The Efficacy of Overeaters Anonymous in Fostering Abstinence in Binge-Eating Disorder and Bulimia Nervosa

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Dissertation submitted to the Faculty of the
Virginia Polytechnic Institute and State University
In partial fulfillment of the requirements for the degree of

Doctor of Philosophy
In
Counselor Education

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May 6, 2002
Falls Church, Virginia

Keywords: Overeaters Anonymous, eating disorders, binge-eating disorder, bulimia nervosa

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The purpose of this dissertation is to identify the variables associated with abstinence from binge-eating disorder and Bulimia Nervosa in the twelve-step recovery program of Overeaters Anonymous. The data were gathered through the completion of a survey by 231 active members of Overeaters Anonymous in the Washington metropolitan area. In addition to assessing the demographic composition of the aforementioned population, the variables that were assessed comprise the 'tools' of Overeaters Anonymous. They include: attendance at OA meetings, reading/writing from the Twelve Step literature, adhering to a food plan, having a sponsor, giving service, taking time for prayer and meditation, and making phone calls to other members. The activities of binge eating and bulimic participants were also examined to determine whether or not statistically significant differences exist between these two populations.

Results revealed the typical OA participant to be a college educated (80%), Caucasian (89%) female (84%), between the ages of 34 and 44 (30%), married or living with a partner (44%), and employed in a full-time capacity (71%). Eight-four percent of the respondents were binge eaters, 15% were bulimic, and 1% anorexic. Multiple regression analyses revealed longer lengths of involvement in OA, a decrease in the frequency of relapse or 'slips', performing service, greater attendance at meetings, and progress on the ninth step, to be predictors of abstinence at the .05 level of significance.

A lower frequency of relapse was predicted by longer lengths of involvement in OA, greater adherence to a food plan, increased frequency of phone calls to other members, and more time spent writing about one's thoughts and feelings at the .05 level of significance. Lastly, Independent Sample t-tests revealed bulimics to have significantly longer mean lengths of abstinence than did binge eaters. Alternately, the difference in the frequency of relapse or 'slips' between the two populations was not significant, suggesting that both bulimics and binge eaters have a comparable likelihood to relapse or slip back into eating disordered behaviors.

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Chapter I. Introduction

"Hi, My name is Kiki, and I'm a gratefully recovering binge eater…"

These are the familiar words echoed in Overeaters Anonymous (OA) meetings throughout the century. Modeled after AA, OA views eating disorders as an addiction. While the alcoholic can abstain from alcohol, the situation in OA is inevitably more difficult as complete abstinence from food is not feasible. It is for this reason that the OA tools of recovery were developed to complement the Twelve Steps of AA.

Overeaters Anonymous (OA), which is a fellowship of approximately 8,500 meeting groups in over 50 countries worldwide (www. Overeaters Anonymous.org), is designed to help the compulsive eater who suffers from binge-eating disorder or Bulimia Nervosa. The seminal diagnostic criteria for Bulimia Nervosa include recurrent episodes of binge eating accompanied by recurrent inappropriate compensatory behavior in order to alleviate the weight gain associated with the bingeing (e.g. self-induced vomiting; laxative and diuretic abuse; fasting, or excessive exercise). Binge-eating disorder is characterized by a pattern of regular and sustained episodes of binge eating without regular compensatory behaviors (see Appendix C for specific DSM-IV criteria).

The program's emphasis on anonymity and 'principles before personalities' underlies its relative obscurity in the research on the treatment of eating disorders. Although OA is not a treatment modality, it can provide a successful adjunct to treatment, and for many individuals the program is their initiation into recovery and often what sustains them once in recovery (Yeary, 1987).

Eating disorders can be considered a cultural and social malaise affecting all socioeconomic levels of our society today. Women in the United States have become

heavier with each generation, yet the physique presented as the ideal for health and beauty has simultaneously become progressively slimmer. In a survey described in the Harvard Mental Health Letter (1997), 31% of fifth- to eighth-grade girls said they were dieting, 9% said they sometimes fasted, and 5% had deliberately induced vomiting. By the early 1990's, 37% of men and 52% of women thought they were overweight and 24% of men and 40% of women said they were dieting (1997).

This myopic perspective and chase for that one ideal size has led Americans down a destructive path, triggering psychological, physiological, and behavioral consequences, including binge eating, food obsessions, and eating disorders (Seid, 1994). Because of the devastating effects, self-help programs like OA have been developed to assist individuals for whom food has become a debilitating illness. But how effective is OA in meeting the needs of its participants? Unfortunately, no one seems to know the answer to this question, as there is a dearth of research regarding the efficacy of OA on compulsive eating disorders.

Background of the Problem

Given the American public's creed that one can never be 'too rich or too thin,' it is not surprising that we have transformed the pursuit of thinness into a national obsession. Wilfley and Rodin (1995) eloquently describe the current crisis in our Western culture as one where thinness has come to symbolize competence, control, and sexual attractiveness. However, the need to be "thin" is not a new trend. Fashion images possessing the 'waif-look' began with the superstar model Twiggy in the seventies and have continued into the nineties with models such as Kate Moss and

television sitcom character Ally McBeal. All of these idealized images are expressions of what has become our national obsession with thinness.

In contrast, obesity seems to represent laziness, self-indulgence, and a lack of willpower. At the conclusion of the 1995 National Institute of Health Consensus Conference on Obesity, Stunkard and Sobal (1995) stated, “Obesity creates an enormous psychological burden… in terms of suffering, the burden may be the greatest adverse effect of obesity” (p. 417). Another psychological burden is weight-loss programs. The methods used for voluntary weight-loss treatment programs have caused more harm than good, both physiologically and psychologically (Berg, 1992). For instance, many individuals who have participated in weight loss treatment programs, such as Weight Watchers, Jenny Craig, and Nutrition Centers or seek out diets such as Atkins, Sugar Busters, and Metabolite Natural Substances, typically experience only brief remission of symptoms. In some cases, the symptoms gradually worsen to create a vicious cycle of dieting, bingeing, and purging. Those who suffer from binge-eating disorder usually gain back all of the weight they once lost and sometimes more. Studies from numerous eating disorder centers suggest that the attrition rate for most treatments is considerably high, suggesting participants are often dissatisfied with the treatment that they receive (Yager, Landsverk, & Carole, 1989). As a result of the high attrition rate in weight loss programs, completing studies of any significant duration is particularly an arduous task (Kayman, Bruvold, & Stern, 1990).

Although treatment modalities utilized to address eating disorders are numerous and include individual, cognitive, and behavioral therapies, pharmacological treatment, and self-help groups, evidence on the efficacy of these modalities is limited. Many

individuals with these disorders rarely seek professional help, and in long-term studies, many drop out. In Yager et al's (1989) study on the satisfaction of women with eating disorders, results revealed that the professional treatments most often utilized comprised of individual psychotherapy (52.9%), behavior therapy (28%), group therapy (24.6%), and nutritional therapy (18.6%). The authors noted that treatments were generally seen as helping only "a little".

The level of service that individuals with eating disorders receive may be attributed to managed care programs, which limits the amount of sessions clinicians are able to have with their patients. Because of this limitation, more women and men are turning to self-help groups, which do not impose a set number of sessions. Humphreys (1999) states, involvement in self-help groups is becoming a critical component to maintaining or effectuating recovery from eating disorders. The Harvard Mental Health Newsletter (1997) states that more information about self-help groups is, indeed, needed. Moreover, as the methodological quality of the AA literature has improved, clinicians have become increasingly interested in facilitating relationships between treatments and twelve-step groups (Humphreys, 1999).

Several studies (Wolborsky, 1981; Bramer, 1986; & Overeaters Anonymous, 1992) document the efficacy of the OA program. For example, a study of 40 bulimic women conducted by Malenbaum, Herzog, Eisenthal and Wyshak (1988) suggest, that, as a group, women with bulimia who participated in OA typically found the experience beneficial. Similarly, a study by Bramer in 1986 documented positive behavioral changes (binge/purge behavior) and improvements in quality of life (personal needs and

goals) in 37 bulimic women who attend OA in one Midwestern State. Because of the limited sample size in both studies, it is difficult to generalize from these findings.

With respect to binge-eating disorder, a 1981 study by Wolborsky determined OA to be an effective means of dealing with compulsive eating. Members reported to have achieved considerable abstinence from compulsive overeating, substantial weight loss, and prolonged normal weight maintenance. Participants also reported improvements in emotional stability, spirituality, and a host of physical conditions. Although this particular study revealed positive results for those struggling with binge-eating disorder, it did not isolate those clients who were suffering from Bulimia Nervosa from the group.

