NMDS111

Session 12

Eating Disorders, Obesity and Body Image
Session Overview

Eating disorders, obesity & body image

- Understanding eating disorders
- Exploring the experiences of those with eating disorders and the impact this has on nutritional management
- Understanding obesity
- Body acceptance: exploring women's and men’s self-experiences
- Stigmatisations associated obesity and the impact this has on nutritional management
What are Eating Disorders?

• Mental illness which is characterised when eating, exercise and body weight/shape become an unhealthy pre-occupation of someone's life.

• Include anorexia, bulimia and other binge eating disorders.

• Female adolescents and young women are most commonly affected, but men are also affected.

(BetterHealth Channel, 2017)
Eating Disorders

- Behavioural signs:
  - Constant or repetitive dieting
  - Evidence of binge eating
  - Evidence of vomiting or laxative abuse
  - Excessive or compulsive exercise patterns
  - Development of patterns or obsessive rituals around food preparation and eating
  - Avoidance of all social situations involving food
  - Frequent avoidance of eating meals by giving excuses
  - Change in clothing style, such as wearing baggy clothes
  - Eating unusually slowly

(Eating Disorders Victoria, 2017)
Eating Disorders

• Physical signs

  • Sudden or rapid weight loss, frequent changes in weight
  • Sensitivity to the cold (feeling cold most of the time, even in warm environments)
  • Loss or disturbance of menstrual periods (females)
  • Signs of frequent vomiting - swollen cheeks / jawline, calluses on knuckles, or damage to teeth
  • Fainting, dizziness
  • Fatigue - unable to perform normal activities
  • Heightened sensitivity to comments or criticism about body shape or weight, eating or exercise habits
  • Heightened anxiety around meal times
  • Depression or anxiety, moodiness or irritability

(Eating Disorders Victoria, 2017)
Anorexia nervosa

• Involves an inability to stay at the minimum body weight considered healthy for the person’s age and height.

• Persons may have an intense fear of weight gain, even when they are underweight.

• They may use extreme dieting, excessive exercise or other methods to lose weight.

• Most persons with anorexia nervosa deny that they have an eating disorder.

(Zipfel, Giel, Bulik, Hay and Schmidt, 2015)
Anorexia nervosa

- Two main sub-types of anorexia are recognised:
  - **Restricting type**: most commonly known type of Anorexia Nervosa whereby a person severely restricts their food intake.
  - **Binge-eating or purging type**: less recognised; a person restricts their intake as above, but also during some bouts of restriction the person has regularly engaged in binge-eating OR purging behaviour

(Eating Disorders Victoria, 2017)
Anorexia nervosa: Treatment

• The biggest challenge in treating anorexia nervosa is having the person recognise that they have an illness.

• Medications such as antidepressants, antipsychotics, and mood stabilisers may help some anorexic patients when given as part of a complete treatment program.

• Although these drugs may help relieve depression or anxiety, no medication has been proven to decrease the desire to lose weight.

(Zipfel, Giel, Bulik, Hay and Schmidt, 2015)
Bulimia nervosa

• The person binges on food or has regular episodes of significant overeating and feels a loss of control. They then uses various methods -- such as vomiting or laxative abuse -- to prevent weight gain.

• The exact cause of bulimia is unknown.

• Genetic, psychological, trauma, family, societal or cultural factors may play a role – however is likely due to more than one factor.

(National Eating Disorders Collaboration, 2017)
Bulimia nervosa

• Behavioural signs:
  • Frequent trips to the bathroom, especially after eating. The length of time taken for these bathroom trips can depend on the amount of food consumed and the need felt by the sufferer to purge themselves of it.
  • Food avoidance, dieting behaviour. This may because of a fear of gaining weight (as in Anorexia Nervosa) and it may also be to avoid the unpleasant ritual of purging afterwards.
  • Fluctuations in weight
  • Erratic behaviour and mood swings
  • Self harm, substance abuse or suicide attempts

(Eating Disorders Victoria, 2017)
Bulimia nervosa

• Physical signs:

• Erosion of dental enamel from vomiting, tooth decay
• Dehydration
• Stomach & intestinal ulcers
• Inflammation & rupture of the oesophagus and possibly stomach
• Irregular or slow heart beat, heart failure
• Swollen salivary glands, chronic sore throat and gullet
• Indigestion, heartburn and reflux
• Abdominal pain and bloating
• Electrolyte imbalance resulting in cardiac arrhythmia, muscle fatigue and cramps
• Bowel problems, constipation, diarrhoea, cramps

(Eating Disorders Victoria, 2017)
Bulimia nervosa: Treatment

• Most often, a stepped approach is taken for patients with bulimia.
  • Physical health management
  • Support groups
  • Cognitive Behavioural Therapy
  • Nutritional counselling and advice
  • Drug treatment – antidepressants

• Hospitalisation – but is rare. (Eating Disorders Victoria, 2017)
Binge Eating Disorder

• Binge eaters do not throw up their food, exercise a lot or eat only small amounts of only certain foods.

• Resultantly binge eaters are often overweight or obese.

• People with binge eating disorder also may:
  • Eat more quickly than usual during binge episodes
  • Eat when they are not hungry and until they are uncomfortably full
  • Eat alone because of embarrassment and feel disgusted, depressed, or guilty after overeating

(Eating Disorders Victoria, 2016)
Binge Eating Disorder: Treatment

• Psychotherapy

• Medications

• Behavioural weight-loss programs

• Self-help strategies
  • Self-help books, videos and support groups.

(Mayo Foundation, 2017)
Pica:
- Persistent eating of non-nutritive substances
- Often occurs with other mental health disorders

Rumination Disorder:
- Repeated regurgitation of food, which may be re-chewed, re-swallowed or spat out

Avoidant/Restrictive Food Intake Disorder (ARFID)
- An eating or feeding disturbance manifested by persistent failure to meet appropriate nutritional and/or energy needs

(Eating Disorders Victoria, 2016)
Other Specified Feeding or Eating Disorders; and Unspecified Feeding or Eating Disorder

Two new categories of eating disorders are:
• Other Specified Feeding or Eating Disorders (OSFED)
• Unspecified Feeding or Eating Disorder (UFED)

These categories are used to describe a person who shows signs of disordered eating, but does not meet all of the diagnostic criteria for one of the three recognised eating disorders. (APA, 2013)
Types of OSFED

- Atypical Anorexia nervosa
- Binge Eating Disorder (low frequency or duration)
- Bulimia nervosa (low frequency or duration)
- Purging disorder
- Night Eating Syndrome

(Eating Disorders Victoria, 2016)
Nutritional Considerations

- Nutrition therapy is indicated for patients with eating disorders as vitamin/mineral deficiency is frequent.

- More than half of patients with Anorexia Nervosa failed to meet the RDA for vitamin D, calcium, folate, vitamin B₁₂, zinc, magnesium, and copper when assessed by diet history.

- Deficiencies are also commonly found for several vitamins, including thiamine, riboflavin, niacin, B₆, folate, C, E, and K. (Winston, 2012; Mitchell & Crow, 2006)
Nutritional Considerations

• Zinc in particular has been found to enhance the rate of recovery in anorexics by increasing weight gain and improving anxiety and depression.

• AN patients are commonly supplemented with calcium and Vitamin D, despite uncertainly about Vitamin D status in the AN population.

(Winston, 2012)
Social Perspectives on Eating Disorders

• Since the early 20th century, media sources have encouraged young women to idolise and follow specific role models.

• These “heroines” are praised for being beautiful and thin.

• Young women thus are conditioned to believe that in order to be truly happy, successful and worthy of admiration, they too must be beautiful and thin.

(Rudkin, 2003)
Social Perspectives on Eating Disorders

• These images are perceived as the master status, with those who do not meet this standard branded as inferior or unfit – “stigmatized”.

• Bodily beauty as a cultural goal presents a strong risk of anomie, because beauty is largely an innate physical attribute.

• The average woman does not have a reasonable opportunity to achieve the objective as being thin as her celebrity role-models are.

(Rudkin, 2003)
Social Perspectives on Eating Disorders

- The ‘Thin Ideal’.

