

Ideal Body Weights

What do they really tell us?

In our last newsletter, we focused on how dieting and weight loss to any degree, are a significant harm to health. Health practitioners have struggled to find a useful way to assess health using weight measures. Unfortunately, they've bought into the message from the Life Insurance companies, that "their data showed" that mortality and disease was directly related to being "overweight". This stigma of being "overweight" has remained and compounded over the decades into such an all consuming obsession that we are now faced with an unprecedented epidemic, if you will, of girls, women, and men who are resorting to disordered eating and self-punishment as a way to achieve this "ideal body weight" or ideal body image that the media portrays as beauty. As one girl put it, "I will not be happy until I am thin. Will you help me to lose weight?". Her request broke my heart. She is a beautiful, healthy looking girl who could be so happy with life, by all outward appearances. Why did she think losing weight would bring her happiness?

This newsletter will help those suffering with weight issues to see that the Ideal Body Weight charts are not on the level of the 10 commandments spoken directly from the mouth of God to Moses. These charts truly were developed by imperfect, flawed thinking human beings. We must learn to think more critically about these charts, and challenge whether they are useful or not. Hopefully this newsletter will help you to sort through those issues for yourself in order to have peace with your body size and weight.

"The Origin of the Special Charts" - Louis Dublin

In the early 1940's, Louis Dublin of the Met Life insurance company compiled all of their actuarial data on their policy holders to see if there were any associations between weight and mortality. **He interpreted data to say, that even modest weight gain over the age of thirty, was associated with greater increase in mortality.** He preached the message that the greatest threat to American's health was being overweight. He was the most influential person in the twentieth century to change the whole nation, including doctors, on the attitudes towards weight (Gaesser, 1996 p. 39). He promoted the concept of "**average weights**", then "**ideal weights**" and that it was **not OK to gain weight with age**. Thus with his standards, he diagnosed a weight problem with half of Americans even though their average weight had not changed since the turn of the century.

Later, in 1959, 26 other life insurance companies were also pooling their data on 4.9 million policy holders and finding that with increasing weight gain there was also increasing

Editor's Notes

Oops!.....

We had planned on having articles on the mind-body connection for this issue, as well as more on self acceptance than we have. Basically we just ran out of room, as the material we do have turned out to be longer than expected. The good thing about that is that we have most of the material for the next edition (Nov./Dec.) already laid out! The mind-body material will be in that issue.

What is ideal?

Our article on ideal weight takes a look at the concept that has so many people trying to meet some supposedly healthy weight for their height. The premise is that such a weight truly exists, even though individual factors such as frame, muscle mass versus body fat ratio, fitness, dietary habits, lifestyle and so on are ignored. Is it realistic to be pursuing an "ideal body weight"? Furthermore, once you understand how arbitrary these criteria are, is there such a thing at all? We hope that this article will shed some light on the issue.

Guest writer

Our guest this issue is Judy Sargent. Her new book, "The Long Road Back: A Survivor's Guide to Anorexia", was just released, and should be on the bookshelves now. We are grateful to her for sharing her thoughts with us, as well as the poem written by her sister - a good example of the impact eating disorders have on those close to the sufferer.

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Body Image

Most females have a negative body image not because they have unattractive bodies, but because they see themselves inaccurately. A significant percentage of women consider themselves too fat, holding unrealistic expectations about body size and weight. By age 18, more than 50% of women of normal weight consider themselves too fat. Fifty per cent of 9 year old girls, and 80% of 10-11 year old girls are on some type of diet.

Research studies claim that body attractiveness is so highly valued that it has the single most important impact on many individual's self worth. Studies have also shown, however, that those who exercise are much more likely to be pleased with their bodies and more likely to consider themselves physically attractive. As long as exercise is done in moderation (not compulsively), that may be a positive step toward improving both body image in general, and one's sense of self worth.

This newsletter is a publication of the Westwind eating disorder recovery centre, and is intended for general information only. It is not intended to provide personal medical or psychological advice, which should be obtained from a qualified health professional.

