic stress disorder. They've been sexually or physically abused. They will work for eight or ten years to recover from that...

Our daughter was sexually abused on several occasions and it wasn't until after her death that we as parents were able to find out the specific details of what had happened to her as she had declared the sexual abuse as an adult to her doctor and therapist. I feel strongly that, had we known the specific details, we may have had an opportunity to have brought closure to Alyssa on what happened and had an opportunity to support her in any criminal charges should she wished to have laid them, and maybe, yes maybe, even had a chance to save her life.

I believed with everything in my heart that we could have saved Alyssa from what she referred to as the monster within. But we were wrong. We can't bring Alyssa and all the others back who have died from eating disorders in Canada and indeed around the world.

● (1615)

The establishment of your status of women committee on eating disorders has given me so much hope that we can work together in partnership to save lives from this horrible and lethal illness. While there has been progress in eating disorder treatment over my 24 years as an advocate, it has been at a very slow and painful pace for those who suffer and their families.

Now I know I don’t have time to read all my recommendations—and I hope those have been forwarded to the committee already—but there’s one I must read: emergency and ICU training. We must ensure intensive training is required for clinicians who treat gravely ill eating disorder clients. They must have ongoing training to keep up to date on best practices and changes in treatment delivery. I believe, from our daughter's experience, that it is critical that all ICU staff be educated about re-nourishment and re-feeding syndrome and the essential need to re-nourish clients very, very slowly and monitor very closely to avoid electrolyte imbalances, seizures, cardiac arrhythmia, and even death.

In addition, we must look at different therapies to provide treatment for those who have suffered from post-traumatic stress disorder and abuse—verbal, physical, emotional, and sexual.

**The Chair:** Thank you very much, Mrs. Stevenson. Indeed, we thank you very much for writing the recommendations that you have passed on. We'll have them translated and distributed to all the committee members.

Thank you very much for the four very, very good testimonies.

We will start with the questions.

Mrs. Truppe, for seven minutes.

**Mrs. Susan Truppe:** Thank you, Madam Chair.

I'd like to welcome and thank each of you for your very personal testimony. I know it was probably hard for many of you who experienced it personally, so I just want to take a moment to thank you. I'm sure all of us here really appreciate that and know the difficulty that you had.

I'll start with Madame Lemoine.

Thank you, certainly, for your story. It's nice when we can talk to someone who has experienced it and can give us ideas that may help at the end of this study.

Just so I'm understanding, I think you said you had it from being a teen to 25, and then you lost 40 pounds and you had to go in for surgery for your gallbladder.

**Ms. Patricia Lemoine:** Right, that's correct.

**Mrs. Susan Truppe:** When did you know it was wrong? Did you know it was wrong during that teen to 25, that whole time? Did anyone diagnose that, or did you have to figure this out on your own?

**Ms. Patricia Lemoine:** I think I knew something was wrong, but as it was mentioned by others, there's so much dialogue as a teen in school and with your friends about appearances and looks that it seemed like we were kind of all obsessed a little bit with our bodies. I did ballet also, not that it's not a great activity, but in my case it probably didn't help. You had to fit and look a certain way.

I think that I knew there was a problem, but I didn't quite know what it was. I just knew that I was always in a place of in-between, of never really being happy with the way I looked. If I would lose weight, then some people would say that I looked too thin, and then if I was a more normal weight, then I would be told, "Well, you have such a pretty face, you should really lose 10 pounds".

**Mrs. Susan Truppe:** What age were you, then, when you finally knew that you had it and you tried to get help? Or did someone suggest you get help?

**Ms. Patricia Lemoine:** I think while I was suffering gallbladder attacks. I went three times to the emergency room before they actually decided that they should really remove it, because it was threatening my pancreas. That's when I knew there was a serious problem, but I think I was so scared of talking about it with my parents. I lived on my own, so I could pretty much do whatever I wanted. I didn't really want to talk about it either because I was afraid that people would say that I was shallow, that I was superficial. The stigma, I think, was a big problem. But I knew something was wrong; I didn't quite know what it was.

● (1620)

**Mrs. Susan Truppe:** So you were in your twenties, then?

**Ms. Patricia Lemoine:** Yes, early twenties.

**Mrs. Susan Truppe:** What help did you get, then? You approached someone? You had the gallbladder operation, or you went in for the third time. Did you finally say to someone, maybe not your parents, but maybe someone at the hospital...? Was there an awareness that you could look for some type of treatment, or did you ask yourself what you could do?

**Ms. Patricia Lemoine:** I was so distressed while I was recovering from the gallbladder surgery, and I was able to speak to the psychiatric nurse at the hospital but they wouldn't let me see a psychiatrist because they said my case wasn't important enough. I'm sure that's not what they meant, but that was probably not the right thing to say to someone like me at the time. So they agreed to have me see a psychiatric nurse. I think it was for about 12 or 15 sessions I was allowed to see her, so every week.

They had initially put me on Effexor XR, which is to treat anxiety, and my anxiety was really just related to food because I was constantly thinking what I should be eating or not eating. It was constant additions and subtractions in my mind as to what level I should be eating of anything.

I took Effexor for about six months, but I think the physical side effects were so awful I decided I did not want to be on the medication so I stopped. After that I found out I wasn't allowed to have covered sessions, and I would have to go into private care. I did a few, but then it was so expensive it was not affordable.

**Mrs. Susan Truppe:** You have done a great job. It seems like you did a lot of this on your own almost without support—

**Ms. Patricia Lemoine:** Yes.

**Mrs. Susan Truppe:** —so kudos to you.

If you could offer one practice that worked for you during this whole time whatever or whenever it was, what would you say? If you had a best practice that you thought really worked, and maybe for someone else who has to do this on their own it would help, what would you suggest? Or do you have a suggestion?

**Ms. Patricia Lemoine:** I would say the people in your life should be people who support you. If you find your friends or some family members are speaking to you about your weight, or about your body, or anything really in your life that is detrimental to your development, then you should really cut them out of your life because you will not get better if your inner voice and your inner dialogue is positive, but the people around you are constantly second-guessing what you're doing.

I would say to get the proper support around you if you can't find professional help.

**Mrs. Susan Truppe:** Thank you, and I have one final question for you.

Do you feel there is more awareness now than when you were going through all this?

**Ms. Patricia Lemoine:** I think people discuss it more, but I think to be honest with you I find in my experience no one really talks about bulimia, about that kind of eating disorder, because a lot of people find it's really disgusting to make yourself throw up, etc.

I see personally a lot of awareness about anorexia, but especially bulimia, no. I don't think a lot has evolved.

**Mrs. Susan Truppe:** Ms. Stevenson, I have a question for you, and I'm very sorry for the loss of your daughter, Alyssa. Thank you for sharing that.