- Young women agree with and strive for the cultural goal of being thin and beautiful, but are simply unable to attain it through normal means - so are forced to circumvent the process of eating entirely.

- The social norms governing women’s appearance and behaviour result in concern about the implications of food consumption for the look of the female body.

(Rudkin, 2003; Germov & Williams, 2017)
Factors Influencing ‘Thin Ideal’

• Rise of consumerism – promote a thin ideal of beauty that majority unable to attain thereby create virtually infinite demand among consumers. e.g. Atkins and Zone diets.

• Cultural preoccupation with thin ideal: Government dietary guidelines.

• Women’s desire to be attractive and pressure of conforming in patriarchal society.

(Germov & Williams, 2017)
Eating Disorders and Stigmas

• Several studies suggest that only a minority of individuals who suffer from eating disorders ever seek treatment.

• Stigma is a significant barrier to the treatment of mental disorders.

• One possible barrier to treatment seeking among individuals with eating disorders is the fear of being stigmatized.

(Stewart, Keel & Schiavo, 2006)
Eating Disorders and Stigmas

• Many members of the public believed that individuals with eating disorders should “pull themselves together” and that such persons “had only themselves to blame”.

• In a study completed in medical and nursing staff in a general hospital, 59.4% of respondents stated that patients with anorexia nervosa were responsible for their condition.

• Tendency to blame individuals may have considerable negative consequences.

(Stewart, Keel & Schiavo, 2006; Crisafulli, Von Holle & Bulik, 2008)
Eating Disorders and Stigmas

• Anorexia nervosa and bulimia nervosa do not have the same public manifestation as other mental illnesses.

• Essentially, these illnesses are a private family affair.

• As a result, the stigma associated with eating disorders comes from the mistaken impression that others (parents in particular) are to blame for the illness.

• The stigmatisation isolates parents from their peers and other family members.

(Deloitte Touche Tohmatsu & The Butterfly Foundation, 2012)
Men and Eating Disorders

• Issue of men’s body image is of particular interest because it is thought that cultural attitudes towards the male body have been in a state of change since the mid-1980s.

• Men are becoming more concerned with body image.

• Social pressure is on men to achieve ‘muscular ideal’ – indicates strength and masculinity.

• Male body ideal exaggerates masculine traits to convey power and dominance.

(Germov & Williams, 2017; Pope et al., 2000)
Men and Eating Disorders

• Advertisements celebrate the young, lean, muscular male body, and men’s fashions have undergone significant changes in style both to accommodate and to accentuate changes in men’s physiques toward a more muscular and trim body.

  (Grogan & Richards, 2002)

• The muscular ideal has become widespread as evidenced by the athletic looking male model – highly toned muscles, large biceps and six-pack of well defined abdominal muscles

  (Germov & Williams, 2017)
Eating Disorders

• It is widely believed that our society’s ideal of the female body has grown steadily thinner over the years.

• Men increasingly are faced with changes with body image, however differs to that of women.

• Changes in body image in both men and women is evident over the past three decades.

• Portrayed in the ever changing bodies of popular celebrities.
Role of Nutritional Medicine in Treatment

• Eating disorders are typically precipitated and perpetuated by a combination of genetic, developmental and psychological factors, requiring a multidisciplinary team approach to treatment.

• Greater understanding of the factors that contribute to the difficulties leading to patients treatment being resistant will help improve treatment outcome and reduce morbidity and mortality in these disorders.

(Yager et al., 2012)
Role of Nutritional Medicine in Treatment

• Those with eating disorders have issues with trust which can be compounded with previous relationships with the family and other physicians being negative.

• The presence of comorbidity has been shown to be associated with increased difficulties in treatment which include depression, anxiety disorders, substance abuse and characterologic disturbances.

(Yager et al., 2012)
Role of Nutritional Medicine in Treatment

• Important to ensure the provision of quality services for those with eating disorders.

• Referrals are important – multidisciplinary approach.

• Many organisations who aim to undertake strategies to build quality, sustainable eating disorder treatment responses delivered by public specialist mental health services.