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mortality. This massive study called the Build and Blood Pressure Study (Gaesser, 1996 p.45) was heralded as the most definitive and persuasive truth that obesity was killing Americans. **Met Life came out with then a set of “desirable” weight tables which were even lower than before (about 8-10 lbs lower).** The drop in numbers appeared to create another obesity epidemic, not because Americans had gained weight, but because the standards had been dropped (Gaesser, 1996 p. 46).

The problems with the actuarial data of the Life Insurance companies were many.

1.) First of all, policy holders were screened for health problems and weighed on average 7-10 lbs less than the normal public.

2.) They were not representative of the general populations in regards to ethnicity, economic or racial factors.

3.) The life insurance studies also fall short of scientific standards in that did not define a fixed database over a specified number of years. Anyone who bought a policy during the years of the study were included. Even though they looked at policy holders over a span of twenty years, the average length of any policy holder was only 7.8 years. Not exactly the twenty year study it appeared to be.

4) Also their weight was only taken at the time they bought their policy and not throughout the years. Thus someone could enter the policy weighing 160 lbs and lose 30 lbs and live, and another could weigh 130 lbs and gain 30 lbs and die. But the analysis of the data would indicate that the risk of dying was higher for the person who weighed 130 lbs (Gaesser 1996 p.87-89).

It seems ludicrous to speculate that one person was healthier than the other based on a weight that was taken once in their lifetime. As you can see, these are serious flaws when trying to draw conclusions about the effect of weight on mortality.

All that these tables, of weight and

age, revealed was that weight generally did go up with age, for many individuals, and not surprisingly, so did mortality.

The Met Life studies say nothing about the fact that there were significantly lower mortality rates for 40-50 year old people who were actually considered quite overweight by their tables compared to those who were under or at their proposed ideal weight standards.

What is Body Mass Index? Is it different from Ideal Body Weight (IBW) tables?

Body Mass Index is a calculation which you can do by taking your height in meters squared divided by your weight in kg. Health care professionals recommend that the number resulting from this calculation be between 20-25, and regard that as a healthy weight range. Between 25-27 is considered borderline for health risks and 30 or more is considered high risk for health problems related to obesity. It is like the IBW tables in that it takes into consideration your individual height and weight and it

A Winner's Creed

If you think you are beaten, you are;
If you think you dare not, you don't;
If you'd like to win, but think you can't
It's almost a chinch you won't.

If you think you'll lose, you're lost;
For out in the world we find
Success begins with a person's will,
It's all in the state of mind.

Life's battles don't always go
To the stronger or faster hand;
But sooner or later the person who wins
Is the one who thinks "I can."

does give you approximately the same range of weight. However, it doesn't factor in age, whether you are male or female, amount of lean body mass (muscle) or fat tissue or your frame size which IBW charts tried to do. Therefore, it is only an **estimate** of what may be a healthy weight range for you.

It was developed based on population studies that revealed that in general, the population that fell below a BMI of 20 began to develop nutrition and health related problems and those who fell in the over 30 range also began to have health related problems.

Isn't being overweight the cause of many health problems such as diabetes, high blood pressure and heart disease?

It seems that weight has been guilty by association rather than by cause. It makes sense that people with poor eating habits and sedentary lifestyles tend to gain weight over the years, but it is not the body fat per se that makes a person unhealthy. We know from the research being done now on diabetes and heart disease, that if people who have unhealthy lifestyles will change their diets, eat less fat more fiber, and if they become more active, they can reduce the progression of atherosclerosis, reduce their blood pressure and they can stabilize their blood sugars— all without losing much weight if any at all. Now if body fat was the real culprit we wouldn't be seeing any of these health improvements until they lost weight down to their "ideal" weight. But this is turning out to be a false notion. There is no such thing as one ideal weight that can be assigned for a particular height because everyone is made with unique genetic variability and we can be healthy within a wide range of weight if we eat and exercise appropriately.

Does the average individual need to be using ht/wt tables or Body mass indexes at all?

You might think that there is nothing wrong with height weight tables, but they actually cause more harm than good. For those who happen to fall into the "ideal ranges", they may have a false sense of security that they don't need to eat healthy or exercise because their weight is OK. If you have this mentality, think again. Heart disease is not partial to what you weigh. It can strike anyone, thin, or heavy alike, so we all need to improve our lifestyles to prevent this disease.