Just so I'm understanding, it was a 12-year battle, and it also sounds like you didn't get any help from anyone either. It almost seems like you had to do almost everything yourself too up to a certain point.

What kind of help did you get?

**Ms. Elaine Stevenson:** Absolutely nothing. Back in 1990 when Alyssa was diagnosed, there were no adolescent eating disorder treatment programs in Manitoba. When I started to become an advocate, that was the first thing we really worked hard to do. We opened the first adolescent day treatment eating disorder program in Manitoba in partnership with the government on May 8, 2001.

I was very happy to work on that. But none of that benefited Alyssa because at the time that opened she was then an adult so we had to go the private therapy route for Alyssa. We had absolutely no choice.

**Mrs. Susan Truppe:** Ms. Beattie.... Do I have one minute or am I done? It's a fast seven minutes. Sorry.

**The Chair:** Thank you for your cooperation.

[*Translation*]

Ms. Ashton, you have seven minutes.

[*English*]

**Ms. Niki Ashton:** Thank you very much. I'd like to thank all of the witnesses who joined us today. You gave us some very powerful and very personal testimony, and I really thank you for opening up like that.

We've heard from many people, especially from the clinical perspective, which is obviously extremely important, but there's no question your testimony today will help us tremendously in guiding our work and in sharing experiences others might relate to.

I want to thank Ms. Beattie and Ms. Stevenson for sharing your personal stories but also your advocacy with us.

I'll be directing my questions here to Ms. Lemoine and Ms. Steeves.

Ms. Lemoine, thank you very much for sharing your experience. I believe you're actually perhaps the only person who has self-disclosed having lived with an eating disorder, so that's extremely courageous. Thank you very much for doing that.

I understand you also have a blog where you have talked about some of what you have gone through. I'm wondering what your experience has been in people reaching out to you and asking for help. What are the most common things you're hearing? Do you hear from people as well—you spoke about the financial burden—who are struggling financially to be able to get the care they need? What are they saying? What are you hearing?

● (1625)

**Ms. Patricia Lemoine:** I co-authored the surviving eating disorder blog on America's mental health channel, HealthyPlace.com out of Texas, so I do write a biweekly column. Most of the comments that my co-author Jessica and I get are from women who will write to us and ask, “How did you recover? How can you actually get to a place where you feel comfortable living every day and it's not a daily struggle?” So it's mostly that, and mostly women who are starting to recover and they feel triggered. They want to know how to get over that hump, or ways to stop the triggers or to manage them. Very often also what I tell them is that this all seems like it's easy because I'm here today and it worked out, but there was a daily struggle leading up to that point. Also, I have days when I'm not feeling so good.

What we're asked is basically everyday questions in terms of, “Can you actually do it? Can you actually recover and it won't consume your whole life?”

It's mostly encouraging comments. Sometimes we get distressing ones, but mostly it's actually very positive and it helps me to stay recovered, giving peer support.

**Ms. Niki Ashton:** That's great to hear. Thank you.

Ms. Steeves, I also want to thank you for the analysis you brought forward today.

We heard again from clinicians and experts in this area and many of them have talked about the bias that people with eating disorders face as a result of the fact that it's largely a feminized experience. You spoke about the patriarchal system that bombards young women with an unachievable body image. I wonder if you could share with the committee how much profit is being made or the size of the corporate interests that make money off young women.

**Dr. Valerie Steeves:** That's a really good question, actually.

Mrs. Stevenson mentioned the diet industry, and it is a multi-billion dollar industry, and I completely concur that's part of the puzzle.

This is wrapped up, I'd say, in a particular consumer understanding of youth and adolescence, so I think you have to put this in the context of the entertainment industry, put it in the context of the clothing industry or the makeup industry.

Through my lifetime I've seen a real shift. Adolescents were kind of off limits. Certainly, children were off limits for marketers when I was a girl. We've seen that market open up, so I think this is actually quite central to consumerism as a whole. I think this is one of the strategies that is becoming more and more common in the private sector, to collect detailed information about individuals and use that information to shift their social environment and encourage certain kinds of consumption.

I can't put a dollar figure on that. One of the things we'd like to do as a follow-up to the eGirls Project is to look at what's called behavioural advertising, and to get a much better understanding of how these algorithms work and the kinds of interventions that the private sector makes in order to encourage certain kinds of consumption, and that type of thing.

**Ms. Niki Ashton:** As a follow up—and I know you talked a bit about this in your presentation—I wonder if you could let us know if the federal government can implement policy and regulations that could curtail the media's ability to prey on young girls. I'm thinking in terms of privacy legislation in that area.

● (1630)

**Dr. Valerie Steeves:** I have two recommendations or there are two areas that might be interesting to examine. The first one is in regard to privacy legislation. The Personal Information Protection and Electronic Documents Act, our private sector privacy legislation, has a reasonable purposes section that says that organizations can collect information and use it for purposes that a reasonable person would consider appropriate in the circumstances.

The Privacy Commissioner's office has on occasion implemented a particular interpretation of this section to limit advertising to children. I would suggest that there's a lot of room to examine whether or not the use of this information in this way is appropriate. I would certainly make the argument that reasonable people would see that it was inappropriate because of the cost attached to it.

I think that's one avenue that would really be worth thinking critically about.

The other is consumer practices as a whole, or advertising. Unfair marketing practices are certainly under the purview of the federal government. I understand it's a difficult road to walk, because you are balancing censorship and freedom of speech and all these other kinds of issues. At the same time, children are recognized as a vulnerable population in society and are often given greater protection because of that. Certainly Quebec has limited advertising towards children within the Civil Code system. France has taken the lead in Europe by suggesting that the size of models in media, whether it's magazines, TV, or movies, should be regulated.

So I think there are things we can do to push back against this. It's kind of similar to rape culture to a certain extent. Things are kind of spinning out of control.

I have four daughters and a son. My youngest daughter is 16. She was talking about “thigh gap” and she said that thigh gap is all anyone is talking about in high school now. She's naturally thin and slender and she said people were walking up and saying, if you have thigh gap, “I hate you because you have a thigh gap”. If you don't have thigh gap then you're fat and ugly. Those discussions don't come out of anywhere. I think that's the thing that really strikes me.

Ms. Lemoine was talking about “the voice in my head” and “the bully in my mind”. We've talked about media stereotypes and about triggers. I would suggest that young people as a whole are under incredible pressure because of these kinds of media messages. Girls in particular are vulnerable to it for all sorts of reasons although I agree that some young men are too.

**The Chair:** Thank you very much, Ms. Steeves.

It's very interesting indeed, but we have to move on to the next questioner.

Mrs. O'Neill Gordon, go ahead, please.

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

First of all I want to thank all of you for taking time to be with us today. Through our study we certainly have learned and have gained a very interesting awareness of what eating disorders really mean and how there are people out there in our community we need to reach out to and provide with the necessary information that is out there for them.

