Danny Lennon: And here we are. Ari welcome back to the podcast. It's good to have you here again my man.

Ari Snaevarsson: Thanks for having me again Danny. It's great.

Danny Lennon: Yes. As I was just saying before we started recording, I've lots of questions on this particular topic we're going to cover today. For you I think it's definitely the most important that can be discussed and right now is certainly one of the most prevalent that either people listening are facing, have faced or definitely know someone close to them who at some point will face. The last time you were on we talked about re-feeding in Anorexia Nervosa specifically that episode was a big hit, and so for anyone listening who is interested in clinical nutrition. If you haven't listened to that episode yet go back and listen. I believe it was 222 perhaps. I'll double check that for you guys and put it in the show notes, but I think in that particular episode you raised lot of interesting questions and ideas that led onto a lot of great discussion, particularly from a lot of the dieticians that listened to the show afterwards. So, I think we have lots of bases to cover, more interesting conversation in this particular episode.

So today, we wanted to get into maybe a broader discussion around recovering from an eating disorder, and then maybe throughout this we'll narrow down into some specifics. But from the get-go I suppose maybe a good place to start would be when we talk about eating disorders there's obviously a large spectrum here when we're talking about a disorder all the way from some

very severe eating disorders and all the way down to maybe people who are just showing some behaviors or patterns of a disordered eating or perception of food. So, due to that do we need to discuss recovery separately for each thing or are there enough commonalities that we can start broad, and then focus on specific later or how do you think we should get people to think through that term 'eating disorder' and how we can kind of classify from there?

Ari Snaevarsson: That's a really good question, and so this actually brings up something that is very much missed in eating disorder treatment. So, what I've said before and it sounds a little bit rough but I've said is that anorexia is really the only real eating disorder in the real sense of the word, where the others are more what we can accurately call psychiatric disorders and they are actually eating disorders but the difference is that anorexia is primarily a biological and metabolic disorder at its root which was something that I kind of touched on but not really when we last spoke. It's driven by disturbances in hunger patterns and how the body sees and processes food, whereas the other disorders like bulimia, and binge eating, and even down to ARFID and OSFED and all of those are going to be much more psychologically based, and so treatment is going to definitely be different for those. However, and we'll get into this more, but in the book that I've written here I address all of them and the reason that's possible is because we can look at recovery from a general sense of feeling a relationship with food. However, there are going to be specific strategies, especially in formal treatment that are going to differ between different eating disorders. So, hopefully that somewhat answers the question there.

Danny Lennon: Sure. There are probably a lot of different places we can jump into this and I might bounce around in this discussion with different ideas, and then towards the end we might be able to tie some of it together. One thing that maybe is a first thought for me at least is that for people who have suffered or suffering from any form of eating disorders is trying to see where the light at the end of the tunnel is and deriving some optimism of what to do and how to make a recovery and that kind of maybe ties into this other idea of how much of a recovery is possible in all cases, and can we get to a state of full recovery. And if that is so then on the back of that what factors may increase the probability of that recovery being a success? So, within those two questions let's start with that first one of determining what a full recovery actually means, and who

is that possible for, and maybe alleviating some of the typical concerns and questions you hear about that from patients that you work within the clinic as well as kind of clients?

Ari Snaevarsson: Right. When it comes to full recovery it's a murky term, and it's kind of thrown around and different professionals like or don't like to use it. I think part of the problem with the term like that, even though I use it and colloquially it's easy to use that in treatment, part of the problem is that it makes it sound like things like relapses are there for disqualifiers from true recoveries. So, full recovery makes it sound like you are this perfectly intuitive eater who has no more not only behaviors but intrusive thoughts or urges or anything like that. But in reality that's not an accurate goal. It's not a realistic goal for those people to shoot for, and so I guess I would hesitate to even assign the term full recovery, although, again I have used that before. I just think that relapses and things like that are part of the process and they shouldn't be demonized and kind of made to turn this into the 'partial recover' category.

Danny Lennon: Even within the broader term of recovery itself what is it that we're essentially shooting for, what is the kind of center of the bulls-eye for the things we are attempting to change. And therefore how does that influence what that process might look like from then on?

Ari Snaevarsson: Sure. Yeah. Well, so for things like – so let's start with anorexia would definitely be, it's kind of the beast here when we talk about different eating disorders and treatment for any of them. That's the hardest to recover from and it's the most life consuming eating disorder. Recovery from anorexia would generally speaking look like remission of symptoms in the sense that – so the client is no longer restricting food intake and they're able to maintain a healthy bodyweight which is a pretty important classification there that they're able to maintain that healthy bodyweight, they're no longer restricting food intake, they also no longer report intrusive thoughts on a regular basis, so they don't consistently feel like they have to restrict or that they have to over exercise or purge which I'd mentioned last time that purging type anorexia is still a type of anorexia. So, really just remission of any symptoms that would render them in anorexic as basic as it sounds. Those are going to be all we look for. They don't need to be – like I alluded to earlier, they don't need to be these perfectly

intuitive eaters or anything like that; they just need to get past that restricting stage.