No large-scale studies to date have been conducted to empirically differentiate bulimic participants from those with binge-eating disorder. Moreover, few studies have examined how the utilization of the OA tools affect abstinence and relapse from said disorders.

The reason for the limited information is undetermined. However, one would probably assume that given the strong emphasis on the tradition of anonymity across twelve-step programs, it logically follows that resistance to outside intrusion exists. The present study extends these earlier studies in its assessment of a larger sample of both bulimic and binge eaters and in its examination of the specific methods used in OA.

Statement of the Problem

Eating disorders such as Bulimia Nervosa and binge-eating disorder have multiplied in the United States over last 20 years. A study conducted by the U.S. Department of Health and Human Services (McGinnis & Foege, 1993) assessed that dietary factors were accountable for at least half of the 1 million preventable deaths per

year, which made them the second greatest cause of preventable death in the United States.

Approximately 35% of women and 31% of men age 20 and older are overweight or obese, up from 25% in 1980 (Choban, Atkinson, & Moore, 2001). Obesity is directly linked to many chronic diseases – such as heart disease, stroke, certain cancers and osteoarthritis. In addition to medical consequences, the psychological effects of obesity range from lowered self-esteem to depression (Choban et al., 2001).

More serious forms of eating disorders (e.g. Anorexia Nervosa and Bulimia Nervosa) affect 2% of the female population, while subthreshold variations of these disorders are 5 times more common (Garfinkel et. al., 1995). It is estimated that one out of five college aged women will develop an eating disorder (Angelo, 1995). The prevalence of bulimia in the college aged population has been estimated to range from 3% to 8% depending on the assessment measures (White, 2000). Bulimia Nervosa is more prevalent than Anorexia Nervosa, the starvation disorder, yet a large percentage of those seeking treatment for Bulimia Nervosa have a history of Anorexia Nervosa (White, 2000). In a study by the American College of Sports Medicine, 62% of females in sports such as figure skating and gymnastics were said to have experienced symptoms of Anorexia Nervosa or bulimia (American College Health Association, 1994).

Because of the exponential growth in eating disorders and the severity of their impact on societies' psychological, physical, and spiritual well-being, more information regarding efficacious interventions in the treatment of eating disorders is needed.

Clinical Significance of the Study

The present study has both clinical and practical considerations. Clinically, this study is meant to increase the awareness of counselors and practitioners working with individuals that are suffering from eating disorders. It delineates a demographic profile of the OA participants in the Washington metropolitan area and provides insight into the specific techniques that are the most effective for those individuals who suffer from binge-eating disorder and Bulimia Nervosa.

Given OA's relative remoteness in the treatment literature, little is known about the specific methods utilized in this twelve step program that are effective in effectuating abstinence in individuals with eating disorders. From a practical perspective it is therefore expected that the results of this study build on previous studies of OA, but provide information pertaining to Bulimia Nervosa and to specific aspects of the OA program that were not available in previous studies. Lastly, it is hoped that the results of this study will be helpful to those struggling with eating disorders. For it is the victims themselves that are ultimately confronted with surrendering old ways of thinking and being in an effort to acquire a new manner of living that comes as a result of working the tools and Twelve Steps of Overeaters Anonymous.

Purpose of the Study

Given the paucity of data on OA, the present study is designed to investigate which components of this twelve-step program facilitate recovery from binge-eating disorder and Bulimia Nervosa. As participation in the OA recovery program involves the utilization of the OA tools, such tools were examined to determine if they are related to abstinence and relapse from binge-eating disorder and Bulimia Nervosa. The tools of

OA include: performing service, sponsorship, literature reading and writing, adherence to a food plan, attending meetings, using the telephone, and applying the principle of anonymity (Overeaters Anonymous, 1992).

Research Questions

This study was be guided by the following research questions:

1. What is the demographic profile of those participating in OA in the Washington Metropolitan area?
2. Is the use of the individual OA tools related to abstinence from compulsive eating for those with binge-eating disorder and Bulimia Nervosa?
3. Is the use of the individual OA tools inversely related to relapse into compulsive eating for those with binge-eating disorder and Bulimia Nervosa?
4. Are there statistically significant differences between bulimics and binge eaters with respect to their length of abstinence, frequency of relapse, and utilization of the OA tools?

Assumptions and Limitations

This study is based on the following assumptions:

1. All of the participants in this study are aware of what eating disorders are.
2. All of the participants in this study have either been professionally diagnosed or self-identified as suffering from an eating disorder.

3. All of the participants in this study have been in attendance at OA meetings for a minimum of thirty days.
4. As the study is specific to the Washington Metropolitan area, results cannot be generalized to the general population.
5. Sufficient reliability has been established as it has been assumed that the participants in the study answer the questions honestly.

This study has the following limitations:

1. As the study exclusively addresses those participants who are over the age of 18, results cannot be generalized to adolescents or children.
2. As the researcher for the study assumes a dual role, that of data collector and data analyzer, the potential for bias exists.
3. As participation in the study is entirely voluntary, active participants of OA may be more amenable to participate in the study, thereby underrepresenting those who are less involved.
4. The study defines abstinence as “the absence of compulsive eating behavior, with compulsive eating including bingeing, purging, chronically dieting, and overeating” (Overeaters Anonymous, 1995). As the survey is limited to self-report of the identified abstinence criteria, an inherent level of subjectivity exists in the obtained results.

Definition of Terms

Abstinence: Abstinence in OA and for the purpose of this study is defined as the action of refraining from compulsive eating, which includes bingeing, chronically dieting and other purging-related behaviors. It is further defined as following a food plan that eliminates binge-triggering foods. The participant is considered abstinent when she is eating foods prescribed by a predesignated food plan at specified meal times during the day (Malenbaum et al., 1988, p. 140).

Alcoholics Anonymous: A non-profit, non-professional organization whose purpose is recovery for alcoholics based on the twelve steps of the organization.

Binge eating: An episode of binge eating is characterized by both of the following:

1. Eating in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar amount of time under similar circumstances.
2. A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating) (American Psychiatric Association, 1994).

Binge-eating disorder: The American Psychiatric Association defines the essential features of this diagnosis to include recurrent episodes of binge eating with subjective and behavioral indicators of impaired control over, and significant distress about, the binge eating without the inappropriate use of compensatory mechanisms (i.e. purging,

laxative use, etc…) that are characteristic of Bulimia Nervosa (1994). Those diagnosed with binge-eating disorder would have been previously classified as classic compulsive overeaters.

Bulimia Nervosa: Bulimia Nervosa is characterized by recurrent binge/purge cycles in addition to which the individual is excessively influenced by food and weight. Binge eating, which is compulsive overeating followed by some form of purge that may include the following: diuretics, diet pills, laxative abuse, enemas, or other medications; fasting; or excessive exercise (American Psychiatric Association, 1994). For the purposes of this study, Bulimia Nervosa was operationally defined as self-identified individuals who have an eating disorder that is characterized by binge eating followed by purging through the use of vomiting or other compensatory mechanism.

Compulsive overeating: OA describes compulsion as by definition: "an impulse or feeling of being irresistibly driven toward the performance of some irrational action" (www.OvereatersAnonymous.org). It is not merely how much one eats that makes one a compulsive overeater, rather it is the ways in which one tries to control their intake of food. Some overeaters eat in secret, while others flaunt their overeating. Some binge and purge while others alternate between overeating and undereating. The one thing all compulsive overeaters have in common, however, is that they are driven by forces they don't always understand to eat more or less than they need, and they eat this food in ways that are not rational (Overeaters Anonymous: Questions & Answers, 1999, p. 2).

Disease concept: OA adopts the disease concept as defined in AA. Alcoholics Anonymous defines alcoholism as the result of an allergy to alcohol, i.e., the alcoholic's allergy to alcohol results in uncontrollable cravings for more alcohol whenever he imbibes (Alcoholics Anonymous, 1976). OA believes that compulsive overeating is stimulated by an allergy to processed sugar (and, in some cases, white flour). After ingesting sugar, allergy sufferers experience cravings for continuing amounts of sugar-laden foods. It is believed that this process is stimulated by a hypothalamus that strives, because of the allergy, to maintain a high blood-sugar level. As the sugar passes through the digestive process, the blood-sugar levels drop. The cravings to eat then resurface in an effort to elevate the sugar to its previous level (Pope and Hudson, 1984). This concept lifts a portion of the responsibility and guilt for the development of the disease from the individual but presses for the mature need to manage the problem (Miller & McCrady, 1993).