My first question is for Patricia Lemoine.

First of all I want to thank you for taking the time to share your personal experience and thank you for being here with all of us.

As we were saying, some attitudes of course are changing a bit. As you mentioned, it was great to know that your boss could also see the need for you to be here. Right off the bat, I thought that a few years ago the attitude was probably that you wouldn't have felt like talking about it. So it's nice to see that attitude is out there now.

This has been a very important study and one that we're all learning much from. No doubt attitudes have changed, but, in your experience as advocate, what types of awareness around eating disorders would you say are still needed out there? How would you like to see that created?

**Ms. Patricia Lemoine:** I think I did not have such a great experience with the medical community. Most of the doctors that I saw throughout the years didn't have such good bedside manner in terms of talking about a woman's body. I think that for me would be fundamental, because if you go to get help and you speak to someone, you would think that a medical professional would actually be nice and compassionate about this, but then you find yourself in a dialogue that is actually very negative that surrounds dieting and what you should do and negative body talk. I think that might prevent you from actually speaking and getting more help. I would really encourage more—I don't know if it would be training, because I think a lot of it is maybe the personality trait of not being sensitive. I think maybe someone could learn to be sensitive, so I would really focus on the medical community.

● (1635)

**Mrs. Tilly O'Neill Gordon:** You're saying focus on the medical communities, how they express...and deal with the patient.

**Ms. Patricia Lemoine:** I think that's a big need, yes.

**Mrs. Tilly O'Neill Gordon:** They too need to learn a lot more about it. When you look at eating disorders, it's not just not the ordinary person, it's all of us who really need to tune in a little more than what we have.

My next question is for Elaine Stevenson. First of all, I want to say I look forward to seeing the recommendations you have sent, because you certainly have had a lot of experience to pass on to all of us. And though the day doesn't allow the time, we look forward to seeing what you have to offer us in suggestions for our recommendations.

With your particular experience, could you tell us about resources that exist to help a family who is suffering from this in terms of support for victims of eating disorders?

I'll go with that question first. What are some of the experiences out there?

**Ms. Elaine Stevenson:** First of all, one of the most, I think, incredibly wonderful resources is offered by the National Eating Disorder Information Centre. Merryl Bear, the executive director, was one of the presenters before your committee. As a family member I travelled years and years ago to NEDIC in Ontario to, quite bluntly, ask Merryl if she could help me save my daughter's life.

A lot of eating disorder programs will concurrently run support programs for families of children who have eating disorders and are in treatment. And that's the real problem. It's okay for the families to go to those support programs because they have a child in treatment in one of the tertiary care hospitals or community-based eating disorder programs. But often there's a caveat, and unless you have a child in treatment, you can't go there for family support. So for seven years I was vice-president of the Eating Disorders Association of Manitoba. We helped with others to organize a support group for families, because there was an urgent and desperate need for it, and that urgent and desperate need exists consistently across our country.

**Mrs. Tilly O'Neill Gordon:** Thank you.

My next question is for Valerie Steeves.

I noticed that you said girls are under much pressure to have a certain look, and we certainly see that every day, especially in the media, as you said. The environment has changed and has caused a lot of pressure on girls. In academia, do you know if there is any research or a community of experts who study eating disorders to give that extra help that's needed?

**Dr. Valerie Steeves:** The literature that I'm familiar with is more within the communications and sociological disciplines, and it focuses more on body image. But there is quite a bit of work that's been done on body image, both within the community as a whole and in online media and other forms of media. I'd be happy to provide some references to that literature if that would support the committee's work.

**Mrs. Tilly O'Neill Gordon:** I was mentioning this to another bunch of witnesses the other day, that after having a study ongoing here on our committee, I noticed that in a new catalogue that came out there were some bathing suits on people who were not really skinny; they were wearing them and showing off these bathing suits. So I thought, well, maybe we are...some people out there must be listening and hearing how bad it really is.

**Dr. Valerie Steeves:** Yes. There are best practices. Dove actually has taken the lead as a corporate player and has come up with some really interesting advertising.

A magazine in Australia tried to implement that with regular-sized bodies, and their advertisers all pulled and they had to pull the magazine. Women loved it, girls loved it, it got tons of positive feedback, but the advertisers pulled their support from the magazine, so they went back to the regular ones.

But there are best practices, I agree, and we should identify them and encourage them.

**Mrs. Tilly O'Neill Gordon:** Yes. It's tough out there for the girls.

● (1640)

**The Chair:** You have 15 seconds.

**Mrs. Tilly O'Neill Gordon:** I was just going to ask...well, forget it, I guess. My 15 seconds are done. That's okay.

**The Chair:** Thank you very much for your understanding.

[*Translation*]

Ms. St-Denis, you have seven minutes.

**Ms. Lise St-Denis (Saint-Maurice—Champlain, Lib.):** I will come back on something my colleague said about what measures the federal government could take. We know that some parts of health care fall under provincial jurisdiction and that the federal government cannot infringe on provincial jurisdiction.

Did you think about what you could ask the federal government to do so that the situations which have been described can be improved? For example, Ms. Steeves, you talked about the media. Communications could fall under federal jurisdiction. Do you have any specific requests of the federal government, as this is an area under federal jurisdiction?

[*English*]

**Dr. Valerie Steeves:** The Competition Bureau is beginning a preliminary examination of behavioural targeting and of the marketing model that drives a lot of this kind of advertising. They've been looking at children's privacy and the impact on children. As an unfair trade practice, there is space there to examine it.

In addition, I think it might be worthwhile to think about some kind of regulatory framework or legislation that might set some standards for body images in advertising. I think that would be amazing, because you're right; when we look at the Dove ads and we see regular girls or regular women up there, it's like “Whoa!”

If we could change the visual environment that children live in, it might actually have an impact. I would suggest you consider that as a possibility as well.

[*Translation*]

**Ms. Lise St-Denis:** Thank you.

I would like to come back to what Ms. Beattie said. I am asking the question because it is very important that the matter be included in the report. We have to take this into account.

You said that it is important for us to recognize that eating disorders are mental health problems. That is not sufficiently recognized.

Have you ever thought of proposing programs about that? In fact, mental health is an important issue here. The federal government has created some specific programs to address that type of issue. Have you thought about that?

Ms. Stevenson, do you think that this idea could hold some promise?

[*English*]

**Ms. Elaine Stevenson:** I thought the question was for Laura. It was for me?

[*Translation*]

**Ms. Lise St-Denis:** Do you think that we could ask the government to create this type of program?

[*English*]

**Ms. Elaine Stevenson:** Yes. I think we need to provide programming that educates the general public, doctors, physicians, and any clinicians dealing with the treatment of eating disorders and mental health on these illnesses. I am amazed and sometimes extremely frustrated by the number of people who you'd think would know more about eating disorders and actually don't.