From the discussion in our last newsletter, we discussed how weight alone has very little to do with health (outside of the extremes). Why then should we be dictating to people what they should weigh? Instead shouldn't we be focusing on healthy eating and exercising? If, by their healthy changes, they lose weight down to a different plateau that is easy to maintain, then fine. But if these "ideal" weights are being promoted as the weight everyone should strive for, then we are setting our society up to become diet crazed in the attempt to be "perfect", even though there is no perfect body weight or shape. This is exactly what has happened and this has led to many people seeking help from diet doctors or weight loss clinic, starving themselves on 600-800 kcal/day, taking amphetamine drugs to suppress their appetites, exercising vigorously to the point of weakness and exhaustion, only to "fail" at their diet because they couldn't maintain these tortuous demands. Is there any wonder people develop emotional problems and disordered eating habits when food becomes such a forbidden enemy?

While we know that Ideal Body Weight charts are certainly not the only issue re-

lated in the development of eating disorders, every eating disorder began with a diet. And people begin to diet when they feel they do not fall into society's standards. At least, by minimizing or removing this one stumbling block, there is one less reason for people to have to diet or force themselves to meet some arbitrary standard, so that they can have peace about their bodies and themselves.

So what should we be looking at to see if we are healthy if it is not weight?

There are many things people can evaluate to decide if they are healthy or not. They can go to a nutrition expert such as a dietitian who specializes in cardiovascular and diabetes health. They can assess their diet to see if it is high enough in fiber, low enough in fat, salt and sugar, and to see if it meets the nutritional guidelines of Canada's Food Guide. They can also assess their activity level with a fitness professional and determine if they are getting at least 20 min. of cardiovascular and muscle strengthening exercise per day or more (up to about an hour a day). The key is to think in terms of what is healthy - not in terms of weight loss. They can also go to the doctor regularly for blood sugar, blood pressure and cholesterol checkups to make sure those are all in order. Smoking and alcohol reduction or avoidance are also very important factors in determining good health.

Stress management and coping with life's pressures may require the outside help of a professional counsellor. There are so many things that contribute to good health, do not let yourself become so focused on weight that you miss all the rest.

References:

Gaesser, Glen A., 1996, *Big Fat Lies: The Truth About Your Weight and Your Health*. Fawcett Columbine, New York.

Considering a Residential Treatment Program?

What should one expect if one goes into a residential treatment program? We think that the client should have a good idea of what he or she expects to get out of a residential treatment stay, rather than being too focused on what the treatment team expects. The obvious answer is that one would like to be immediately rid of the disorder once and for all. Certainly that is possible, and will happen if you are stubborn enough to keep at it, and refuse to give up. And we all know people with eating disorders are a stubborn lot, right? Treatment and recovery might be best thought of as a process of skill building and problem solving. One could focus on that, rather than just a singular focus on symptom extinction, which is the outcome of treatment at some point, but often not as soon as you might like.

We always want to look at what it is our clients feel they need to do to overcome their eating disorder. What skills do they need to develop? Do they need to learn to live again? Relax? Be assertive? Eat in company, or dine out? Build relationships? Resolve conflicts? Resolve past abuse issues? Grieve? Develop improved body image? Learn more about healthy eating patterns and let go of myths and rules that may dominate eating? Shop for groceries? Build self esteem? Develop/grow spiritually? Improve problem solving skills? And so on - the list gets pretty lengthy. We may touch on quite a few of those concerns with clients, emphasizing some more than others with each client - trying to meet individual needs. We do feel that a person's stay with us should address as many issues as possible, but we don't expect that proficiency will be achieved in dealing with all of them. (That would be perfectionism - something to let go of). Most good treatment facilities recognize that the time a client spends with them is going to

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Sister, We Say

after three years of recovery, over twelve years of falling skin, you tell me you are writing a book of it. You, my sister, my other bone, my spirit's handbag, carve onto the page, this story which you have made. You want me to hear it, you want the seven early pages to empty into me their silt. I say, read, and you do, furling back the beginning, soothing the edges with skinny hands. I hear you say, twelve smuggled cups lined like tiny soldiers under your bed, water weight, the scale and her arm, you and your tricks. The nurses in their steady white. They could see you as you could not see yourself, the shrinking visage, your bones entry over time, more clearly, the jutting knobs, the crevices open mouths.