(Jones, 2010)
Role of Nutritional Medicine in Treatment

• Encourage consumption of nutrient dense, sugar free foods.
• Frequent smaller meals.
• Support digestion
• Increase foods rich in potassium and magnesium
• Consider nutrient deficiency such as water soluble vitamins.
• Consider biochemical functioning.
• Support!
Understanding obesity

Retrieved from: https://cdn.pixabay.com/photo/2016/12/16/15/20/lose-weight-1911605_960_720.png
Understanding Obesity

• Obesity is a major public health problem across the world.

• Obesity results from excessive caloric intake, decreased energy expenditure and/or from a combination of the two.

• Body mass index (BMI) used for classifying overweight and obesity = Weight (kgs) / Height$^2$ (mts)

• $\text{BMI} = \frac{70 \text{ kg}}{(1.75 \text{ m})^2} = \frac{70}{3.06} = 22.9$ (ideal)

(WHO, 2017)
## International Classification

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<tr>
<th>Classification</th>
<th>BMI (kg/m²)</th>
<th>Chronic disease risk</th>
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<td>Underweight</td>
<td>&lt;18.5</td>
<td>Low (but increased mortality and morbidity from other causes)</td>
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<td>Severe thinness</td>
<td>&lt;16.0</td>
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<td>Moderate thinness</td>
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Cut offs may not be appropriate for >65 year olds, see page over for further detail.

(WHO, 2017)
Understanding Obesity

• Worldwide obesity has nearly tripled since 1975.
• In 2016, more than 1.9 billion adults, 18 years and older, were overweight. Of these over 650 million were obese.
• 39% of adults aged 18 years and over were overweight in 2016, and 13% were obese.
• Most of the world's population live in countries where overweight and obesity kills more people than underweight.
• 41 million children under the age of 5 were overweight or obese in 2016.
• Over 340 million children and adolescents aged 5-19 were overweight or obese in 2016.
• Obesity is preventable.  

(WHO, 2017)
Health Consequences of Obesity

• Cardiovascular disease (mainly heart disease and stroke) - already the world's number one cause of death, killing 17.7 million people in 2015

• Diabetes – 422 million people worldwide have diabetes.

• Musculoskeletal disorders – especially osteoarthritis.

• Some cancers (endometrial, breast, ovarian, prostate, liver, gallbladder, kidney and colon).

(WHO, 2017)
Understanding Obesity

• The aetiology of obesity includes both genetic and environmental factors which include:
  • Environmental factors related to lifestyle, cultural or socio-economic conditions
  • Psychological factors
  • Metabolic factors
  • Gut microbiota
  • Nutrigenomic factors

Socioeconomic Environmental Impacts & Obesity

• Strongly influenced by environmental factors, such as:
  • **Poverty**
    – Poorer diets in low SES
  
• **Housing conditions**

• **Work situation**
  – Decrease in energy consumption at work, increase in calorie intake at work and transportation methods.

(Youseff, n.d; WHO, 2017; Rosengren & Lissner, 2008)
The Media & Obesity

- Advertising gives children confused messages about nutrition, and can change their food preferences and buying behaviour.

- Subsidies of agricultural products play an important part, as children as well as adults are influenced by cheap prices.

- Labeling and packaging claims confuse the public or poor education means that the public are unable to judge which products are high in fat and by how much.

(Youseff, n.d.)
Childhood Obesity Causes

- Food choices
- Lack of physical activity
- Sedentary pursuits
- Overweight parents
- Genetics
- Certain diseases

(Better Health Channel, 2013)
Culturally and Linguistically Diversity Communities & Obesity

- Psychosocial factors associated with the incidence of obesity in CALD groups include:
  - Competing priorities and lifestyle barriers
  - Inadequate social support or physical facilities
  - Language and cultural barriers to understand health promotion messages
  - Poor health literacy
  - Availability and marketing of junk foods
  - Lack of government policy specific to CALDs

(Cyril, Nicholson, Agho, Polonsky, Renzaho, 2017)
Obesity & the Nutrition Transition

• Low and middle income countries now facing “double burden” of disease – particularly in urban settings.

• Whilst continuing to face infectious disease and under-nutrition, at the same time they experience a rapid upsurge in chronic risk factors such as obesity and overweight.