Danny Lennon: From the get-go if we're trying to set in place a process for anyone with an eating disorder where there's going to be some degree of recovery. When you are in that initial point with a patient and you're maybe setting some initial goals with them what are the metrics that you're essentially looking to assess, because as you say, if it's going to be a recovery from this that's obviously for something like anorexia presumably going to be quite a substantial period of time. So, how do you get people to think through – what other metrics can we assess maybe on a more ongoing basis, what are some of those small steps to focus on in that initial period that you would push people's attention towards?

Ari Snaevarsson: You know that's a good question because it's common that you would see recovery as you haven't succeeded until you've recovered. So, the question gets at the idea of what can we measure, so what can be track progress in terms, and then what sort of realistic goals can we set. To answer that I think I would put exposure therapy pretty high up there, so exposure therapy and just exposures in general are a great way of measuring progress because regardless of the eating disorder there is obviously going to be some degree of you know the individual has an issue when they sit down in front of food something is going wrong. So, if we can measure how they view food and whether they – so I'll take the example of the anorexic, if they are able to complete more meals, and often in the clinic that I work in that is the metric we use, we say let's shoot you complete four out of six meals today something like that, and not refuse any meals. It could also be things that are a little bit more subjective, so like mindfulness cues and being able to use those coping skills in moments of intense urges, and refraining from engaging in behaviors little things like that. So, that the goal is not full recovery all the time because that's just not going to be realistic, especially if someone is pretty deep in the trenches of their eating disorders, and instead it's those little markers of progress.

Danny Lennon: At the risk of this being a bit broad of a question, and then maybe we can dive into the specifics afterwards. But at least from an overview level when we are thinking about that recovery process what are some of the factors that may increase the probability of that process being a success?

Ari Snaevarsson: So, the standard model of care for anyone with any eating disorder which in and of itself the fact that we group them altogether in formal treatment might be a bit of an issue. But regardless we're going to look for things like exposure therapy what I already alluded to that's going to be something that needs to happen pretty regularly. They need to have a support system. This is something that I've advocated for multiple times in my videos, and then in the book as well. When I talk to clients that having a really big support system is super, super important not just in the sense that you have a few people to report to, but just that really everyone in your life who is somehow important to you is onboard with this recovery journey. So, that's another really helpful facet of recovery. I think another one would be access to multiple medical professionals, otherwise known as the treatment team, so if you are able to see a psychiatrist and hopefully a therapist as well as the dietician, a medical doctor, and then if there are any gastrointestinal problems a gastroenterologist like everyone that's part of your treatment team as well working together. Those are all going to funnel into a largely successful recovery.

Danny Lennon: So, just to touch on one of those components that I think is a particularly important one, you mentioned the support system that people have in place and specifically you said about having a big support system and including as many people in maybe different areas of their life that are kind of close to them I guess and having them onboard with that. So, there are kind of two questions around there. One would be from the perspective of the person going through the recovery what should they be looking for from people around them who could be a support to them, and then the second part would be for maybe those listening who want to be supportive of a friend or family member who is recovering from an eating disorder, what actions would you say are advisable and what are not advisable in terms of how they can best be a support to that person?

Ari Snaevarsson: This is where things like the type of language that people use, and I think both discussions will sort of bleed into one another naturally, but the language that people use is really important. So, this is something that I see in the clinic that I work in when – I did an internship there last year before I ever started working there, and I was able to sit through things like family meals where the family would come and eat with the patients, and something

that's really common is there's a lot of language that we don't realize is harmful or counterproductive to one's recovery. So an example would be things like you know parent sitting there with their daughter and saying something like I'm glad that you are completing your meal or you look healthier things like that that seem on the surface to be helpful comments and actually somewhat perpetuates these eating disorder thoughts what we call 'Head Thoughts', and things like that. So, just to give you that actually real answer here I guess what I would say is that body positive language is the most important thing along with eliminating what we call 'Food Talk' at the table, so definitely not talking about dieting or weight loss or things like that at the table but even beyond that just talking about food in general can be a problem because they already have all of these thoughts going on in their head about what they're eating, and what it's doing their body. So, things like that are really important, and then above and beyond that the other thing I want to make sure to say is that it's not about fixing the problem. It's about listening to the problem and making sure that the sufferer of the eating disorder feels safe and heard. It's something that's pretty common, especially with dads, not to over generalize here, but it's common that a dad or anyone really wants to fix the problem and make it go away, and so you'll say things to the person going through an eating disorder like well why don't you try this, why don't you start doing this rather than sitting there as uncomfortable as it can be if you're a loved one of someone going through this, sitting there and truly listening to what's going on and just saying that you know I hear you, and I understand how scary this is, and how all consuming this feels something like that that's extremely productive and helpful.