I was at a health conference a few years back, and a doctor came back to look at our display on eating disorders. He told me that boys didn't have eating disorders. I looked at him and said, “Of course they do”, but he absolutely insisted that it was only a female illness, that boys did not have it. So we really need to take a look at education.

You had a previous question on what the federal government can do. They can legislate with regard to the harmful media advertising to young children that is totally unacceptable. They should go after the diet industry. You see these full-page ads saying, “Boy, if you diet like this, you'll be smarter and richer.”

By the way, this full-page article that was printed in the *Winnipeg Free Press* was written by a diet company. You will find nowhere on this page that it was written by a diet company.

We need to take a serious look at the diet industry. We as individuals, parents, support groups, and clinicians need to be working closely with the media on how we can reduce harmful advertising and how we can enrich programming to those people who urgently need it, including their families.

● (1645)

[*Translation*]

**Ms. Lise St-Denis:** Ms. Beattie, what, in your opinion, lies at the root of eating disorders?

[*English*]

**Ms. Laura Beattie:** We don't know what the causes are. I think we can't have primary prevention until we know. There's genetic vulnerability, the environment, a whole host of things that interact and from all my reading we don't know exactly what causes them. I know research is going on in other countries. It's called the Anorexia Nervosa Genetics Initiative, ANGI, study—Canada is not part of it—to see the genetic components so we can come up with treatments.

When I think about cause I think we need to tease out body image and eating disorders awareness from the actual mental illness of eating disorders. Because when we talk about awareness of eating disorders, we seem to focus on body image; you don't see that in children a lot. You won't see the same type of body image issues or the symptoms and behaviours of a teenage girl or a young woman that you would in a man. They may express it differently. When these people have eating disorders, these young girls and women, they're expressing how fat they are or they hate the way they look. Those are symptoms, and they're behaviours. They're not causes of eating disorders.

I think there is a lot of new neuroscientific research, and they're starting to tease out that we need to focus upstream on our research and not just look at the behaviours and the symptoms, because those aren't the causes. We need to look backwards and find out exactly what is causing them, because right now we don't know. We know there's a whole host of things at play, but in children they look different than in young adults, in young women and in young men, they all look different.

Yes, the environment does play a role, I agree, but there's so much more than just the environment.

**The Chair:** Thank you very much, Mrs. Beattie.

[*Translation*]

I will now give the floor to Ms. Crockatt for five minutes.

[*English*]

**Ms. Joan Crockatt (Calgary Centre, CPC):** Thank you very much and I want to add my thanks to all our witnesses today. I think this has been emotional as well as eye-opening.

Elaine Stevenson, first of all, I feel your frustration at probably having been one of the first in this group to go through all this and I admire your tenacity. I imagine you're doing this in remembrance of your daughter and I admire you for that, so thank you.

I also wanted to say to Patricia and to Laura that I think we should take these testimonies that we've heard from the three of you directly—Valerie, yours is fascinating too, but I'm just talking about the first person—and print them verbatim and put them up on websites so people can see what a real person affected by these disorders goes through, because I think that has been the most eye-opening to me. It's very interesting to hear the medical people who've studied it, but these are young girls and it's you who are going to get through to them.

I was particularly struck too, Patricia, hearing you talk about how part of your recovery has been the work that you do, role modelling and counselling. I'm wondering if that is maybe a very important best practice that we've heard here today. Can you talk about that?

**Ms. Patricia Lemoine:** I think it's really important for men and women to see that you can recover and what the recovery looks like. I will often write on the blog and I also do video blogs and I talk about the fact that I'm a normal person. I'm an average girl. I grew up in an average family and had an average upbringing. Very often with eating disorders, it's said to be a white girl's problem and whenever I hear that I think, my God, we have so much to do, because it doesn't discriminate and anyone can be affected by it and everyone—

**Ms. Joan Crockatt:** Can I take it in a bit of a different direction? My time's short, sorry.

I'm wondering about the part of this that is helping you stay cured, which is the modelling. What I'm thinking we've heard is about sexual abuse and I want to ask a question about that, but also that there's a pursuit of perfection here. You managed to get yourself turned around. You're obviously a strong-willed individual. Probably most of these people, boys and girls who are affected, are strong willed. I'm wondering if part of self-actualizing and staying cured that we've heard—it's just a theory and you can tell me if you agree or not—but is your helping others turning that into an empowerment? So more on your personal recovery, is that a best practice we should include in our report?

● (1650)

**Ms. Patricia Lemoine:** I think it should be included, because I think it really starts with you and what you can do to take control of your life and ensure that the disease doesn't control you. It's an internal dialogue. I have to tell myself very often, "No, Patricia, don't go there and don't think negatively." You have to tell yourself that you have to continue, that you're on the right path.

Being able to have a dialogue with people online about that is very empowering. I have people who reach out to me and ask me what I do when I'm having a rough day. I tell myself that I thought I was having a rough day, but clearly that person is having a worse day than I am, and maybe I can help them. It's about walking people through things that have helped me. Sometimes they seem very benign for others, but that actually can really change your life in the moment, because it's all about moment by moment.

**Ms. Joan Crockatt:** The other thing I wanted to lock in is on the discussion that we've had about the connection—and I don't know if it's causative or correlative—between sexual abuse and eating disorders. Dr. Woodside, who we heard from very early on, said that 60% of his patients had been sexually abused. We also recently heard from Bonnie Brayton, who said that violence against women and girls is a cause of eating disorders.

Mrs. Stevenson, you talked about finding out belatedly that your daughter was the victim of sexual abuse. Now that you have some hindsight, and I imagine you in particular.... I'm going to address this to you and then to Valerie if I have time. Can you talk about whether you believe that it's a very strong causative? Should we be putting in best practices and putting teams together to deal with sexual abuse as well? Or is this a separate issue?

**Ms. Elaine Stevenson:** I think we need to have specialized teams who can work on the eating disorder, number one, but also on other concurrent illnesses and the issue of sexual abuse. That did not happen in Alyssa's case, although we told the doctors and the clinicians very early on that we strongly suspected sexual abuse but we had no details whatsoever.

Yet there was a program in the city that just dealt specifically with sexual abuse, and I think therein lies the problem: we need to have programming teams who can deal with the eating disorder, with the sexual abuse, and with the obsessive-compulsive disorder. You can't expect the family and the person who's suffering to go to one place for the sexual abuse, one place for the drug addiction, one place.... It's just not feasible and, in my opinion, it doesn't work.

**Ms. Joan Crockatt:** Can I ask Laura, Chair? I notice that she's nodding, and she hasn't really been asked.

**The Chair:** Maybe somebody could ask the question.

Thank you very much.

[*Translation*]

Ms. Sellah, you have five minutes.