• Not uncommon to find under-nutrition and obesity existing simultaneously.

(WHO, 2017; FAO, n.d.)
Obesity & the Nutrition Transition

• In the developing world obesity is seen as a result of a series of changes in diet, physical activity, health and nutrition, collectively known as the 'nutrition transition.'

• As poor countries become more prosperous, they acquire some of the benefits along with some of the problems of industrialized nations.

• Caused by inadequate prenatal, infant and young child nutrition followed by exposure to high-fat, energy dense, micronutrient poor foods and lack of physical activity.

(WHO, 2013; FAO, n.d.)
Obesity & the Nutrition Transition

• Globalisation has changed the face of obesity.

• Increased availability of foods at lower prices means the poor have richer diet, however nutrient depleted and energy dense.

• Also lower SES have limited access to nutrition education.

(Baker & Friel, 2014; FAO, n.d.)
Addressing Obesity

- Obesity needs to take a multifactorial approach.

- Need to examine from several levels
  - Individuals
  - Community
  - Local government
  - National levels
  - Globally

(WHO, 2017)
Obesity and Social Science

• Interest in the social aspects of obesity is not new.

• Extensive writings about the social and psychological consequences of obesity, including the stigmatisation and discrimination of obese and even overweight individuals, by Jeffrey Sobal.

• Scholars with more anthropological twist have written about the different social perceptions of obesity. i.e. the positive view of fatness among some indigenous people.

(Swinburne et al., 1996; Qvortrup, 2010)
Body Image Through the Ages

• 120 BC – Venus de Milo, Greek goddess

• 1400s - Botticelli’s Birth of Venus (pictured)

• 1500s - Leonardo da Vinci’s Mona Lisa

• 1600s- Rubens garden of love

Picture taken from Public Domain

(Youseff, n.d)
Body Image Through the Ages

- **1880s** – Plump body, pale complexion.

- **Early 1900s** – Plump body, corseted, hour-glass look.

- **1920s** – Era of the flat-chested, slim hipped flapper.

(Images retrieved from Creative Commons; Youseff, n.d)
Body Image Through the Ages

• WW II – Emphasis back on curves.


• 1960s – The gaunt twiggy look. Typical models BMI 15.3.

(Images retrieved from Creative Commons; Youseff, n.d)
Body Image Through the Ages

• 1970s and 1980s – Tall, thinner look with muscular tone.

• Early 1990s – Waif-like figure of Kate Moss. Pre-teen look in adult women.

(Images retrieved from Creative Commons; Youseff, n.d)
Body Image and Acceptance

- Late 1990s – Narrow hips, yet large breasts, rare without implants.

- 2000s – Average model BMI and % of body fat <18 whereas average American BMI was 26.1 and % body fat >32%.

(Images retrieved from Creative Commons; Youseff, n.d.)
Thin Ideal and Dieting

• Thin ideal = social desirability of a slender body shape which is considered the epitome of beauty and sexual attractiveness.

• To achieve thin idea, food choice is implicated – women assess food in terms of its dieting value, “dieting” or “fattening” food.

• Can lead to ‘yo-yo’ dieting with detrimental effects of feelings of guilt, anxiety and deprivation associated with food and eating.

(Germov & Williams, 2017)
Body Image and Acceptance

• Increasing amount of people seeking to control their weight.

• In a substudy of the ALSWH, 74% of more than 11,000 women (47-52 yo) reported trying to control their weight and only 1 in 5 was happy with her weight.

• 43% of women also wanted to lose more than 6 kg in weight.

(Germov & Williams, 2017)
Body Image and Acceptance

• The socially desired body ideal may change over time in terms of size and shape, but the existence of an ideal of women to aspire to has remained consistent.

• The thin ideal is a relatively recent phenomenon with factors such as food shortages caused by the Great Depression (1929) and WWII contributing to its emergence.

• Models and celebrities play a major role as the public face of beauty changes.

(Germov & Williams, 2017)
Body Image and Acceptance

• Study of the body image construct and its influences is important because body image dissatisfaction among women is culturally pervasive and can lead to the development of eating disorders.

• It has especially been a concern in college environments where emphasis is placed on appearance.