Danny Lennon: With that idea that language itself can be harmful even at the surface people may not realize it, once someone knows obviously we can do something about it. But this probably speaks to the importance of what you said previously, of making sure people around you and in that support network are all on the same page, and they know about what's going on, they know about how you feel addressing this. Then with that said though that kind of throws up this other question of how does someone open up to these people, because I mean if we want them to understand the challenge being faced, and how to be supportive, first they have to know about it. But sometimes people can find it difficult to tell even the people closest to them, and maybe in fact in some case those people who are closest could be the most difficult to talk to.

So, I'm just interested to hear from what you've learned talking to patients on this and what you would typically do in practice. What do your conversations look like with them typically when they have concerns about opening up either to family members or close friends or anyone else that could be a potential member of that support network?

Ari Snaevarsson: There are lots of questions and worries at that point. This is something that I've worked with directly with the clients that I work with. We almost always, especially if they're younger have to go through the whole process of them opening up to their parents about this if they haven't already, and to anyone else who is really close to them whether that be a significant another family member they live with or a therapist. So, you know really anyone but this brings up a really important question because this is a very personal and vulnerable thing to have to bring this up, and it boils down all the way to the level of you know every meal you are eating now you have these people assuming you live with them, you have these people now watching you eat, and you're constantly thinking about you in the sense and it's such a deeply personal thing that it can be scary to invite other people into that world. So, one thing that we tend to do and one thing that I make sure to talk about is kind of flipping the script of what strength means. What I've told the clients in the past is that I know it can be scary to open up to let's say your parents about an eating disorder simply because they might see you as not being strong that's something that I hear often. But at the same time this is a whole new sense of the word strength you know as corny as that sounds, there is a lot of strength to be had in opening up about something this personal. There is also a lot of strength in just going through something like an eating disorder and I think often times opening up about this reverses and switches the dialog at home in a very positive sense, because no longer is you know is this kind of pushed under the rug and it's dieting talk frequent in the house, and now everyone can be on your team, so to speak, although like I spoke to earlier even that can be a little bit troubling and that's still something that we need to work on. But yeah it's really about – there's not much more to say other than that it has to happen that you have to open up to these people but in my opinion that's the best way to look at it is just that you are showing another side of you, another strength that you have.

Danny Lennon: Yeah. I guess kind of related to that with the support network we're touching on this idea that by having this group of people

around you that are on the same page are putting you in an environment that's going to increase the likelihood of the recovery being a success. And obviously if there's going to be certain behaviors someone is trying to either add or eliminate or at least alter the same would probably extend beyond just the people around us and typically the environments that that person is placed in or that they put themselves in. So, from a perspective of modifying their environment, and again this could include other people and certain situations and where they spend their time. How do you get people to think through the idea of what kind of situations and environment they should or shouldn't put themselves in, and what degree of I suppose change does that create in someone's life because presumably it creates a bit of upheaval at least initially?

Ari Snaevarsson: Yeah. There is a lot of areas that need to be changed. That's a good question because even if you don't go through an eating disorder I think it's pretty apparent to all of us that diet and nutrition, and talk about peoples' qualities and exercises very apparent and very readily heard without you asking for it, and so that's a big part of this is that this is part of your environment. I work at the residential level of treatment and we once the patients are discharged they now are going to be going home, even if they are going down to partial hospitalization they're still going to be going home for part of the day, and they're going to be re-exposed to this world. So, it's really important that they have early exposure to it in treatment, but what I would say in terms of altering that environment is first and foremost you have to really, really honest with yourself. So, social media is the perfect example here where any social media platforms that you're using that you as someone going through an eating disorder have noticed are troubling you know this is where people post their best sides not only in terms of pictures but in terms of like accomplishments. Perfectionism is a very common theme in eating disorders. This can be a really big problem and separating yourself from that world can be super, super helpful. So, that's usually an area that pretty commonly is advised to cut off. I would also say though that let's be really careful about who you're spending time with. Again, as someone going through an eating disorder whether the people that you're spending time with are in full understanding of what this means and what their language means. Let's say that you are spending time with people who are what we could almost call orthorexic or just very, very into the clean eating lifestyle and you are someone who is going through

an eating disorder or recovering from an eating disorder it's really important to check something like that and see to what degree is this actually benefitting your life, and to what degree is this worsening symptoms. And of course, it doesn't mean you have to cut everyone off, but it's really important to have that talk with people and make sure everyone is onboard with what your true goals are there. I know that's somewhat broad answer but environment is going to be such a big part of this, and there are so many facets of the environment that need to be altered on some level for anyone going through a pretty severe eating disorder. So, those are two places to definitely look.

Danny Lennon: Right. I think it just probably speaks to the idea that it's not just about addressing that first line of what we do with food and how we view food, and the person's behaviors around meals but it's realizing that there are many things outside of that that are playing indirect and direct roles on influencing some of those behaviors and patterns that they also have to be addressed as opposed to being completely focused on the behavior with the food, if that makes sense?