Eating Disorder Not Otherwise Specified: This category is for disordered eating that does not meet the criteria for any specific eating disorder.

OA/H.O.W.: A group within OA that has been formed to offer the compulsive overeater who accepts the twelve steps and twelve traditions as a program of recovery, a disciplined and structured approach. Therefore, the OA/H.O.W. plan of eating, steps, traditions, and tools of recovery are not suggestions, but requirements for recovery. H.O.W. stands for the honesty, openness, and willingness needed to work this program of recovery.

Overeaters Anonymous: An official, non-profit organization that is a twelve-step recovery program patterned after AA. The group substitutes the words “compulsive overeater” for “alcoholic” and “food” for “alcohol.”

The Overeaters Anonymous Tools: OA believes that adherence to the twelve steps are facilitated by the utilization of the OA “tools.” They include the following: (1) Plan of Eating; (2) Sponsorship; (3) Meetings; (4) Telephone; (5) Literature; (6) Writing; (7) Anonymity, and (8) Service, all of which are described more in-depth in the literature review.

Twelve Steps: The Twelve Steps (Appendix A) are the foundation upon which OA has been built. Derived from the Twelve Steps of Alcoholics Anonymous, they reflect practical experience and application of spiritual insights as recorded by thinkers throughout the ages. They offer a new way of life without the excess use of food and are the means by which the disease of compulsive overeating can be arrested (Alcoholics Anonymous, 1976, p. 10).

Twelve Traditions: The traditions (Appendix B) are the means by which OA remains unified in a common cause. Originating in AA, they are suggested principles to ensure the survival and growth of all OA groups (Alcoholics Anonymous, 1976).

Summary

Bridging the gap between Twelve Step programs and professional treatment is emerging as an essential therapeutic task in the addictions field today (Zweben, 1993). The Twelve Step programs not only effectuate recovery from addictive substances, but can complement medical, psychiatric, and psychological treatment as well (Chappel, 1992). Just as alcohol treatment programs are strengthened by AA, it is this author's desire to determine the applicability of OA to the treatment of eating disorders.

Chapter II. Review of Related Research

This chapter provides an overview of the history, current information, definitions, etiology and treatment research on binge-eating disorder and Bulimia Nervosa (see Appendix C for DSM-IV definitions). Their parallels with addictive disorders is also discussed followed by a synopsis of the Overeaters Anonymous (OA) recovery program. The overview illustrates the dearth of research on the efficacy of OA as applied to binge-eating disorder and Bulimia Nervosa.

Historical Overview

Lesley Hornby Armstrong, nicknamed Twiggy, a thin, 5'6", 97-pound model from England during the late 1960's, burst upon the American fashion scene displaying what some would refer to as "an ideal symbol of beauty." Twiggy's emaciated 31-22-32 skeleton appeared in several magazines including Seventeen and Vogue. Admired for her image, thousands of young American women began to pattern their clothes, makeup, hairstyles, and body after her (Beuf & Eininger, 1978).

Because of the response to be more like the image of Twiggy, many experts in the field of eating disorders today believe that there is a correlation between Twiggy's appearance and an increase in food-related dysfunction. To support this view, Beuf and Eininger (1978) note that the first outbreak of Anorexia Nervosa and Bulimia Nervosa occurred during the flapper era, a period in the 1920's where young women who adopted bold and unconventional actions and dress were referred to as 'flappers'. During this time, slimness began to be emphasized as desirable and stylish.

Responses to how responsible Twiggy was for the evolving trend in body shape vary, given the various psychosocial and historical pressures in existence. For this

reason, attention must be given to the histories of our mothers and grandmothers that serve to illustrate the persistent prevalence of eating disorders among contemporary women.

Prior to and during Victorian times a woman's body was expected to reflect a "mother-earth" image. As long as her primary identity was tied to the role of the mother, moderate plumpness was tolerated and became symbolic of fertility and health. During the 1900's, the ideal woman grew older and more matronly. As Lurie (1981) points out, the Victorian woman was typically the mother of many children in a society that defined her role as skilled domestic manager and tutor. In contrast, women with a "thin-framed" body appeared gaunt, fragile, and pale. Bulk in men personified power, while plump women were considered sexually satisfying.

Following the Victorian era, the body image of women began to change. Moderate plumpness, which was once regarded as a symbol of fertility and health, began to be associated with being old, of a lower class, and intellectually inferior. Slimness became equated with wealth and status and the fashion industry emerged to cater to the thin ideal of the upper class. Thus, high status clothing, combined with a thin physique became a major criteria for distinguishing upper- and lower-class women. Bruch (1973) argues that there comes a time in having socially arrived that one no longer needs to demonstrate one's leisure class status. The social class distinctions between rich-thin and poor-fat that began shortly after the Victorian era continue with a vengeance today. Studies conducted in the 1950's through the 1980's revealed that obesity occurred seven times more frequently among lower-class than upper-class women (Goldblatt, Moore & Stunkard, 1985).

Ironically, the hypothesis that men prefer Twiggy's thinness is at best uninformed. After questioning hundreds of men about such preferences, Glamour reported very few men who described Twiggy as the 'ideal woman.' Bo Derek would be far more appropos (ANRED, 1996). Nevertheless, the quest to be thin continues to be a struggle for many women despite what men have to say. Often lacking in a firm and secure sense of identity, women struggled to emulate the old adage that "one can never be too rich or too thin." As long as this worldview is maintained, fad diets and unhealthy body images will continue to proliferate in their promise of love, male approval and solutions to the problems of life.

This unrelenting pursuit for thinness that has dominated our society for more than twenty years is unquestionably a major force in the etiology of eating disorders today. The media, dependent upon its consumers, continues to encourage an ultra-slim image that is unhealthy and nearly impossible to maintain. In the quest for thinness, it is therefore not coincidental that eating disorders have now reached epic proportions.

Current Information on Eating Disorders

It is currently estimated that one-third of the people in the United States are now obese, up from 25% just 15 years ago (Brownell, 1995). Moreover, serious forms of eating disorders affect 2% of the population, while subthreshold versions of these disorders are five times as common (1995). Substantial increases in mortality and morbidity are associated with these conditions. Anorexia Nervosa, a disorder characterized by extreme weight loss coupled with an intense fear of becoming obese, has the highest mortality rate of all the psychiatric disorders (ANRED, 1996). Obesity is

the second leading cause of preventable death in the United States today (ANRED, 1996).

Eating disorders, which have become a major health concern, are more frequently seen in female patients, although estimates of the male-female ratio range from 1:6 to 1:10 (American Psychiatric Association, 2001). In the United States, eating disorders appear to be equally prevalent between Caucasian and Hispanic women, more common in Native American women and less common among African American and Asian women. However, several studies in Southeastern United States suggest that eating disorders are even more customary among African American women than previous research would suggest. African American women evidence more Bulimia Nervosa than Anorexia Nervosa, and are more likely to purge with laxatives than by vomiting (American Psychiatric Association, 2001).

Comorbid psychiatric disorders are frequently seen in patients with eating disorders, with estimates ranging from 42% to 75%. Eating disordered patients with personality disorders are at a greater risk to be dually diagnosed with mood or substance abuse disorders. Moreover, sexual abuse is reported more often in woman with eating disorders than in women from the general population (American Psychiatric Association, 2001).

On any given day 65 million Americans are dieting and they have over 30,000 diets to choose from (ANRED, 1996). As a result, the diet industry in the United States profits between 40 and 50-billion-dollars-per-year from its consumers (ANRED, 1996). Diet camps, exercise spas, diet support clubs, and the low calorie industry have

flourished. Billions of dollars go to the very industry that perpetuates our fears (Pipher, 1995).

Culturally, our Western ideals promote the notion that thinness equates to beauty, a belief that only serves to reinforce the necessity of weight control. Pipher (1995) believes that the increase in dieting, eating, and body shape concerns among participants of the Western culture has led to a phenomenon of "normative discontent" with respect to body shape. Wilfley and Rodin (1995) also suggest that as non-Caucasian groups and developing non-Western cultures gradually adapt the values and norms of the dominant Western culture, they too are confronting an increase in eating disorders and eating-related difficulties. While those struggling with Bulimia Nervosa represent only a small percentage of the population, binge-eating disorder, a disorder characterized by the rapid consumption of a large amount of food in a discrete amount of time without purging, is even more common.

Binge-eating disorder

Stunkard (1959) first delineated binge-eating disorder as a subgroup of individuals who engage in recurrent binges. The term 'compulsive overeating' that used to refer to the eating disorder that was addressed in OA technically refers to those with binge-eating disorder. OA defines compulsive eating as a serious physical, emotional and spiritual illness for which there is no cure.