• Social media has also been highlighted as an area of concern

• Body image is not a static concept.

(Selzer, 2006; Fardouly et al., 2015)
Body Image and Acceptance

• Body image is an issue of concern especially to young people.

• It affects:
  • their sense of identity and self-esteem.
  • how they maintain a healthy lifestyle and relationships.
  • how they demonstrate to others the values of respect, care and compassion and inclusion.
  • And affects how they deal with self-esteem and body image as an adult.

(Selzer, 2016)
Stigma and Obesity

• Bias, stigma and discrimination due to weight are frequent experiences for many obese individuals.

• Serious consequences for their personal and social wellbeing and emotional health.

• Perceptions about the causes of obesity may be partially responsible for the stigma and bias.

• E.g. Assumptions that can be prevented by self-control, patient is non-compliant and caused by emotional instability contribute to negative attitudes.

(Puhl & Heuer, 2010)
Stigma and Obesity: The Workforce

• Obese employees are viewed as less competent, lazy and lacking self-discipline by their co-workers and employers.

• Negative impact on employee wages, promotions and decisions surrounding employment status.

• Research also shows obese applicants less likely to be hired than thinner applicants.

• Discrimination and rejection.

(Puhl & Heuer, 2009)
Stigma and Obesity: At School

• Many forms of weight stigmatization occur in educational settings – preschool to tertiary education.

• Face harassment and rejection from peers, biased attitudes from teachers, etc.

• Research suggests stigma toward overweight students begins quite early on with negative attitudes reported amongst pre-schoolers who associated overweight peers with characteristics of being mean, stupid, ugly, unhappy, lazy and having few friends.

(Puhl & Heuer, 2009; Swami et al., 2008)
Stigma and Obesity: In Healthcare

• Weight stigma also exists in healthcare settings with negative attitudes regarding overweight patients reported by several healthcare professionals.

• Research evidence that even health care professionals who specialise in treatment of obesity hold negative attitudes.

• Patients may be less likely to seek medical care, delay important preventative healthcare services and cancel appointments.

(Puhl & Heuer, 2010; Puhl & Heuer, 2009)
Stigmatisations and Obesity: Consequences

• Research indicates that individuals experiencing weight stigmatization have higher rates of depression, anxiety, social isolation, low self-esteem and poorer psychological adjustment.

• Negative consequences on food and nutrition - under and overeating are likely.

• Implications for physical health by avoidance of health care services due to bias in medical settings – thus may contribute to additional complications and co-morbidities.

(Lewis et al., 2011)
Stigmatisations and Obesity: Your Role

• Consider that patients may have had negative experiences with other health care professionals – be sensitive.

• Ensure you ask an array of questions – explore all causes and other presenting problems.

• Emphasise changes to behaviour rather than just the number.

• Supportive health care environment and friendly patient reading material.
Summary

• The three main types of eating disorders: anorexia nervosa, bulimia nervosa and binge-eating disorder.

• Women are much more likely than males to develop an eating disorder. This has been attributed to a number of reasons both within women and society at large.

• Wide variety of vitamin and mineral deficiencies to consider.

• Evidence suggests genetic and other factors play a role.
Summary

• Stigma associated with eating disorders plays a major role in the treatment and experience of those suffering from eating disorders.

• Educating the public on eating disorders is vital to overcome stigmatizations.

• Eating disorders require a multidisciplinary approach.

• Referrals are important to ensure the provision of quality services for those affected.
Summary

- Obesity is a major public health problem across the world.
- Bias, stigma and discrimination due to weight are frequent experiences for many obese individuals.
- Obesity and associated stigmas impacts upon individuals on many levels, particularly emotional.
- Body image representations play a major role.
Summary

• Body image of ideal woman has altered over time – it is in constant change.

• Thin ideal = social desirability of a slender body shape which is considered the epitome of beauty and sexual attractiveness.

• Repercussions regarding dieting and impacts on nutrition and food choices.

• Impacts also on emotional level – extreme dieting leading to eating disorders.
References


References


References


References


References


References


References


• Youssef, A (n.d.) *Understanding Obesity through Sociology.* University of Pittsburgh.

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