Ari Snaevarsson: Totally. Yeah, and then that's something that's pretty common sentiment where people say that eating disorders aren't about the food. Even though that term is thrown around a lot, but it's so true. It's like very often the food itself is not the problem it is everything else and the sort of mental environment that you've created over time, and food just sort of fits into that as just one piece of the puzzle. But changing the food alone is generally not going to be enough which is why with the clients that I work with even though I am a nutrition coach we often times spend a lot more time on habits that aren't related to nutrition. Of course, we do touch on the nutrition piece quite a bit, but it's just because so much else alters and influences the way you view food, and the way you eat food, and really all of that. So, yeah you are totally right that the food itself is just a small part of this.

Danny Lennon: Yeah. I want to go back to something you said earlier that kind of important idea that we shouldn't view things in this binary fashion of recovered or not recovered. And part of that you mentioned that someone shouldn't necessarily then see relapses as being oh you are not recovered or you are not able to recover, and I said that maybe part of the process in that it's going to happen in many cases anyway. Do we know the kind of frequency which that may happen, and again that's probably depending on the case

we're dealing with. But beyond that what seems to be the most effective thing in practice for dealing with such events?

Ari Snaevarsson: Well, when it comes to relapses this has a different meaning for different eating disorders. So, if someone who is going through anorexia nervosa a relapse will refer to restricting if it's restrictive type or purging if it's purge type. Someone who is a binge eater a relapse could look like a binge session, and then all the way down to someone with ARFID it could look like refusing whole food meals things like that. So, there are a lot of different definitions of relapse and it's important to notice that because sometimes eating disorders and eating disorders symptoms can push through the sort of the continuum of disordered eating, especially in treatment where you are exposed to other people dealing with other eating disorders. Someone who is purely anorexic and has no binge eating component going into treatment can develop binge eating symptoms and it could work in the opposite manner as well. And so, now we have to ask well what really defines a relapse and it seems like it's going too far into it but really it's important because for someone who is going through anorexia if they were to have a binge eating session out of nowhere it's a legitimate question whether that is a relapse because it's not a behavior that they are used to, but it's still a behavior that they engaged in. And so, to answer all that I would say that it's another reason that it's really important to remove the presence of relapses and urges and things like that as a qualifier of recovery, and instead look at the positives and look at things that you are doing. So, this is one reason that I am such a big advocate of exposure therapy is that once you have graded exposure therapy up to a certain point you can say for a fact that someone has recovered. If you were to take someone who is bulimic and you take them through exposure therapy over months, and months and they get to the point where they can eat a meal in front of let's say a bathroom, this is a pretty common exposure therapy technique, in front of the bathroom with the door wide open and does not engage in a behavior even when left alone you can say that that is a pretty concrete form of evidence that that's recovery. So, recovery can differ by definition depending on not only of eating disorder but how it's experienced and all of that. But really it is important to move away from the paradigm that relapses can't be part of recovery.

Danny Lennon: Yeah. Earlier when we talked about the language to be used you mentioned the value of body positive language, and that I

suppose ties into body positivity in general. So, when we discuss that concept first what is the most accurate way for people to frame what body positivity is, and then second from a pragmatic perspective how does one actually cultivate body positivity or at least what are some of the initial starting points that may help to cultivate body positivity?

Ari Snaevarsson: Yeah. This is something where I think there is a strong negative connotation because of the general atmosphere of nutrition and things like that where when I say something like body positivity it immediately gets a bit of a cringe or wince from a lot of people because it's seen as this far-out social justice movement where in reality, at least for how I have seen it, there is nothing too political or social about this, although those are elements. Really what it means is that it's impossible to incite meaningful lifestyle change from a place of self hatred and lower self-esteem, especially if something like your body – so if you are trying to become a more intuitive eater which is the direction I try and have all my clients work in, moving towards intuitive eating and moving away from the intense dieting practices that are prevalent. If you were trying to do something like that it's really difficult to come at that from a place of disliking your body and needing your body to change, and especially in the binge eating sort of worlds where it's still seen – you know weight loss is still seen as a viable solution to the problem unfortunately. People continually look at their bodies in a negative way and look at their bodies as they need to change this. In reality often times the exact opposite happens, and when you demonize your food choices and demonize your body and you are that negative towards yourself. Even though it's understandable when you're in a mental place like that, it has the exact opposite effect and it just leads to more emotional eating, and perpetuating the restricting cycle or binge-purge cycle and it makes the problem worse. And so, body positivity, to finally answer the question, really means having respect for your body and not speaking down on your body, but also – for example, exercise is a perfect example here. Doing things like exercise out of love for your body, and out of expressing the strength that your body carries rather than punishing your body or forcing yourself to look a different way out of hatred of your body and things like that. So, it boils down to loving the body that you're in and just appreciating your body.