Binge episodes are characterized by out of control eating, in a discrete period of time, an amount of food that is significantly larger than most people would eat under similar circumstances (as cited in Brownell & Fairburn, 1995). Binge-eating disorder differs from Bulimia Nervosa in that these individuals do not utilize compensatory

mechanisms, such as self-induced vomiting, laxative use, fasting, and excessive exercise (see Appendix C for diagnostic criteria). Although documented over three decades ago, binge-eating disorder has only recently received empirical attention and is currently included in the appendix of the Diagnostic and Statistical Manual, 4th ed. as an example of an eating disorder, not otherwise specified (Peterson, Mitchell & Englebloom (1998).

Although binge-eating disorder has only recently been recognized as a unique condition, it is the most common eating disorder, affecting two percent of all American adults (National Institute of Diabetes and Digestive and Kidney Disease, 1993). Obese binge eaters report significantly more psychological distress, such as depression, anxiety, and obsessive-like behaviors, than do nonbingers. Binge eating affect as many as 30% of persons entering weight-reduction programs and its prevalence increases with increasing degrees of overweight. While most individuals with binge-eating disorder are obese (more than twenty percent above a healthy weight), people who are at a normal weight can also be afflicted. Binge-eating disorder affects every three women for every two men (1993).

Binge eaters consistently engage in excessive food consumption usually in response to negative emotions, which is repeatedly beyond the individual's ability to control. Binge eaters also tend to have a more distorted body image than non-binge-eaters. This would imply that although not a criteria for the diagnosis, distorted body image and binge eating are the primary symptoms of binge-eating disorder (Marcus, 1993).

Research into the correlation between successful weight management and binge-eating disorder has identified significant differences between those with and without binge-eating disorder. Specifically, when placed on a low-calorie food regimen, those with binge-eating disorder displayed less compliance, earlier posttreatment weight gain, greater rates of attrition, and larger weight gains at the one-year follow-up. Marcus, Smith, Santelli, and Kaye (1992) suggests that those with binge-eating disorder have greater perfectionistic tendencies along with negative emotional responses that result in greater attrition and less adherence to the food plan. It was further confirmed that those who were obese with binge-eating disorder have a greater prevalence of mood disorders than obese non-bingers.

Kensinger, Murtaugh, Reichman, & Tangney (1998) conducted research to identify psychological characteristics and eating behaviors associated with binge-eating disorder in women. Of their sample of 62 women, 36 (58%) met the criteria for binge-eating disorder and 26 (42%) did not. Those with binge-eating disorder reported not only greater binge eating, but also greater disinhibition and poorer eating self-efficacy compared to those without the disorder. Moreover, those with the diagnosis display greater psychological distress and depression, lower self-esteem, less helpful coping strategies, more hunger, and less cognitive restraint than those without a diagnosis of binge-eating disorder (1998).

In a retrospective study of 582 residential weight control program clients, DiGioacchino and Sargent (1998) found a relationship between binge eating and practicing multiple methods of alternative weight control. This relationship is expected, as those who fail in their weight control attempts typically try different methods when

traditional treatments are unsuccessful. This research lends credence to the notion that many professionals “are incapable of dealing with the recalcitrant nature of binge-eating disorder” (1998, p. 176).

Compulsive overeating, herein and diagnostically referred to as binge-eating disorder, is as much a psychological illness as it is a physical one. Kornhaber (1970) described binge eating as the “stuffing syndrome” (as cited in Maddox and Long, 1999). The author hypothesized that internal distress and anxiety are “stuffed down” by binge eating, similar to the process of self-medicating through the ingestion of chemical substances. Moreover, Yanovski, Gormer, Leser, Gwirtsman, and Yanovski (1994) found that those with binge-eating disorder have a harder time remaining in generic weight-loss treatment programs than do non-compulsive eaters. Binge eaters also tend to regain any lost weight more quickly. Focusing on the binge eating and the cognitions beneath the behavior are therefore critical treatments that need to be resolved if clients expect long-term weight control. Moreover, given the myriad physical and psychological causes and consequences of binge-eating disorder, it is improbable that any one treatment will be appropriate for all individuals. Consequently, an examination of the effectiveness of multiple treatment techniques (e.g.: tools) is most efficacious.

Bulimia Nervosa

More prevalent than Anorexia Nervosa, which is a disease characterized by self-imposed starvation, Bulimia Nervosa, a disease seen in normal weight individuals who regularly binge and purge, affects between 1.1% to 4.2% of adult women, and between 4 and 10% of college females. The mean age of diagnosis is 19 years of age (Maddox & Long, 1999; American Psychological Association, 2001). The prototypical bulimic is

described as one who is well educated, good-looking, high achieving and a perfectionist. As there is clearly less general sociocultural reinforcement for slimness and dieting than for females, the ratio of women to men diagnosed with Anorexia Nervosa or Bulimia Nervosa is approximately 10:1 (Andersen, 1995).

The incidence of Bulimia Nervosa has increased steadily in the past 20 years. Cases of Bulimia Nervosa have dated as far back as 14th century manuscripts, wherein there was "a tradition of induced emesis between banquet courses by surfeited Roman patricians" (Parry-Jones, 1994, p. 146). In terms of actual incidence figures, there remains some ambiguity and debate among researchers because only a minority of those with eating disorders seeks medical attention.

As Flood (1989) notes, Bulimia Nervosa is a predictable experience. Ironically, many people who suffer from Bulimia Nervosa were raised in families or are in relationships that are unpredictable. Additionally, depression affects nearly 75% of those struggling with Bulimia Nervosa and sexual abuse has also been reported more frequently (between 20 and 50%) in bulimic patients than in the general population (Iwasaki, Inoue, Kinikr and Hikiji, 2000). Furthermore, alexithymia, the inability to consciously experience and express emotions, has been described in many patients (Maddox & Long, 1999).

A significant number of bulimics are also reported to abuse alcohol or drugs. Brisman and Siegal's (1984) review revealed that 13.3% of bulimic female students have abused alcohol or consider themselves alcoholic as compared to 3.6% of nonbulimic female students. Clinical reports from patients further indicate dually directional symptom substitution in which individuals often substituted food for alcohol or

vice versa in attempts to avoid one or the other substance (p. 114). The act of bingeing and purging provides the bulimic with the illusion that she can regain a sense of control. Unfortunately, the experience can be addictive, setting forth a vicious cycle that, like any other addiction, can be "cunning, baffling and powerful" (Anonymous, personal communication, August 28, 2000). Such research supports the need for additional study and investigation into bulimia's relationship to the addictive process.

Etiology

It is universally accepted that eating disorders are multifaceted in their etiological makeup. Cultural, individual, and family factors mutually contribute to their development. Garner and Garfinkel (1982) have been the forerunners during the past decade in replacing single-factor causal theories with the view that eating disorders are "multidetermined." While dieting is inevitably a precipitating factor, biological, psychological, social, and spiritual processes are also involved in contributing to their development. More recent research has also provided greater awareness of the "perpetrating effects of starvation, with its psychological, emotional, and physical consequences" (Garner & Garfinkel, 1997, p. 146).

Moreover, there exists much overlap in the psychological characteristics shared by persons with eating disorders. As previously mentioned, the most common pattern of behavior is that of binge eating (Weiner, 1998). A binge episode may be triggered by merely seeing or tasting a particular food, almost as though the individual is addicted to the item (Gilbert, 1986). Binge eating has also been described as a "futile attempt to restock depleted emotional stores, when attempts at doing everything perfectly have failed" (Burrows, 1992, p. 150).

Weiner (1998) found that the personality characteristics for individuals at-risk for substance abuse are likewise present in those with Bulimia Nervosa and binge-eating disorder. These include:

1. A need to obtain affective experiences through action rather than through feeling or talking.
2. An inability to regulate tension.
3. A need for immediate gratification.
4. Poor impulse control.
5. A fragile sense of self.

Weiner (1998) also hypothesized that binge eating is a response to emotional distress – tension, loneliness, anxiety, boredom, anger or interpersonal conflict. The pattern of negative thinking that leads up to and follows a binge episode can be self-reinforcing. Moreover, it mimics the patterns experienced by those with drug and alcohol dependencies.