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

First, I would like to thank the people who are with us, as well as those who are appearing via videoconference. Their statements are shedding light on the issue of eating disorders.

In fact, from the start of our study on eating disorders, we knew that this was a fairly complex problem. It is a biological and behavioural disorder. There should be a multidisciplinary team to work on this issue and to then work on a course of treatment.

My question is for Ms. Laura Beattie.

You said that you treated your daughter at home by way of a family therapy. I would like to know why you chose to look after her at home. Is it because it was so hard to find treatment within a specialized program? Did you deal with other obstacles which led you to look after your daughter at home?

[*English*]

**Ms. Laura Beattie:** Well, when I first went to the doctor he didn't know what to do. He wasn't aware of the family-based treatment that was offered in our city, and I couldn't just sit there and watch her die. I found the information online, and I realized that this happens all over the world and families don't have the access to treatment.

Family-based treatment is endorsed by the Canadian Paediatric Society, and it is the first-line treatment for adolescents, and they are using it in young children and they're starting to use it in young adults as well.

I didn't know. I had called the eating disorders clinic, but it was an intake worker who wasn't aware of the difference in adults versus children and adolescents. It was very new at the time; the treatment was only months old. So I started using it myself, and in the meantime I had to wait for a pediatric referral and an adolescent psychologist's referral. I really didn't know what to do and I knew I had to do something.

We're really trying to treat our children at home, because if you're in the treatment centre or your child's in a hospital, you have to bring them home anyway. You have to do all this anyway. It might not be as acute, it might not be as horrific as mine was, although this is a very common scenario. You still have to bring them home, and that's when children and teens relapse, when they're brought home from a treatment centre and parents don't know what to do.

I found a forum online, and there were parents doing this at home. You're basically making an in-patient clinic in your house; that's how you treat them. You put parents in charge.

● (1655)

[*Translation*]

**Mrs. Djaouida Sellah:** Thank you for your explanations.

[*English*]

**Ms. Laura Beattie:** This type of treatment is where you want the parents in charge, you want to empower the parents, that's what it is.

[*Translation*]

**Mrs. Djaouida Sellah:** Indeed, the patient or her family need some kind of structure. In that case, you provided it.

I heard you talk about the Maudsley family therapy. Did this therapy help your daughter get better? If so, can you tell us what this therapy is based on?

[*English*]

**Ms. Laura Beattie:** Sure, the Maudsley method. Maudsley is a hospital in London and this is where it started. The clinician saw that people with eating disorders would go home and relapse. They would be feeding them in the clinic, the hospital, and then they would relapse when they got home.

So they developed this family-based treatment, where they would empower the parents. It's in three stages.

Stage one is where the parents take charge of re-feeding their child, and I described it to you, I wanted to show you how difficult it was. Now, these are very set stages, three stages, they sort of blur into one another as you're doing it because it really depends on the age of the child.

Stage two happens when the child is almost weight-restored; you can see a significant difference in their sociability, in eating patterns. It's like your child has returned to you, and you're slowly giving them back the control and responsibility, and it has to be age-appropriate. What you do with a 15-year-old or a 16-year-old is going to be totally different from what you do with a 10-year-old, because most parents are in charge of their 10-year-old's food, whereas at 16 or 17, they have a lot more freedom. So you're working towards the freedoms and the responsibilities that are age-appropriate. If you have a 10-year-old, it's going to take an awful lot longer than it will with a 16-year-old or a 17-year-old.

Then you go into stage three, and that is when your family's returning back to normal, the therapist is working more with the parents and trying to get them back into what is considered a normal family dynamic. You don't talk about what caused the eating disorder; it's agnostic to what caused the eating disorder. Old-style therapy was "Let's delve into it. Let's find out what's wrong with your family." FBT is totally agnostic: for some reason your child has an eating disorder, you move forward, and the therapist helps to empower the parents to help them get their child back on track. The problem is, the therapist can't tell you how to do it.

**The Chair:** Thank you very much.

[*Translation*]

Mr. Young, you have five minutes.

[*English*]

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

Thank you, everyone, for spending your time with us today.

I would like to start with Valerie Steeves.

I was very, very interested in your comments on the eGirls Project and what the girls were telling you about how they feel about themselves from sites on the Internet. We've heard the term "pro-anorexia sites" today, and we know there are sites where people actually encourage others to commit suicide.

Would you describe sites like Facebook and other social sites as dangerous for children and girls?

● (1700)

**Dr. Valerie Steeves:** What we found is that the architecture of the site privileges visuality or visualness, which emphasizes the pressure on girls to look a particular way.

So like I said, when we originally started this project we assumed that online spaces would be a place where it would be easier for girls to challenge underlying discriminatory patterns and tropes. And yet we found that these kinds of online spaces, like social media in particular, increase the importance of your visual look and you alienate yourself from your body and begin to manage the image of yourself and judge the image of yourself. And you know that part of the game is that other people are judging you.

**Mr. Terence Young:** Does that create a precondition for an eating disorder?

**Dr. Valerie Steeves:** We're talking about a continuum of behaviour and a continuum of environmental factors. I go back to the testimony you've heard about the voice in my head—

**Mr. Terence Young:** Let me ask you, would you recommend that parents encourage children to use those sites? Or would you issue parents a caution?

**Dr. Valerie Steeves:** I issue caution. Again, it's an age question.

I do a lot of research on kids between grades 4 and 11 and we're finding that a large proportion of grade 4 kids have cellphones, for example, and text. A lot of kids have Facebook accounts, even though technically they're not allowed to because they're under 13 years old. There are good reasons to be very cautious about encouraging kids to embrace that kind of social media because it does give these kinds of messages a direct path into the child's social environment.

So yes, personally I think there is a caution there.

**Mr. Terence Young:** Thank you very much.

Patricia, I want to thank you for coming here today. And I want to thank you for your courage and giving up your privacy in working to help others who suffer from bulimia and anorexia.

When you first knew you suffered from an identified disease, a disease that could be diagnosed, what roadblocks did you have to getting care? Do you know if those roadblocks are still present today in Canada?

**Ms. Patricia Lemoine:** The initial roadblock for me was the fact that after those sessions that I was allowed, I would have had to pay $125 to get therapy. So that was a big roadblock because I had just graduated and it was really expensive. I would say that it was the financial burden. Not only was this ruining my life, but this was also ruining my finances.

At the time I was engaged; I had to talk to my fiancé about it. He was obviously instrumental in my recovery. But those roadblocks are still there from what I know.

**Mr. Terence Young:** I wanted to ask you a couple more questions.

You mentioned you had taken the antidepressant Zoloft as part of your treatment. Was it Zoloft or Effexor?

**Ms. Patricia Lemoine:** It was Effexor XR.

**Mr. Terence Young:** We know that they cause a lot of adverse effects.

Would you feel comfortable talking about the adverse effects that Effexor caused you?