Danny Lennon: Yeah. I think one of the really important things you touched on there was the negative connotations that can come with

something like body positivity or you also see the same thing with the Health at Every Size movement as well is that there's often this – probably two parts. One is just maybe a miscategorization from some people and I think it's easy to fall into that because of some of the messages you see from people who extrapolate that out to ridiculous proportions. So, if someone is saying something like excessive fatness and obesity is not unhealthy and it's a complete social construct or whatever we could dream up as a message. Obviously, that is potentially dangerous. However, from talking with some people who are more knowledgeable in this area of the Heath at Every Size recently I've come to see that the people who really understand and purport these messages they are actually promoting the idea that no matter what your size you can still adopt health promoting behaviors, and so it essentially says rather than focus solely on losing weight which can lead to a lot of negativity, and obviously stigma, and feelings of not doing well or not making progress. Instead no matter who the person is they can always focus on adopting healthy behaviors, and I think the same thing could be said here with body positivity. People might be of a miscategorization of what people are trying to say if they're using that in the strict sense of – at least originally meant, because a few people on the internet have extrapolated it to more ridiculous conclusions?

Ari Snaevarsson: I think you are exactly right about that, and I think it's great that you've mentioned that because here is one thing where even the acronym of HAES or Health at Every Size you used it correctly. I think a lot of people – I hear a lot of people call it Healthy at Every Size and it seems like a small difference but really – you're totally right, what it is, is focusing on the fact that anyone regardless of what they look like, what size they are, how much fat they have deserves to a) get fair treatment from medical professionals, b) they get to focus on their health without having messages of weight loss forced on them at every turn which isn't to say like you said earlier, someone who had moderate to obese bodyweight it's undeniable that there is ill health consequences associated with that. So, it's not to make any claims in that direction. It's just to say that everyone deserves that, so that's why it's really important to even just teach people that the acronym stands for Health at Every Size and not Healthy at Every Size. So, I am very glad you brought that up.

Danny Lennon: Yeah. I think the real thing when you dig into that of that it's more focus on health promoting behaviors and that anyone can start to

do those. It kind of shifts the goals towards – people now are focusing on the process and the behaviors to follow each day as opposed to some endpoint bodyweight, right? So, if they haven't reached it then instead of feeling like a failure now they can say well there are all these behaviors that I have now adopted, I started to do some exercise or started to eat healthy food whatever it is these behaviors can now be seen as signs of success even before or in lieu of that weight loss, right? And I think that's kind of the maybe the center of the bulls-eye for lot of people as opposed to just saying we need to lose weight not really talk about any of the rest of the stuff?

Ari Snaevarsson: Absolutely. This is something where with a lot of the clients that I work with they come to me initially with the weight loss goal, and I've always sort of had – basically the way that I coach is that I meet people where they are at, and so even if they have a weight loss goal I still work with them and I help people wherever they're trying to go, but we always have a body positive, intuitive eating focus and generally speaking that means we're going to move away from a weight loss goal. So, when I meet with clients in that capacity and they send me a text that's pretty common where they say I'd like to change my goal to building healthy habits or focusing on actually enjoying food without all of the shame and hatred that is such an important moment to me, and it's one reason that I actually do take on weight loss clients because I think that there's a lot of potential in clients like that to reframe the paradigm and sort of reframe the way that they see nutrition. So, yeah it's so, so important that everyone is able to focus on these healthy habits without always having to focus on changing your body and looking different.

Danny Lennon: I think it's interesting that you mentioned that this maybe bastardized version of body positivity or Heath at Every Size we see because you also mentioned intuitive eating which is another term that suffers the kind of same fate often, and it's not hard for someone to search around that line and to again find some sort of bastardized version of what that actually means, and it leads to some people maybe dismissing it, and I've certainly heard arguments like that of oh well if people eat intuitively that just means they eat what they want and they're just going to eat a ton of junk food all the time. And I have a really hard time believing that people would do that if they're told to eat intuitively in the manner that it's meant to be discussed and what it actually stands for. I've seen really strange arguments. I had one person on

Facebook get into a debate with me before who'd kind of claimed that any strategy where someone isn't using MyFitnessPal is going to be suboptimal to using MyFitnessPal to track diet if they're trying to eat healthy and get in shape which is again I think a ridiculous position, but kind of tells you the degree that how far this can go. But it kind of also really gets to the core of people misunderstanding what intuitive eating is the same way we've mentioned some other terms are misunderstood. I'm just wondering how often do you see kind of a misunderstanding of that and for yourself how do you most accurately think of what intuitive eating is supposed to be?