Yes, my sister, you write it from your end now. You have heard the poems which mourned you, the early don't dies, the closet, the dark satin mouth, the flesh evaporating in air. And the new one, the- she is my sister, the nurse, the catapult Minnesota, the Wisconsin woman. I say try to count her, you can't, she moves on feet like anyone.

But you bring me back. You carry me on your shoulders like a big sister could. You say, mom said, dad said and other things I never heard of. I hold my breath for what I do know. My voice rising with your voice. You saying, "you're dumb" me saying, "well, you're fat" On the pages, what will hide in the corner, shivering, what will come to point?

I remember. I was there when Mom weighed you. I was little sister. I stood watch. Under my skull, in the darkness of flesh, I could see the weights, solemn black metal, hard, un-jarred in the space your breasts had left. Yes, you hid them in your bra, ankle weights, their steel nipples un-fed. My mouth closed over words which sat, bead-like, in the dark of my cheek.

Or the other, that you will not remember. The long night you could not sleep. I was home on a visit, next to you on the floor. Outside the night would not end. She sat on her heels rocking, the windows stretched up and up. You took pills as mom brought them. The couch was very still. You were saying no. No. Not the electric shock treatment, ECT, no. NO. No. And mom took me by the arm, "get her to, get her, she needs it, you don't know what it's like, it might save her" If I were a good sister, would I have taken you, wrapped in white gauze, out by foot, past the houses lined up, past the grass in the marsh, on into the what? I did not do it. I can not say. You tossed through the night. In the morning, five AM, we took you, 68 pounds, to the hospital, where I held your fingers as if they were mine, until they wheeled you off.

Judy, my sister, your brown eye, your body rising to breathe, have I told you lately, hello. I am glad that you are here. You were the one I thought had been lost. My sister, so sorry, your fingers, your voice down the hall, I have carried you under my skin, so gentle, so gingerly. Have you heard me? I have passed you my high school boyfriends, one at a time, rivulets of tears, I have gone with you into that room, my head, your head, let me in, let me in, let me stop it, let me be, you, let me stop, let me go, let me come. home. sister. mine.

By Anne Catherine (Sargent) Capobianco

The preceding poem was written by my sister, Anne, shortly after I started writing, "The Long Road Back: A Survivor's Guide to Anorexia" It is a passage that I find deeply moving. Not only does it depict the suffering of someone afflicted with an eating disorder, it speaks of the profound impact that such an illness has on the entire family and anyone that cares for the individual.

Anorexia Nervosa is an insidious but tenacious illness. As a youngster growing up with asthma, I was once hospitalized on a pediatric unit that housed a girl suffering from anorexia. I recall thinking to myself at the time, "How sad! She must have been abused or something" Reflecting on my own voracious swimmer's appetite and love for gourmet food, I thought, "Thank God. That would never happen to me" I had no idea that the frail skeletal-looking body that lay in the bed next to mine would, in the not so distant future, resemble my own.

The beginning of my long harrowing saga started innocently. I never dreamt that a "simple diet," as part of my self-devised, self-improvement campaign would lead to ten years of severe anorexic illness, 26 hospitalizations, 3 intensive care unit stays, steal my adolescence, and nearly kill me. I thought that losing weight would make me happy and it would boost my self-esteem. In reality, the eating disorder made me miserable. I was horribly cold, couldn't sleep, suffered from obsessive thoughts, osteoporosis and fractures, and chronic depression. In summary, I was in desperate need of finding effective treatment.

In the years since my recovery, people have sometimes asked me, "Why do you think you became anorexic? What factors contributed to your anorexia?" The answer is a complex one. Certainly, the factors are different for each and every individual, and I think that multiple factors contribute. There

is no one "cause." However, I've been able to pinpoint the following factors as likely culprits in my own case:

Unresolved grief over the loss of my twin brother at age 4.

Low self-esteem.