White (2000) ascertains that dieting, body dissatisfaction, and actual weight status are the most prominent risk factors for the development of eating disorders. Dieting is the most researched and significant risk factor for Bulimia Nervosa and has been identified by researchers as the first behavioral symptom to occur (Hamain & Devlin, 1999). Body dissatisfaction refers to how the body is perceived, experienced and evaluated. Women with eating disorders typically perceive their size and shape as unacceptable. Lastly, an elevated weight status is thought to encourage Bulimia Nervosa and binge-eating disorder because it augments the pressure to be thin, and can support dieting and body dissatisfaction.

Empirical evidence suggests that many eating disordered individuals have difficulty identifying and expressing emotions. Clinically referred to as alexithymia, the inability to identify and communicate emotions and distinguish between emotional states and physical sensations is common in bulimics and binge eaters (Esplen, Gallop, and Garfinkel, 1999). Bruch (1973) correlates the experience of loneliness and emptiness, as well as feeling misunderstood, all to binge eating. These symptoms are characteristic of long-standing alexithymia.

Research has also demonstrated a relationship between the severity of the binge eating and depression and anxiety (Telch & Agras, 1994). This is not surprising given the guilt, shame, and self-loathing that result from binge eating. However, studies reveal mixed results as to whether depression is the cause or the effect of either disorder (White, 2000).

The separation of the eating disorders research from obesity research is in large part attributable to their history. The fields have different emphases, with the obesity field being dominated by medical perspectives and concerns with physiology and health risks, and the eating disorders field having stronger roots in psychology, psychiatry, and the social sciences (Garfinkel, p. ix as cited in Brownell & Fairburn, 1995).

The breadth of eating disordered concerns participating in OA meetings eloquently illustrates the overlap between these two fields. It was for this reason that the Diagnostic and Statistical Manual: Fourth Edition (1994) added binge-eating disorder to its appendix for disorders under consideration for inclusion.

Treatment Research Findings

Estimates of long-term recovery (greater than five years) from compulsive eating are less than 5% (Garner & Wooley, 1991), and follow-up studies ranging from one to four years are similarly discouraging (Kayman, Bruvold, and Stern, 1990; Malenbaum et al., 1988). Several behaviors were, however, consistently associated with brief periods of recovery from compulsive eating disorders. Those most consistently associated with abstinence from compulsive eating included adherence to a food plan, attending a support group, and long-term individual psychotherapy (Bonato & Boland, 1987; Kayman et al, 1990; Perri et al, 1988). Support provided from family, friends, or romantic partner appears to be helpful to the recovery process. Conversely, parents were typically portrayed as unhelpful to the recovery process (Rorty, Yager, and Rossotto, 1993).

Fairburn, Cooper, Doll, Norman and O'Connor's (2000) research on the natural course of binge-eating disorder and bulimia revealed different outcomes between the two disorders. Two cohorts of bulimics (n=102) and binge eaters (n=48) were studied prospectively over a five-year period. The recovery pattern for the bulimic cohort revealed only one third of the patients to be in full remission from the disease (did not meet diagnostic criteria) at the five-year assessment point. The remaining cohort was evenly divided with one third of the cohort continuing to present some symptoms of a clinical eating disorder and the remaining third fully meeting the diagnostic criteria for Bulimia Nervosa. At the five-year assessment point, those with binge-eating disorder showed more success, with only 18% having any form of clinical diagnosis. However, 39% of the binge-eating disorder cohort did continue to meet the criteria for obesity.

This study was the first of its kind to reveal different outcomes between bulimics and binge eaters, validating different diagnoses for the two disorders. Limitations inherent in the study included its small number of binge-eating participants and a sample that is exclusively female and younger compared to clinical samples.

The treatments most frequently implemented in combating binge-eating disorder include cognitive-behavioral therapy, interpersonal therapy, and self-help groups (National Institute of Diabetes & Kidney Disease, 1993). Cognitive-behavioral therapy teaches patients to monitor and modify their eating habits as well as change the way they react to difficult situations. Interpersonal therapy examines clients' relationships with friends and family and helps make clients alterations as necessary. Self-help groups can also provide beneficial support. Which mode or combination of treatment modalities is most successful in effectuating recovery from binge-eating disorder is under debate (National Institute of Health, 1993). Although pharmacological studies have revealed inconsistent results, the preponderance of the evidence suggests positive effects for binge eating from fluvoxamine and desipramine (Agras, Schneider, Anmow, Raeburn, & Telch, 1989).

Conventional treatment strategies for binge-eating disorder have utilized behavioral self-management training (Buckmaster & Brownell, 1988). Ferster, Nurnberger, and Levitt (1962) commenced this early behavioral approach with the inclusion of self-monitoring and stimulus control techniques. Self-monitoring pertained to keeping records of the type, amount and caloric content of one's daily food consumption. Stimulus control techniques address environmental cues associated with compulsive eating. For example, clients are encouraged to eat while sitting down and at

regularly spaced intervals. Both techniques are focused on increasing the individual's awareness of what he/she was eating and to minimize external reinforcers for compulsive eating.

This particular behavioral approach also supported freedom from restraint and de-emphasized any strict adherence to one particular food plan. Smith, Williamson, Bray and Ryan's (1999) study on the relationship between flexible verses rigid dieting strategies confirms this perspective. Those participants that engaged in flexible dieting strategies consistently demonstrated an absence of overeating, lower body mass and lower levels of depression and anxiety. Alternately, rigid dieting strategies were significantly associated with calorie counting, solitary binges and a higher body mass. While other behavior modification programs have included exercise, social support, and a longer treatment period (Brownell & Foreyt, 1985), they have not proven successful for treating the effects of compulsive eating once the treatment had been discontinued.

Interpersonal and cognitive therapy also demonstrated an ability to reduce binge-eating symptoms; however, this intervention is costly and may be unnecessarily intensive for individuals with binge-eating disorder (Peterson, Mitchell, and Englebloom, 1998). Particularly in this age of managed care, examining available treatments from a cost-benefit perspective has become a necessity. Peterson et al. (1998) suggest that self-help interventions may facilitate the dissemination of treatment to a wider population of individuals who could benefit from it. Carter and Fairburn (1995) also note that self-help treatment has the additional advantage of bypassing obstacles to treatment including cost, accessibility, and the stigma associated with obtaining help from a mental health professional.

Peterson, Mitchell, and Englebloom (1998) demonstrated no differences in outcome for group cognitive-behavioral therapy administered in therapist-led versus self-help formats for binge-eating disordered individuals. While limited by a modest sample size, this study confirms that self-help approaches to treatment are viable treatment alternatives.

While the number of treatment options available to those struggling with this disorder has increased dramatically, there has been a movement in the general field of psychotherapy toward eclecticism and integration of different therapeutic approaches (Garfield, 1994). Applying multiple treatments to different eating disorder patients is not new and has formed the foundation of multidimensional approaches to psychotherapy (Garner, Garfinkel, & Bemis, 1982).

Research into the treatment of Bulimia Nervosa reveals mixed results. Studies on bulimia have documented success with cognitive-behavioral, drug, and group therapies. Specifically, cognitive-behavioral therapy appears to be the most effective treatment for Bulimia Nervosa (Garner, Fairburn & Davis, 1987). While not equivalent to cognitive-behavioral therapy, antidepressant drug therapy has proven to curtail binge-purge frequency and lower scores on depression inventories (Agras, Schneider, Arnow, Raeburn & Telch, 1989).

In a study looking at the current treatment status for Anorexia Nervosa and Bulimia Nervosa, Herzog, Keller, and Strober (1992) found no consensus among medical doctors and psychologists regarding how to treat eating disordered patients. The descriptive data did find universal support for the use of talking therapy with both groups of patients. Furthermore, the clinical perspective of the respondent influenced

professional's support of drug therapy. Medical doctors were more likely to support drug therapy than were psychologists.

Of greatest significance, this study suggests that clinical decisions are not primarily influenced by treatment studies in the professional literature. For example, anorexics were as likely as bulimics to receive all three treatments (cognitive-behavioral, drug, and talking therapies) proven effective only for bulimics. Their results also highlight how often treatments are endorsed in clinical practice despite the lack of controlled studies documenting their efficacy. Treatments for Bulimia Nervosa are not as highly endorsed by clinicians, as the literature would predict (Herzog et al., 1992).

Keller and Lavori (1988) do speak to the importance that the patients themselves play in determining which type of treatment is administered. For this reason, the need for ascertaining which client characteristics most benefit from the various types of interventions exists.

Antidepressant drugs have been treating those with Bulimia Nervosa since the early 1980's. Originally intended for those patients that were concurrently depressed, it was soon noted that nondepressed bulimic clients similarly improved. Since that time, Peterson and Mitchell (1999) have found more than 20 studies to confirm significant improvement in eating disordered behavior (bingeing and vomiting) with the use of antidepressants. Fluoxetine hydrochloride has been one of the forerunner antidepressants approved by the FDA to combat Bulimia Nervosa. Symptoms of depression, anxiety and body dissatisfaction were also rectified with antidepressant medication.