Ari Snaevarsson: Yeah. This is something that I posed on the – so the book that I wrote has a associated Instagram page and I posted something about this specifically because I had sent a text to a client last night that I think perfectly illustrates, at least for right now, perfectly illustrates how I see intuitive eating and how I believe a lot of people should see it. I am not going to read of the text, but basically what I said was that – so I ate two cookies last night, and with the text I was saying I'm about to eat a cookie and I was saying it's not because it was my cheat day, it's not because I fit it into my macros, and it's not because I was having a rough day. I ate them because cookies taste great. I enjoyed the taste of cookies, and upon eating them nothing happened. My gut didn't pop out, my blood pressure didn't spike, a tornado didn't tear through the neighborhood. I'd mechanically digested it, my body absorbed its nutrients, I smiled and I went to bed. And as simplistic and maybe even reductionist as that sounds the probably is that people rarely view food like that. Usually on one end people see it as junk food is bad and awful. It's a sign of low self control, and so you have to restrict it by any means. On the other hand, it's basically just who cares. I've tried dieting before and it sucks, and I had a tough day so I'll just eat these cookies until I feel better. And neither end is that a healthy way to look at food. Intuitive eating strikes the balance where it says let's get you back in line with your body's natural hunger and satiety cues which are these very strong deep seated biological drives that are you know they're true drives that speak to a certain metabolic state. And there's something to be said about listening to those and not listening to anything else, although things like social eating do have, you know, they have their place. But basically intuitive eating then in that sense would mean that you no longer have food rules. You have total allowance to eat whatever you want, whenever you want because you're an autonomous adult

and you shouldn't have to be forced by some book to be told to eat a certain way. But also, it means that you get to enjoy eating again, and you get to actually love what you eat now because it's healthy, and not because it's your cheat day but because it's food and food was meant to be enjoyed.

Danny Lennon: Yeah. I guess that's just another metric almost something people can look towards as that is something that we should strive to attain when we're at that place where we can do that. I think maybe when you think about it it's probably a pretty obvious realization but we probably don't often think about it this way. But realizing that the diet industry is not really in the business of health promotion and it's quite a distinct thing when we're talking about dieting versus health promotion, right?

Ari Snaevarsson: Yes. This is a big area. So, the diet industry in my mind kind of offers what I would say is the poison apple here. So, when we look at correlations with increases in obesity, type-2 diabetes anything related to the metabolic syndrome. There is a lot of arguments about – like looking at the chronology of it and when it's increased, there is a lot of arguments about whether it's carbs or fat by which it doesn't really seem to make too much of a difference, and Kevin Hall was on your show and made some pretty good like – he has done some amazing studies on that. Then there are arguments about increased calories and whether that makes a difference, and while I've heard some solid arguments there. The increase in calories is probably not quite enough to justify the amount of obesity we've seen, and then there is arguments about high fructose corn syrup there isn't really anything. But there is one place where people don't look and that is that starting in the '70s fad diets really took off and that was like Weight Watchers, and even Overeaters Anonymous and people don't really look at that but that was very much in line with when obesity and type-2 diabetes those rates spiked. The diet industry is a cash cow. It's really ineffective and inefficient, but it uses that to its advantage. It basically uses its own futility to keep people in the system, so that they buy more and more of their products and continue to believe the messages that they're told that you don't look good unless you're absolutely shredded, and you have no self control unless you're eating you know nothing but Paleolithic foods which you know that is very misguided. So, yeah really the diet industry works that's too different than big tobacco, it just keep people in the system and

knows that it can make people 'addicted to what it's offering,' and it's not in the service of helping out self healing us at all.

Danny Lennon: And I think the more unsustainable you make a particular method or product or whatever you are promoting from a diet industry perspective the more unsustainable that is. The more that kind of insulates them from any blame, right? Then it'll always come back down to well you didn't stick to it for long enough or you didn't stay doing it or when you failed is when you stopped doing what we said, but that's always going to happen if you make something that's unsustainable and restrictive enough.

Ari Snaevarsson: Absolutely. Yeah. This is why it's so insane to even think that we're continuing to look at these lifestyle intervention changes to try and get people to lose weight, and we haven't changed the system in so long because somewhere in the neighborhood of 77% of weight lost is regained within the first year or so with most diets. The really shocking statistic is the biggest loser and that within 6 years of the finale they couldn't do a reunion because 70% of them had either regained all the weight lost or added more. Yeah it's a totally inefficient thing and it works just like you said, ketos definitely guilty but a lot of diets are where they say you have to follow these very stringent rules and if you do that then you'll lose weight which is true you will, but almost nobody can do that forever, and then the people that fall off are just sort of cast out well they didn't follow the diet correctly. It's a really easy way to force people into the system. Absolutely.

Danny Lennon: Yeah. And one thing you kind of notice as you go through some of these longer terms studies looking at people's ability to maintain weight loss or those who had the highest adherence to certain diets for the longest period of time. The ones where there is that highest adherence or there is after a certain follow up that's been the most success at maintaining that weight lost. The one commonality they have is not the type of diet because there is a variety of different approaches that have been taken. The seeming commonality, at least that I've seen and people can correct me, but that I've certainly seen is the interventions where there was the most support and structure with either meetings with a dietician most regularly, follow-up support meetings any of these support networks. The ones that had a high amount of that seem to be better in the long-term and the ones that just give people general dietary advice and see how they got on will always have those poor results long-term once you follow-up. So, I think

again that moves us away from worrying about which approach is best and starting thinking beyond just the food component and saying how do we build and place health promoting behaviors that have a positive reinforcement from social support networks as well.