Obsessive-compulsive / perfectionistic tendencies.

A feeling that my life was "out of control" secondary to my parents' difficult divorce.

My parents' obsessive focus on weight, which only contributed to my own.

I was a competitive swimmer and my father used to weigh me (something I found humiliating). My father used to tell me that I was "fat" and needed to lose weight. Kids at school used to tease me because of the moon face side effect of the medication, prednisone that I was taking for asthma. They called me, "Chipmunk cheeks."

More important than pinpointing a cause is finding a treatment that will work. The good news is that effective interventions are available. Many people have asked me, "What made a difference for you? What is the key to recovery?" My answer is usually a variation on the same theme. First, the individual must acknowledge that there is a problem and that he or she needs help. The second step is to seek professional treatment. The third step is to become an active participant in your own treatment. A healthcare provider can help guide you in the process of recovery, but you've got to decide that you want recovery for yourself (Not to "please" your family member, treatment team member, loved one, or spouse). Nobody can climb into your head and make that decision for you. Finally, it is absolutely essential to maintain a minimally safe weight and healthy eating protocol. It is not possible to recover while maintaining a severely malnourished state.

I'd like to share these words of wisdom. An eating disorder is not really about

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weight, eating, excessive exercise, or purging. It is about self-esteem. It is about how one feels about oneself. The key to recovery is in finding other healthier things that bring you joy and happiness. True happiness comes from within, it cannot be gleaned from reading the numbers on a bathroom scale. Work to find other means of gaining a sense of control over your life and the world around you. Try to channel your energy into another direction. Just imagine how much you could accomplish if you were to channel the energy that you are currently using for your eating disorder into another area, the possibilities are unlimited! Make goals and work towards them. What do you see yourself doing 6 months, 3 years, and 5 years from now? Is an eating disorder in your future? If not, what step(s) can you take today to begin moving your life in another direction? I encourage you to set your goals high and dream. You have the ability to accomplish anything that you set your mind to achieve. A full recovery is within your reach!

The doctors once labeled me a "chronic anorexic." They told my parents that I was schizophrenic and would eventually end up in a state mental hospital. I am telling you this story to let you know that it doesn't matter how long you've been ill, or what you or your family has been told. There is always hope. I am now fully recovered and leading a happy, healthy, full life. If I could do it, you can too. Just remember that the challenge of an eating disorder is in attaining recovery, not in remaining sick. My thoughts and prayers will be with you.

Judy Tam Sargent, RN, MSN

Judy's new book has just been released and has received positive reviews. Look for it at your local bookstore. She also has a web site, which is located at <http://www.angelfire.com/ms/anorexianervosa/index.html>

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be limited, and each program strives to accomplish what they think is best for the client, and will bring that individual as close to recovery as possible within the time available.

Think of your recovery as a pyramid, with mastery of the eating disorder being at the top. Building skills to reach that top is the process of recovery - the skills serve as a solid foundation at the base. A residential stay in a treatment facility can be looked at as speeding up the process, and moving you closer to the top - even giving a taste of what life without the disorder could be like. You don't need to get to the top right away, and that should not be the focus. It's more vital to establish some of the skills necessary to see the top, get a good look at it, and know that recovery is possible. For some, when they leave the treatment facility, most symptoms are gone, and while lapses may occur, full relapse becomes less likely. For many, symptoms persist, but much less intensely than when entering into the facility. Once home, those symptoms still need to be addressed - using the skills you've built up, as well as following up on the relapse prevention plans you developed, and continue to develop.

For us, success is measured by the extent to which new skills have been established during a client's stay. If substantial progress has been made, the probability of full relapse is reduced considerably. Lapses are still quite likely, but as I frequently remind people "a lapse is not a relapse". Once you have a good grasp of what skills you need to strengthen, you can continue to move forward - even though there are some days when that progress can be pretty hard to see. As the saying goes "When you are up to your armpits in alligators, it's hard to remember you came to drain the swamp". No therapist ever expects a rapid solution, nor should you. What many therapists do hope for is a real good running start at a solution, with an ongoing "ripple" effect of the skills learned in the treatment centre that can help carry you on.