**Ms. Patricia Lemoine:** For me the worst were the nightmares. The vivid nightmares that I had caused so much anxiety when I would wake up feeling very thirsty.

Another problem I had was that I suffered from migraines. Effexor XR should not be taken when you take Maxalt, which is something I take for migraines. And my doctor didn't tell me. So I actually had to go to the hospital when I almost fainted from the mix.

**Mr. Terence Young:** Did you have the impression that Effexor caused anxiety or agitation?

**Ms. Patricia Lemoine:** I actually did.

**Mr. Terence Young:** What advice do you have for parents? If a parent notices their daughter's going to the washroom after dinner all the time and they think she might be purging, what should they do?

**Ms. Patricia Lemoine:** If they can't engage in dialogue with him or her, they should try to find someone who is trusted in the entourage of the child to actually try to speak to them, whether it's the parent of another friend or a friend or another family member.

It can go really easily from bad to worse so the sooner you address it one way or another....

**Mr. Terence Young:** What do they do if the child or the teenager denies it?

**Ms. Patricia Lemoine:** Well of course they will because at first it's fine, after—

● (1705)

**Mr. Terence Young:** How do you handle that?

**Ms. Patricia Lemoine:** I'm not a parent myself, but I would really encourage parents to not stop at, "No, I'm not interested, you're crazy, I don't want to talk to you about this, it's my life." I would really encourage them to go past that or find someone who can.

**Mr. Terence Young:** Are there resources on the Internet you would recommend for parents or patients?

**Ms. Patricia Lemoine:** Probably looking at different forums and different websites where parents themselves are talking about what they're going through with their kids might be helpful. Of course, I write for the HealthyPlace and I think it's a great website, a great resource for that. I would really encourage furthering the research.

**The Chair:** Thank you.

Thank you very much, Mr. Young.

[*Translation*]

Ms. Ambler, you have five minutes.

[*English*]

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

Thank you, to all of you, for being here today to tell us your stories. We really appreciate it.

I'll start with you, Ms. Steeves, if that's okay.

I was also fascinated. I have two teenage children myself and just last week my daughter—I don't even know the terminology, that's how out of it I am—didn't retweet something a friend tweeted, but a friend sent her a direct tweet. It was four pictures of really skinny bodies. One was the thigh gap, so I've now heard of it for all of a week. The pictures showed a skinny body part and then each one asked a question. Would you rather have your hip bones showing, or would you rather have this chocolate bar? Would you rather have a thigh gap or a piece of pizza?

**Dr. Valerie Steeves:** If that's a question, pizza.

**Mrs. Stella Ambler:** Yes, I'm for the pizza.

She hates that I monitor her on Twitter. In fact, I have to do it by googling her because she keeps blocking me. It's easy to do, luckily, so I do that. I asked her to take it off.

I said, "That's not appropriate. Please take that off. It's not funny." She said, "Oh, Mom, you're too serious. It is funny. You take everything too seriously."

Then I told her that we're doing a study and that some young girls take this very seriously, and some of them die because they try to have those hip bones that don't come naturally.

I really want to say, first of all, thank you for the work that you do keeping young people safe in cyberspace.

What are the dangers? When it comes to young people's self-confidence and self-worth, what can we do to help? What can be done?

**Dr. Valerie Steeves:** As a committee, or as individuals? We've talked about regulation, so perhaps...what's the—

**Mrs. Stella Ambler:** [*Inaudible—Editor*] thank you for the two suggestions that are in federal jurisdiction. Maybe one of those.

**Dr. Valerie Steeves:** One of the things that I've worked on for a number of years, as I'm sure other people around the table have as well, is education and outreach.

Certainly with young children there is a certain digital literacy and media literacy that's required so they can navigate through all the various images that do bombard them throughout their lives. There are a lot of teachable moments when children are very young. I think that one of the things we can do to be more effective is to talk to kids about this when they're very young, and not wait until they're 13 and 14 and suddenly under all of this pressure. That dialogue helps them question the images they see around them, and then we can model that questioning as well. I think that's incredibly powerful.

As I said, I'm a parent of teenagers as well, so I understand where you're coming from. The research quite clearly indicates that monitoring is not necessarily an effective response because what you want to do is create an environment of trust where you open up spaces for dialogue. I completely agree with what Patricia was saying.

**Mrs. Stella Ambler:** I'm not supposed to be stalking her on Twitter?

**Dr. Valerie Steeves:** Actually, in the research it correlates with less pro-social behaviour. Certainly I've done research with kids who have said if their parents or their family members are spying on them, that means they can't talk to them. It can shut down spaces for dialogue.

I think part of it is that we're stunned by some of the environmental things we see, and they appear very upsetting and dangerous. I'm always fascinated when I talk, particularly to young kids, that they're quite aware of these images. To a certain extent they do think of adults as relatively naive, "Oh, that's so cute. You think that girls shouldn't have to worry about their thigh gap."

● (1710)

**Mrs. Stella Ambler:** Right. In other words, this is her world and I should just recognize that she has to deal with it.

**Dr. Valerie Steeves:** And you are her greatest resource. You create conditions where hopefully she will come and talk to you about it and you open up those spaces.

I think that does come with outreach to parents. It comes with education for kids, it comes with creating spaces for dialogue.

**Mrs. Stella Ambler:** So parents need education too, then?

**Dr. Valerie Steeves:** Yes. I think a lot of parents feel totally overwhelmed by this. Dialogues with parents are often very effective. Nobody loves their kids more than their parents, and yet it's very difficult to talk to their kids about this.

I found as a parent myself, do I talk about dieting? Do I talk about the dieting industry? I don't want to encourage them to diet. I don't want to be the one to bring it up. After walking by a few La Senza ads with my daughters when they were four, I realized, heck, it's been brought up.

[*Translation*]

**The Chair:** Thank you very much.

Ms. St-Denis, you have five minutes.

**Ms. Lise St-Denis:** Oh, I did not expect to speak a second time. I will skip my turn. I will let someone else ask questions.

**The Chair:** You would like to skip your turn?

**Ms. Lise St-Denis:** Yes, I will skip my turn. I did not think I would have a second turn.

**The Chair:** Very well.

**Ms. Lise St-Denis:** Can I give my turn to whomever I want?

**The Chair:** Yes.

**Ms. Lise St-Denis:** I would like to give my turn to Ms. Ambler. I thought that she was saying some very interesting and important things.

**The Chair:** All right.

Ms. Ambler, maybe you can share your time with Ms. Crockatt, who did not have the opportunity to finish her questions.

You have five minutes.

[*English*]

**Mrs. Stella Ambler:** That's very kind, thank you.

I do have one quick question and then I'll give it to you.

There some countries that have passed laws about how thin models should be.