Ari Snaevarsson: Yeah, definitely. It's interesting because even when we have that discussion the implicit assumption there is that we're talking about weight loss. Because you mentioned this new thing we were saying with the health building habits and I think that a lot of people listening to the discussion up until then might have just assumed it must be a weight loss discussion because this superficial metric that we tend to look at – and I think if we're being honest with ourselves, it's because there is – people aren't going to like me saying this, but there is like a sort of fat phobia there. There is a dislike of people of larger bodies and even if there are very strong correlations between obesity and these symptoms of the metabolic syndrome, even if those exists it still doesn't change the fact that we're worried about those symptoms of the metabolic syndrome. The obesity itself absolutely makes it harder for people to move around and causes breathing issues and things like that. But really the issues are the insulin resistance, the high blood pressure, the blood triglycerides things like that. Those are the things we're really, really worried about and yet we keep talking about obesity and overweight, and I think it just sort of cycles into the exact problem we're trying to escape.

Danny Lennon: Right. Yeah, I think it really does get lost quite often of the reason why in a clinical setting weight loss is generally seen as a good thing is not for its own sake, it's because it in general will typically see reductions in blood triglycerides or fasting blood glucose or will improve people's insulin sensitivity all these things that we're trying to change. So, maybe the conversation, discussion needs to move completely to let's do the behaviors and patterns of eating, and lifestyle, and exercise etc, that are going to improve the certain metrics to make a healthier person, and kind of shift that completely away from what can we do just to make this person lose the most amount of body fat. Even though probably you're going to see that happen if you do focus on those health promoting behaviors which is kind of the irony.

Ari Snaevarsson: Yes. That's exactly what I want to get to there was that my sort of radical assertion here is that if we were to tomorrow stop even using the phrase weight loss and instead just only focus on

healthy habits, you know having more protein at your meals, and varied sources of protein, varied vegetables and fruits, and eating these fresh foods, and one big thing is cooking like cooking at least one meal a day, and using mindfulness things like that if we were to tomorrow switch our language and stop talking about weight loss. Start talking about those purely healthy habits we would see tremendous weight loss. If you were to look 1, 2, 3 years down the road I think obesity rates would start dropping. But again, like you said, the irony of it is that they're dropping but it shouldn't even really matter. It should be we get to the point where obesity is now a thing of the past but who cares because it was our hyper-fixation on the obesity, and on the weight, and on dieting that just perpetuated it actually.

Danny Lennon: Yeah. It's such an important kind of discussion and it's something that really is fascinating the more you kind of look into this area because certainly in the past I wasn't aware of it as much as this, and as sensitive to how much it can influence things and just being aware of that. And I think to some degree it may be checking off our own biases to some degree, but also just realizing the amount of literature in some of these areas. And I think this really is kind of ground that can receive a lot more attention in the future, and the pay off could be quite large. But again it's that kind of, at least at the moment, an uphill battle because of the corner we've painted ourselves in with some of previous discussion around diet, and weight, and so on. One thing I did want to get to with you Ari is something from a very kind of pragmatic perspective for many of the people listening who are either let's nutritionists or dieticians or even fitness professionals and personal trainers who are undoubtedly going to encounter clients in the future and probably presently who either will have an eating disorder, develop one or at least exhibit behaviors of disordered eating patterns. So, from that perspective when it comes to noticing certain red flags or being able to identify some of those disordered eating patterns early on etc, how should some of these health and fitness professionals be proactive in essentially screening for this or noticing some of these things. Are there any things they could include in client consult questionnaires and in questions ask people in-person, are there things to look out for in terms of client food diaries etc, like where is the line for them to be proactive in noticing some of these things, so that they're then in a position to be able to refer out to a specialist if needed and so on? How can they be more aware of this by asking good questions, I guess?