In a study by Mitchell (1991), a sample of bulimic individuals was randomly assigned to one of four treatment conditions: placebo only, fluoxetine only, placebo plus self-help manual, or fluoxetine plus self-help manual. Self-help and fluoxetine were both found to reduce the frequency of self-reported bulimic symptoms. In addition, the combination of self-help manual with medication showed cumulative effects on improvement.

More than one study has deemed cognitive-behavioral therapy effective for the treatment of Bulimia Nervosa (Wilson & Fairburn, 1998). In one recent study conducted by Tuschen-Caffier, Pook, and Frank (2001), 67 female patients with Bulimia Nervosa participated in manual-based cognitive-behavioral therapy at an outpatient service facility. At the conclusion of treatment and at the one-year post-treatment assessment, all participants demonstrated significant improvement in both core and unspecific features of Bulimia Nervosa. The components of bulimia that were addressed incorporated core features, such as binge eating, body dissatisfaction, dietary-restraint, and mood related eating behavior, as well as the non-specific feature of depressed affect. This study was the first of its kind to present empirical evidence that supports cognitive-behavioral therapy's effectiveness in the treatment of Bulimia Nervosa in natural, as well as clinical research settings.

Apple's (1999) qualitative research examined whether interpersonal therapy is effective for those with Bulimia Nervosa. The case studies that the author presents suggest that interpersonal therapy is not appropriate for addressing the bulimic symptoms. It is, however, beneficial for those who remain "stuck" in their eating disorder by reason of interpersonal difficulties. Moreover, it is of value for clients who "may

benefit from a therapy that offers some structure, focus and containment without clear behavioral directives" (Apple, 1999, p. 715).

Research on self-help and psychoeducational interventions has primarily involved individuals with Bulimia Nervosa. Huon (1985) conducted a study in which 90 bulimic individuals received monthly psychoeducational mailings and were randomized to receive telephone contact from an "improved" or "cured" bulimic individual or no contact. Nineteen of the sample were abstinent at the end of the seven-month treatment, and 68% were improved; at the six-month follow-up, abstinence rates increased to 32%. Those receiving both the phone calls and the mailings were the most successful.

It is worth noting that approximately 50% of all anorexics experience episodes of bulimia (Bruch, 1973). Although Beaumont (1995) notes that some professionals view bulimia in these patients as a complication of the anorexia, it has also been observed that in some cases the bulimia actually preceded the anorexia. Moreover, it has been found that a relatively large number of "cured" anorectics go on to become bulimic (Morgan, 1989). Given their occasional comorbidity and overlap in symptomatology, these disorders are frequently addressed simultaneously in the treatment literature.

Fairburn and Peveler (1990) proposed a model for integrating and sequencing different forms of treatment into a five-level process for those with Bulimia Nervosa. The authors suggested 1) self-help or written materials; 2) dietary education and advice, perhaps in a group setting; 3) antidepressant drug treatment in combination with advice or support; 4) out-patient cognitive-behavioral treatment; and 5) day or inpatient care with subsequent outpatient treatment. This model was the first of its kind to formally

introduce the use of self-help as an option, which is potentially more economical than other treatment options (Garner and Needleman, 1995).

The self-help group literature suggests that in addition to medical explanations behind the desire to eat compulsively, there are behavioral explanations as well (Katz, 1981). For example, Katz found that those who are socially isolated from primary group relationships have a greater chance of acquiring a Mertonian mode of adaptation, or so-called “compulsive” behavior, such as alcoholism, drug or food abuse. Moreover, Fischer (1983) observed that those who increased their social integration with individuals who reinforced a positive self-concept and decreased their interaction with those who reinforced their negative self-image had a greater chance of altering their behavior (e.g., they ceased to binge and would reach an acceptable maintenance weight).

In examining the organization characteristics and social support of self-help groups, Maton (1988) reported more positive well-being and group appraisal in groups that encouraged bi-directional support. His interpretation for the finding was that both receiving and providing support each lead to distinctive psychological benefits in self-help groups. Individuals who do both thereby accumulate benefits from both. Other effects of bi-directional support include cognitive rehearsal of coping strategies, increased sense of meaning and purpose associated with one’s life situation, social reinforcement for helping and internal feelings of self-worth and efficacy (p. 73). Maton’s second explanation is a “balance theory” interpretation which suggests that the psychological costs to unidirectional receiving (e.g. inferiority, indebtedness) or

unidirectional providing (e.g. not getting needs met, burnout) are offset when individuals both receive and provide support.

In terms of organizational characteristics, Maton confirmed that groups in which roles and responsibilities were shared with a number of participants, rather than concentrated in a leader, were also the groups to report lower levels of depression and higher self-esteem (1988). Groups that were viewed as orderly and organized were also perceived to be those that provided the most benefits to group participants.

In summary, the literature clearly supports the role of social interaction and group membership and structure in the context of behavioral change. Given that 12-step programs like OA embody many of the described characteristics (e.g. bi-directional support and positive social integration), there is reason to investigate whether OA can effectuate similar behavioral changes in alleviating eating disordered symptoms, which, in turn, would promote abstinence.

Eating Disorders as Addictions

The binge-eating symptom present across many eating disorders shares much in common with drug and alcohol abuse. People who eat compulsively and those who abuse alcohol and drugs report strong “cravings” to consume the substance. Both experience a loss of control over their intake, use the substance to regulate their emotional state and cope with stress, and make repeated attempts to stop after becoming preoccupied with the substance. Both may deny the seriousness of their problem or keep it a secret, and both may suffer negative and psychological consequences as a result of their behavior (Brownell & Fairburn, 1995). For these reasons eating disorders are increasingly viewed from the disease model of addiction.

The older model of addiction was based on the notion of physical dependence to a substance, thereby precipitating detoxification as the primary treatment goal. Newer models of addiction, based in research in brain biology, have shifted the primary problem of addiction as reward, not withdrawal, and focus treatment on lifetime abstinence (Dupont, 1998). Given this change in perspective, twelve-step programs are more than traditional treatment alternatives. Rather, twelve-step programs are spiritually based fellowships that support not only the achievement and maintenance of abstinence from addictive behaviors but also lifelong character development (Chapell & Dupont, 1999).

In line with more recent models, Donovan (1988) uses a biopsychosocial perspective to define addiction as a:

> "Complex progressive behavior pattern having biological, psychological and behavioral components…. What is unique about these behaviors is the individual's pathological involvement in or attachment to it, their subjective compulsion to continue it and reduced ability to expect some influence or personal control over it. There is a need to continue with the behavior despite negative consequences for the person and usually the individual will continue the behavior despite more gratifying sources of behavior being available" (p. 545).

Those with eating disorders have shared experiencing intense emotional highs and lows associated with bingeing, purging, and restricting. These feelings can result from the biochemical effect of such quantities of food or from the act of purging itself.

Bulimic binges often occur several times daily, with an individual consuming as much as 5,000 calories per binge and up to 50,000 to 60,000 calories per day. The psychological and physical associations with these 'highs' are the means by which these behaviors become addictive (Riley, 1991). Moreover, the release from the emotional pain and anxiety that fuels the eating disorder imposes an addictive element to the disease.

Sheppard (1994) has postulated that there is an abnormality of the endorphin metabolism within the brain that triggers the addictive process. The compulsive use of a substance or behavior either alters or normalizes this system. Individuals who are prone to addiction are likely to be deficient in their levels of encephalins and endorphins, the brain's natural pain-relieving and pleasure-causing chemicals (Institute for Natural Resources, 1995). Consequently, these individuals are susceptible to substances or behaviors that ameliorate the deficits, artificially soothe the brain, and enhance well being. This improved feeling is the physiological basis of addiction (Sheppard, 1994).

Studies on eating disorders confirm that sufferers most often crave carbohydrate items during "binges" (Kayloe, 1993). When carbohydrate rich foods are ingested, serotonin is released. The cravings for foods that can elevate serotonin levels are a means by which the body instinctively attempts to compensate where neurotransmitter deficiencies exist.

From an addictions paradigm, it is not surprising that abstention from addictive food substances triggers withdrawal symptoms and a craving for the omitted substance or behavior (Sheppard, 1994). Depression and anxiety can proceed from decreased quantities of serotonin in the individual. Hence, compulsive eaters are more prone to

out of control eating, especially high-carbohydrate food, in order to experience relief from the effects of low serotonin levels (Hoffman, 1994).