**Dr. Valerie Steeves:** France did that.

**Mrs. Stella Ambler:** France did, yes. What is your opinion on that?

**Dr. Valerie Steeves:** It's funny because we regulate all sorts of things. We regulate cigarette boxes. I don't see why we can't regulate that kind of imagery.

There is an argument to be made that it's a deceptive trade practice because there are some wonderful educational videos on the Internet where they take a picture of a real model and show you how it's photoshopped, so even the models don't look like models.

It's kind of a bizarre thing that we're so obsessed with this particular image that is very racialized, very heteronormative, and all these other kinds of things. It seems to me that this should be something on which we should have a public debate, and if we think it's a good idea to regulate that, we regulate all sorts of commercial practices, so why not that one?

**Ms. Joan Crockatt:** When you say heteronormative, what are you speaking about specifically?

**Dr. Valerie Steeves:** I suppose what I heard from the girls is that there's a very narrow kind of femininity that they're supposed to emulate online. It's very white even if you're not white. We know there are rising rates of plastic surgery among Asian Canadians, or Asians as a whole actually, to have eyes that look more Caucasian.

We know there are all sorts of discussions about black women or black girls who will straighten their hair, so they can look more white, that type of thing. We are privileging a certain kind of idealized beauty that is racialized, that looks Caucasian, that is hyper thin, tall, and willowy, a particular kind of body.

The heteronormative part is probably my short form for the fact that all of these girls said there is incredible pressure on them to appear sexy but not too sexy, in a heterosexual kind of way, that their sexuality is shaped by the social pressures they feel to be attractive to males within their society. These are kids. I'm not saying this is the fact of life but certainly this is their perception of it.

They all go back to the Hollywood thing: you want to look like Rihanna, you want to be Rihanna. Rihanna is, famously and infamously, in an abusive relationship where as a woman she's abused by her male partner. Yet, she has also infamously said that if you don't sext your boyfriend, you're not a good girlfriend. That comes up in these discussions. It's that kind of objectification of the female body as an object for consumption by a heterosexual male.

● (1715)

**Ms. Joan Crockatt:** Just as an aside, I was noticing that from the movie *Gravity*, the picture they kept showing on the Academy Awards last night had Sandra Bullock floating through the space capsule with these absolutely stick-thin legs. No one has legs that look like that.

I'm wondering if peer pressure is an effective means to combat that. Sometimes we think that regulations or laws are important, but if you had one celebrity or peer group who went online and fought back against this....What do you think?

**Dr. Valerie Steeves:** I've got two quick thoughts, and I know that we don't have a lot of time.

One is that, yes, that happens. The girl who starred in the *The Hunger Games*,what's her name? Do you know who I mean?

**Voices:** Jennifer Lawrence.

**Dr. Valerie Steeves:** Yes, Jennifer Lawrence, was closer to real body weight. Kate Winslet was closer to body weight. And yet both of those actresses have lost a heck of a lot of weight over the 10 years. They're trying to say, look, I don't believe in dieting, I'm not going to lose 40 pounds, I look fine, and yet the pressure is on them. That's unfortunate, because that's an incredibly powerful role model.

For those kinds of youth-led initiatives, where kids get together and say, this is enough, we want to push back, there are all sorts of best practices. There are some in Montreal where girls have gotten together and created a media campaign of their own to say, this is crazy, we're not willing to do this anymore. This is what we look like, get used to it.

But I do want to caution you, because it's very easy to co-opt that kind of outreach. For example, one of my favourite corporate initiatives in this field is the *Seventeen* magazine's Body Peace Project. They had an online campaign to encourage girls to make peace with their bodies and to stop starving themselves to death and all this type of thing. Yet the images that were surrounding the access to this particular site were all of hyper thin pre-teen and teenage girls. They went and they got celebrities to sign the Body Peace Project, and a number of them have had plastic surgery—infamously again—before they were 16, and they were all super, super thin, except for one of them.

What was most interesting about that particular initiative is that the pressure was put on the girl to sign the pledge, “I promise I won't be bad to my body. I'll still that little voice in my head.” I think the challenge for us, as concerned citizens and as regulators, is that voice is not coming from inside their head, it's coming from the environment around them. We're responsible for the environment around them. As much as I support everything that's been said about the need to educate doctors and to get better medical treatments in place, we have to be very critical of those kinds of initiatives because they get co-opted really easily.

**The Chair:** Thank you very much.

[*Translation*]

Ms. Truppe, you have seven minutes.

[*English*]

**Mrs. Susan Truppe:** Thank you, Madam Chair.

I'm going to ask the question of Ms. Beattie, because my seven minutes were up then. I'm going to share my time with my colleague, Terence Young, as well.

I have a couple of questions that I wanted to go over again. When I was talking to the other witnesses here, they had to do a lot of things on their own. It seems like with your circumstance, with your 13-year-old daughter, you were getting nowhere either.

I was just wondering, was it misdiagnosed? Did you determine that it was anorexia or did somebody finally tell you that? It sounds like you were the one who also found the FBT, the Maudsley method. It almost seemed like everything was up to you.

**Ms. Laura Beattie:** Yes. I think it's gotten better in four years, but our primary care providers need a lot more education, continuing education. Our medical students, residents, they're not trained. All they hear about is the obesity epidemic. I did prepare a brief. I've got growth charts in there as well to show you. But, yes, I had to find it online. I suspected. Parents go through huge denial, but I knew how serious the illness was. A lot of times doctors, especially primary care providers, if they don't know what to do, they don't do anything. They can't do anything. We need to educate them and we need to give them the education, the tools, to know what to do.

We need standards all over Canada. It depends where you live, it really does. Even in Ontario, it depends. I'm very fortunate that I live in a city that has this. There are some places that don't have it. I know our treatments have improved. Even from when I started, the FBT has changed.

● (1720)

**Mrs. Susan Truppe:** I'm just going to ask you how it improved in one second, but I like to ask about the best practice that you've learned throughout your experience. But to me, unless there's something else you'd like to add to that, it would be the family-based treatment. It sounds like it worked wonders and really helped your daughter.

**Ms. Laura Beattie:** Yes.

**Mrs. Susan Truppe:** You didn't know of it. You just what, googled, and you went online and found it? Was there anywhere to look for this?

**Ms. Laura Beattie:** I found all kinds of information that was very outdated. I found things on eating disorders awareness. As I said before, and I'm speaking as a parent, on the other side, I was very frustrated, because I saw the stuff on body image, and I saw that show *Dying to be Thin*, and I thought, I have a young child; this is not my situation.

I finally found F.E.A.S.T. I found maudsleyparents.org. And I was stunned. Why doesn't everyone know about this? Why don't we know they are treatable, and that there's genetic predisposition, and predisposing factors, and it's not just about body image. There's so much more to the illness that the public does not know about.