Ari Snaevarsson: That's a great question. I led a webinar for Precision Nutrition talking about this specifically where we talked about identifying disordered eating clients, and one of the things that I was asked very frequently and I had to get back to was when disordered eating clients let's say come to see you, let's say as a nutritionist and they're looking for weight loss advice at what point is it disordered and is it not disordered because with eating disorders, and I'll get to that in a second about referring out and all that, it can be a little bit easier to see if someone is saying – this is something that I actually put on my own questionnaire for clients, I ask if they've purged in the past or currently or if they use laxatives. Things like those are going to be pretty big red flags I think for most people, but then there are smaller things like someone has a "cheat meal" one night, and so the next day they exercise a ton. So, that I guess I would say that it boils down to the subjective experience of the client and if you are noticing as a medical professional that when this client talks about his eating behaviors that there seems to be a lot of either obsession or distress in their voice. I would definitely delve deeper into that and even though this is something that not all medical professionals are either comfortable talking about or in the business to talk about. It could be helpful to get into the discussion of what these behaviors really mean to the client, what they're motivated by and things like that. The reason for that is that we're not just looking to see how has an eating disorder, and then saying okay we have to go see if this person. But I think that we have an obligation as nutritionist to work with people who have disordered eating patterns and kind of let that guide our practice. This boils down to exactly what we were talking about which is that hyper-fixation on weight loss and reducing calories and all that is only going to perpetuate the problem. I also want to answer though in terms of the referring outside of this. That's a pretty interesting question because there is a question of scope and to what degree are you able to work with people with an eating disorder. The real answer is if you're not a dietician – I am not a dietician I am just a nutritionist, I can still work with people with eating disorders as long as I know that they are seeing a treatment team. I have a recent example of a client who actually left my service and is now a patient at the other job that I worked at, although not in the facility that I work in. So, basically what happened is that we noticed very, very restrictive patterns that you know thanks to her parents they were able to notice these pretty quickly, and they basically asked me about the services

there, and then I gave them a line of communication to the admission director and we were able to get around really quickly. The moral of the story is that every nutritionist, and I am speaking about that because that's my field, but anyone in the medical professions should have a referral team at hand, and if you don't then when you run into situations like this you're going to be really confused and worried. So, including anyone who is knowledged in eating disorders in your referral team is going to be absolutely crucial, and that's kind of going to be the answer to that.

Danny Lennon: Yeah, agreed. I think having that team in place from a perspective of a referral is super important, and then to your previous point I think if any of these issues are maybe counter to what you typically do in practice. So, when we talk about body positivity, intuitive eating, Health at Every Size some of these things are more newer concepts or maybe run counter to a typical approach. I think it's not like you need to go full on down that road completely. It's surrounding yourselves with people who are really embedded in with what those things really stand for, and understand that literature in that area, and have seen that in practice with particular people and just having conversations with them can really change your perspective on some of these and give you a more well rounded understanding, and other kind of tool to be useful. So, I would definitely recommend both those things for people. Ari before we wrap up here I wanted to ask just about your book in particular. Number 1, why did you write it, and by that I mean what did you feel maybe wasn't really out there as a resource for people that you could talk about. And maybe just some general information for people about essentially what the book is about, who it's for, and why you wanted to write that?

Ari Snaevarsson: Yeah, definitely. The book is called 100 Days of Foof Freedom: A Day-by-Day Journey to Self Discovery, Freedom from Dieting and Recovering from Your Eating Disorder. The first thing you asked there is actually usually the first thing that I say, which is the reason that I wrote this is because the information out there right now while there are some really good resources, this is still a very small field that hasn't been given a lot of attention, there are a lot of resources out there that will help you understand the general concepts, understand what sort of let's say mindsets you need to cultivate throughout recovery, and the fact that it's not about the food and all that. But it's really hard to take that, and then turn that and distill that into something actionable and usable. And

this is what I've seen time-and-time again not only in the clients that I work with but the patients at the clinic I work at that the problem is not as much that they don't know what to do. It's that a) they haven't been given permission to do it, and I'll explain that in a second, but b) that they don't have a actual purpose driven strategy to get there and that's the big thing. This book is 100 daily tasks that get you from a place of disordered eating, and eating disorder to recovery. Of course, and I mentioned this in here, it's not for anyone who is in timely need medical re-feeding. This is for people who are able to go through self directed recovery. But yeah that's what this is, and so it gives you an actionable step-by-step guide where there's along the way you know no question of what you're supposed to do. So, that you can take all those messages that you've learned and turn them into a actual plan that's sort of what this is. I hope that answered most of the questions there.

Danny Lennon: Yeah, for sure. So, for people who are interested in finding you online or checking out more of your work outside of the book where else can they go online to check out some of your work?

Ari Snaevarsson: So, my website is 100doff.com just the number 100, and then doff.com, I have blogs there, I have the link to the recovery coaching service I offer, a quiz for testing whether you have certain amount of disordered eating, and other resources like videos and things like that. That can be really helpful, and then there is a 'contact me' page there but you can just reach me at ari@100doff.com, so just ari@ 100 the number, doff.com and I very readily reply to emails and I'm always happy to have discussions about this kind of stuff. So, that would be the best way to reach me.

Danny Lennon: Awesome. And so for everyone listening I will of course link up to that and all those details will be in the show notes of this episode. I highly encourage you to go and check that out if anything in today's discussion has resonated with you. And with that that brings the end to the show today. So, Ari I want to say thank you so much my man for taking the time to do this, for the great information and great discussion. I really enjoyed this and like I said at the outset these are really important conversations I have on really important issues. And I am thankful for you to sharing your knowledge today.

Ari Snaevarsson: Definitely. And I appreciate you having me back on the show and I'm really just happy to be able to talk about those concepts because you're right they are very, very important. So, thank you for that.