It is significant to note that for female recovering substance abusers, the new behavior frequently adopted relates to eating disorders. Hatcher (1989) reports that moving into Bulimia Nervosa or binge-eating disorder is not unusual; the behavior is the same, only the substance is changed. The effects of binge eating including feeling stuffed and out of touch with time or reality parallel the rewards for alcohol/drug abuse.

For these reasons, Wooley and Garner (1991) have stated that compulsive eating disorders such as Bulimia Nervosa and binge-eating disorder require a behavioral and psychological management program to normalize eating habits. OA addresses this need through the abstention of trigger food items (e.g. sugar and/or alcohol), and through the application of the Twelve Steps of Alcoholics Anonymous and the OA Tools for Recovery. The 12-step approach is founded on the disease concept. This concept defines the eating disorder as “an involuntary psychobiologic state” (Riley, 1991, p. 719). The disease concept requires acceptance of the following three tenets:

1. Individuals with eating disorders are powerless over addiction, and their lives are unmanageable.
2. Although individuals with eating disorders are not responsible for their disease, they are responsible for their recovery.
3. Individuals with eating disorders can no longer blame people, places, and things for their addiction; they must face their problems and their recovery (Rogers, 1988).

Opponents to this perspective do exist. For example, Wilson (1999) argues against an addiction model of eating disorders based on its conceptual and empirical shortcomings. The author cites no evidence existing for physical dependence and withdrawal symptoms in eating disordered patients that are characteristic of chemical dependency or addiction. Moreover, while food might regulate affect and have biological consequences in some people, the author asserts that this does not make it an addictive substance. Other activities, including stress, exercise, and sex similarly affect emotions and have biological consequences. This does not necessarily make them addictive substances. Moreover, the author states that there is no compelling evidence that eating disordered individuals experience craving as a direct biochemical result of consuming a particular food (e.g. sugar) to which they are sometimes said to be allergic (1999).

Wilson cites a study by Turner et al. (1991) wherein the psychological and biological effects of a simulated carbohydrate binge in bulimic patients and matched controls showed little carbohydrate-specific effect on subjective responses. Each group consumed a drink of either 1200 kcal. of carbohydrates or a placebo with little caloric value. Ratings of mood, prolactin, growth hormone, and cortisol did not indicate any carbohydrate-induced stimulation in either group.

Overeaters Anonymous

Founded in 1960, Overeaters Anonymous (OA) was the first self-help program extended to those suffering from compulsive overeating and offering a new way of life. This program, also spiritual in nature, assists individuals in developing a healthier lifestyle. While OA was originally intended to provide a self-help program of change for

compulsive overeaters suffering from obesity, other eating disorders are now widely recognized and addressed in OA support groups. The modern day version of OA offers recovery for all kinds of eating concerns including Anorexia Nervosa, Bulimia Nervosa, and binge-eating disorder. Subgroups within OA have also developed. These subgroups mandate more rigid adherence to the steps and the tools of OA. For instance, being honest, open, and willing to change (H.O.W.) is one criteria for participation in the subgroup OA/ H.O.W.

Clinicians at the Laureate Psychiatric Clinic and Hospital in Tulsa, Oklahoma, began to integrate the twelve-step approach with traditional psychotherapy for the treatment of eating disorders in the mid-eighties. This occurred after several patients who were unsuccessful in the original Laureate treatment program became involved in AA or OA and made "remarkable recoveries" (Johnson & Sansone, 1993, p, 122).

The worldwide presence of OA today confirms the words used in 1951 in conferring the Lasker award on the sixteen-year-old Fellowship of Alcoholics Anonymous:

> "Historians may one day recognize Alcoholics Anonymous to have been a great venture in social pioneering which forged a new instrument for social change; a new therapy based on the kinship of common suffering; one having a vast potential for the myriad other ills of mankind' (p. XI).

Using the twelve-steps and twelve traditions of AA, OA changes the word "alcohol" and "alcoholic" to "food" and "compulsive overeater." OA participants establish abstinence through prompt and complete cessation of foods that trigger binge eating

coupled with a plan of eating. Attendance at OA meetings, literature reading and writing, regular use of the telephone to connect with other OA members, sponsorship, and giving service to OA are also emphasized as critical to obtaining and maintaining abstinence.

The message in OA states: all are welcomed who wish to stop eating compulsively. There are no dues or fees for membership; OA is entirely self-supporting through its members' own contributions, neither soliciting nor accepting outside donations. OA is not affiliated with any public or private organization, political movement, ideology, or religious doctrine; it takes no position on outside issues. Its primary purpose is to abstain from compulsive overeating and to carry the message of recovery to those who are still suffering (www.OvereatersAnonymous.org). OA defines compulsive overeating as a serious physical, emotional and spiritual illness for which there is no cure. They believe that the illness can be arrested, but never cured. The introduction to the book Overeaters Anonymous (1980) states:

> "Compulsive overeating has many symptoms in addition to mere fat. It is an illness, which isolates, and gradually, or rapidly, causes increasingly serious problems in one or more areas of our lives: health, job, finances, family, or social life."

OA is unique in its core belief that compulsive eating is a progressive, addictive illness. Its central tenets suggest that this illness: (1) can never be eliminated but only managed as a chronic problem, (2) requires that the abuse of food must be interrupted,

and (3) requires that treatment not differ fundamentally from treatment for alcohol and drug dependence. Compulsive eating is also viewed as an impulsive response to stress, which alleviates tension in the same fashion that other compulsive disorders like alcohol and drug abuse do.

No one is sure what causes eating disorders; however, a number of factors such as environment, a certain way of reacting to life and biological disposition are believed to be a part of the problem. Despite the factors or contributing causes, "We have learned in a general way that the reasons are unimportant. What deserves the attention of the still-suffering compulsive overeater is this: there is a proven workable method by which we can arrest our illness" (Overeaters Anonymous, 1980, p. 1).

The Big Book of Alcoholics Anonymous (1976) similarly views alcoholism as a physical, spiritual, and emotional illness for which there is no recovery except through an entire psychic change. The alcoholic behavior is viewed as analogous to an allergy such that the ingestion of alcohol sets up a craving for more and more. The AA literature asserts that they have found nothing that contributes to rehabilitation that is better than AA (Alcoholics Anonymous, 1976).

OA addresses the physical, spiritual, and emotional aspects of recovery unique to the compulsive eater through the utilization of the OA "tools." Application of these tools on a regular basis is critical to participants' achieving and maintaining abstinence. The first of these tools is 'a plan of eating.' Participants are encouraged to adopt a disciplined, well-balanced food plan assigned to them by a knowledgeable authority – a doctor, nutritionist, or dietitian. Whenever possible, food is weighed and measured so there is no guesswork. It is encouraged that participants not consume food containing

sugar or alcohol. Some OA meetings extend their plan of eating guidelines to include taking a multivitamin and 64 ounces of water per day. Unless suggested otherwise, those not at a maintenance weight are further advised to weigh only once a month. According to the OA pamphlet, “A Commitment to Abstinence,” a ‘plan of eating’ is a guide to the food that an individual member should eat each day. While an effective plan varies by individual, “rigorous honesty to not eat foods or amounts not included in one’s plan” is consistently emphasized (Overeaters Anonymous, 1995). Adherence to the plan of eating is fundamental to a member’s attainment of abstinence. It is not uncommon to hear an OA member claim that “nothing tastes so good as abstinence feels.”

Sponsorship is a second OA tool. According to Overeaters Anonymous (1994):

> “Sponsors are OA members who are committed to abstinence and to living the twelve steps and twelve traditions to the best of their ability. A sponsor guides a member through the program of recovery on all three levels: physical, emotional and spiritual. In working with other members of OA and sharing their experience, strength and hope, sponsors continually reaffirm their own abstinence. Sponsors share their program up to the level of their own experience. Ours is a program of attraction; find a sponsor who has what you want and ask how it was achieved. A member may work with more than one sponsor and may change sponsors at will.”

A sponsor’s role is not one of a therapist, doctor, or other professional. Rather, it is the sponsor’s responsibility to listen, support, and provide understanding.

Service is a third OA tool. As carrying the message to the compulsive eater who still suffers is the basic purpose of the fellowship, service is the vehicle through which this is accomplished. Participants are encouraged to give service, no matter how small, to help fellow sufferers and to enhance the quality of their own recovery. "Do what you can, when you can" is iterated throughout OA meetings. From setting up to putting away chairs, welcoming newcomers, leading at meetings, and "accomplishing what needs to be done for the group or OA as a whole are the means by which members give back what they have so generously been given" (www.OvereatersAnonymous.org).