When I found it, I found this incredible parent forum. The F.E.A.S.T. website is full of facts. And it's not just about FBT, because not everybody can access FBT. It's about empowering parents. In the past we've been blamed and shamed, and there's stigma, not knowing what to do. The F.E.A.S.T. site has incredible information.

Just through talking to people, my friends, colleagues at work, they've actually shared this site with other parents who have been alarmed about their child, and they've brought it to their physicians. They're educating their physicians this way.

**Mrs. Susan Truppe:** Thank you.

Am I at the halfway mark yet, Madam Chair?

**The Chair:** There are three and a half minutes left.

**Mrs. Susan Truppe:** I'm going to pass that to my colleague, Mr. Young.

**Mr. Terence Young:** Thank you.

I'd like to go back to Valerie Steeves, please, because as I mentioned, I find your research fascinating.

With regard to the social sites, I understand you weren't ready to describe them as dangerous, and I understand that as an academic you have to be objective and dispassionate, etc. But you also mentioned you're a mother. You mentioned that the sites create pressure to conform, and there was the term “a new environment”. To me it sounds as if it's almost like a parallel universe, where things aren't real, but we're meant to believe they are real, with doctored photos, photoshopped pictures of women, and this pressure. And the Google ads allow corporations to target young girls by their age, their demographic group, to sell them diet products, plastic surgery, and other things that also have their own risks.

You didn't say this, but I know from my own research that they're getting them when their commercial guard is down, if they're mature enough to even have a commercial guard, if their parents have had some training, as you have, or if they have parents who are wise to this and say, listen, don't believe everything you see, and they lecture them. But I would suggest most children don't have that training. Maybe you can comment on that. You also mentioned deceptive and unfair trade practices.

Would you feel comfortable describing these social sites as risky or inappropriate for girls at—and I'm going to give you four different ages, because you mention age too—six years old—because I know a six-year-old who uses social websites—12 years old, 13 years old, and 15 years old?

What advice do you have for parents of girls in those age groups?

**Dr. Valerie Steeves:** My response to the question of whether these sites are risky is that when you sit down with kids and ask them that question, they go, “But look around you. It's everywhere. It's not just online. It's in movies, it's in TV, it's in the ads when I walk through Bayshore.” It's everywhere.

**Mr. Terence Young:** When you say kids, I get confused because....

**Dr. Valerie Steeves:** I'm talking about 11-year-olds to 17-year-olds. They will articulate that quite clearly.

My project is focused on social media, but at the same time I think it's important to recognize that social media provides a snapshot of teen life that we wouldn't necessarily be able to see without social media because it has a public-private aspect to it. But I don't think these are problems that exist on social media only. I think social media gives us a good way of trying to understand the way the commercialization of childhood is affecting young people, both online and offline.

Clearly, kids will say there is no difference. It's all one big social space. They don't see it as a brave new world; it's just the world they're in.

Having said that, I want to second the idea that there's a body image spectrum we're talking about. One of the reasons that media images are relevant to this discussion when you're trying to help people who are suffering from this illness—and it is an illness—is that they can act as triggers. They can silence kids. It makes it harder for people to say they are having this problem, because they're getting all of this feedback saying that being skinny is something girls in particular should pursue, and that type of thing.

I think there is an interrelationship. It's not that girls have bad body image and they become anorexic. I think that's far too simplistic. What I'm trying to say is that particularly for the most vulnerable in our society, girls who are suffering from this particular illness, these are triggers, and we have a responsibility to deal with them. We also have the broader mental and social health of girls as a whole to consider.

● (1725)

**The Chair:** Thank you very much.

[*Translation*]

Ms. Ashton, you have a couple of minutes.

[*English*]

**Ms. Niki Ashton:** Thank you very much.

Ms. Steeves, one issue that has become apparent not just in this study but in other studies in this committee has been the lack of voices that we have in civil society in particular to speak out on the issues that women face. I remember growing up hearing about campaigns around MediaWatch, and about fighting back when sexually explicit ads, or misogynistic ads, were out there. Now we don't hear those voices in the same way.

I'm wondering if you could speak a bit, as an academic, about what you've seen. I mean, who are the voices out there? Are we supporting young women's work in advocating, older women's work in advocating?

**Dr. Valerie Steeves:** Yes, I think there are some best practices and some sites that are particularly useful. Certainly some campaigns have been started by young women to push back against this. One thing we see through social media is that it becomes a snapshot to see the kinds of responses they encounter when they do stand up and say, “Hey, there's something wrong with this.”

Certainly what we see in our research is a rise in slut-shaming; that is, if a woman or young girl does stand up and say something, then she's attacked basically on the grounds that she's a woman. There's the recent thing at the University of Ottawa just over the last few days, where the female president of the student body was attacked, and was basically threatened with rape, in a conversation among her peers on the student government.

That's misogyny at work. I mean, she's being attacked because she's a women, and we know how to attack women: we attack them by threatening to assault them, by threatening to rape them, and by calling them fat and ugly.

Interestingly enough, again, the eGirls Project expected to find a multiplicity of voices and a space for a diversity of views. We're finding that the media, as it's developing, is actually shutting down those spaces in really interesting ways. I think it's happening because the impact of the mainstream message is just becoming more powerful. We look for conformity to a norm, and we're putting more pressure on young people to conform to norms of behaviour, body size, and those types of things.

So it's kind of paradoxical.

**Ms. Niki Ashton:** Ms. Lemoine, we heard about your blog. If we do see initiatives that young women are starting, is there a role for government to support that advocacy? I don't necessarily mean your blog in particular, but is that something we should be looking at?

**Ms. Patricia Lemoine:** I think there certainly should be systems in place to support initiatives that would be taken into schools. I think kids will spend most of their time during the day not with their parents or at home, but just being in school with their peers, hearing the dialogue of the thigh gap. If you spend three or four hours a night with them as a parent, you can't reverse that whole dialogue that was done throughout the day.

I would say it would probably be helpful to have school initiatives to support positive body image, initiatives on how to detect when someone is going through a difficult time when they have low self-esteem, or initiatives on the dormant triggers that are there.

**Dr. Valerie Steeves:** I would just add that we have a Canadian centre of excellence that excels at this type of outreach and education, and that's MediaSmarts. It's one of the largest media literacy and digital literacy organizations in the world. They have phenomenal education initiatives that are geared to do precisely that.

[*Translation*]

**The Chair:** I can't begin to thank you enough for, first, having testified about such personal things, but also for having shown us that there is light at the end of the tunnel. That's what I really appreciated. Despite the challenges which were mentioned, there is hope. So our meeting is ending on a positive note.

I would like to remind committee members that at the next meeting, during the first hour, we will hear from witnesses. During the second hour, we will prepare for our next study. I would invite you to submit your ideas on paper so we can talk about them, with a view to deciding what our next study will be on.

Thank you once again.

The meeting is adjourned.