Anonymity is a tool as well as a tradition. Participants do not allow their last names or faces to be used outside of the OA meeting to ensure the sanctity of their anonymity. All that is shared in meetings and between members should be held in respect and confidence. By placing 'principles before personalities,' anonymity is intended to offer freedom of expression and protection from gossip. Newcomers are reminded of the necessity of this tool in allowing members to grow and recover from this very serious disease. "Whom you see here, What you hear here, When you leave here, Let it stay here!" (OA Tools of Recovery, 1995).

Telephone is another OA tool. Because of the intense isolation that can affect those with this illness, the telephone is used for member to connect with one another between meetings. The telephone connects participants with their sponsors, and is an essential part of the surrender process by which individuals learn to reach out to both give and receive help. In these conversations, participants typically discuss their day to day struggles in an effort to provide "an immediate outlet for the highs and lows we all experience " (www.OvereatersAnonymous.org).

Perhaps most associated with the OA tools are the OA meetings themselves that participants are encouraged to attend. Meetings are a place where two or more compulsive eaters "come together to share the experience before and after recovery and to share the strength and hope OA has given them" (Overeaters Anonymous, 1995). Meetings allow participants the opportunity to identify and share with fellow sufferers. They are also a means for reinforcing continued adherence to OA norms.

The various types of meetings include:

- Open meetings – for anyone interested in attending
- Closed meetings – for individuals who have admitted to having an eating disorder
- Speaker meetings – for individuals to tell their story; these people typically have experienced long-term recovery and share their experience, strength, and hope;
- Step meetings – may be open or closed; usually closed and calls for in-depth study of one of OA's steps or traditions in greater detail.

Literature reading and writing is the last of the seven OA tools. Through the study of the book Alcoholics Anonymous, referred to as the Big Book, and the Twelve Steps and Twelve Traditions, another AA book, OA participants are guided through their twelve-step recovery program. OA also publishes the book Overeaters Anonymous, referred to as the Brown Book, the OA Twelve Steps and Twelve Traditions, For Today (for daily meditation), and Lifeline, their journal for recovery.

The literature, optimally read on a daily basis, is designed to give members insight into their affliction as well as the strength and hope to recover (www.OvereatersAnonymous.org).

The tool of writing complements the reading of the literature. Through writing, participants are able to discern thoughts and feelings that are not always otherwise apparent. It is another means of reacting to life outside of the food, and is ultimately the vehicle through which participants take their personal inventories.

While not a formal OA tool, some participants use the eleventh step process of prayer and meditation as such. Turning to one's Higher Power in an effort to pray for His will and the power to carry it out is the cornerstone of the spiritual recovery found in OA. Regular prayer and meditation are a means to this end, ultimately inhibiting slips or relapse from occurring, and beginning the process of inner psychic change.

In addition to the aforementioned tools of recovery, the twelve steps and twelve traditions of AA are germane to the OA program of recovery. In his description of AA and other twelve-step recovery programs, Maxwell (1984) delineates the value of the 12 Steps:

> "They are the central set of guidelines for action to be taken by the individual member… In almost all psychotherapies, there is consensus about the importance of being honest with ourselves – of recognizing and dealing with our defensive distortions in outlook. There is consensus as well, about a cathartic unburdening of our guilt and hostilities, of our anxieties and our fears – and doing so with another person who is understanding, nonjudgmental, and accepting.

> There is also consensus on the desirability of repairing damaged interpersonal relationships where feasible. We note that the Steps recognize the need for "inner work" as well as interpersonal action. Being willing is often the difficult part, but action with other persons is the necessary follow-through" (p. 91).

The OA program emphasizes accommodation over competition; acceptance of one's situation instead of seeking to conquer it; seeking help, admitting powerlessness; and being humble (Norman, 1984). As in AA, the serenity prayer is their creed: "God, Grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

The first of the OA twelve steps is where the individual accepts powerlessness over food. The second step acknowledges that a Higher Power can restore sanity if He is sought, and the third step entails the surrender of one's life and will over to a Higher Power. The phrase to "let go and let God" that is often repeated in OA circles refers to this unconditional surrender.

An advantage of this accommodative perspective is the development of enhanced self-acceptance. Inherent to the twelve steps is the belief that compulsive eating is an illness, not an absence of will power. A study by Norman in 1984 revealed that a majority of OA participants agreed that joining the group had the effect of decreasing their self-blame. Participant observation, organizational literature, and interviews with OA participants were examined to confirm said hypothesis. An example of how this compulsion ideology, reinforced by an accommodative strategy, helps to neutralize self-blame is when an OA member discusses the importance of being humble

rather than egotistical or selfish, and of being satisfied with oneself. “It used to be,” he said, “I wanted to change things about myself but now (since joining OA) I accept myself as I am” (Norman, 1984, p. 149).

In one of the first controlled psychotherapy treatments for Bulimia Nervosa, Connors, Johnson, and Stuckey (1984) found that having hope about receiving help for the symptoms of bulimia was enough to reduce patient’s binge-purge frequency by 50%. This seminal study demonstrated just how significant faith and hope are for the individual who is caught in the addictive cycle. Johnson and Sansone (1993) further parallel these findings with the manner in which AA perpetuates faith and hope. In the same fashion, when ample recovery is witnessed in the OA rooms, “a very powerful idealizing transference can be generated that is often an important part of the healing process” (p. 130).

Research on Overeaters Anonymous

Studies on the OA organization reveal the typical OA member to be a middle-aged college-educated, white female. In a nationwide study completed by Spitzer et al. in 1992, 44.5% of the OA participants surveyed were identified as compulsive overeaters, 40.7% as bulimic, and 14.8% as anorexic.

With abstinence as the expressed goal, the outcome of OA intervention in the treatment of 40 bulimics was judged on measures of length and consistency to be excellent (Malenbaum et al, 1988). All those in this published study had been abstinent for an average of three years and continued to attend meetings, call their sponsors, and sponsor others. Study participants demonstrated awareness that OA was critical in addressing their behaviors surrounding food, which was necessary before they could

confront more core psychological issues. Moreover, the behavioral structure inherent in the OA tools abdicates the daily struggle with the food, as it becomes a predetermined entity (1988).

Those who began OA as overweight generally considered themselves quite successful, with much credence being given to abstinence and spirituality (Westphal & Smith, 1996; OA, 1992). Westphal and Smith interviewed 27 OA participants and collected questionnaires from 34 respondents to examine characteristics of participants who attend OA and succeed. Their study explored success as the average weight loss and the current reduction quotient (CRQ). CRQ = (Current weight – initial weight) / (Initial weight – Ideal weight). The subjective measure of success in OA was how successful participants felt they were in the OA program. In this study, the average weight loss for participants who entered OA obese was 21.8 pounds – an average body weight percentage of 9.7%. It was further postulated that a loss of this magnitude might lead to health benefits including improved heart and respiratory functioning and reduced blood pressure.

Although spirituality was rated as the most important part of the program, it did not correlate with the CRQ measure of weight loss. Westphal and Smith (1996) speculate that while spirituality is critical to OA participants, it does not necessarily connect to weight control. In contrast, abstinence did correlate with the CRQ, suggesting that it may lead to weight loss. As with many studies conducted on OA, the most serious limitations of this study involve its lack of representativeness and small sample size. Nonetheless, the information gained is useful in beginning to explain which mechanisms behind OA are most effective.

In Bramer's (1986) study of 37 bulimic women participating in OA in one midwestern state, the following hypotheses were supported:

1. Some bulimic women find OA helpful. Specifically, the demographic profile of the typical bulimic woman who does find OA helpful was a Caucasian female, between 31 and 50 years old, and married currently or previously, had a family income of over $25,000 and had completed some college.
2. The self-reported personality profile of the typical bulimic female had a less favorable opinion of herself than the normative sample. She was more pessimistic and more ambivalent in relating to others, and she strived less for recognition in areas that are socially significant or require leadership. The bulimic felt a real need to solicit sympathy, affection, and emotional support.
3. Seventy-five percent of the sample (n=37) practiced binge/purge behavior at least one or more times weekly before attending OA, and only 22% of them had the same incidence of bulimic behavior after attending OA.
4. Ninety percent of the group responded that their lives had improved either "somewhat, much, or very much" in their emotional, spiritual, job, and social lives.

Bramer's study is one of the few available surveys examining bulimic individuals participating in OA. Limitations inherent to this particular study included its limited sample size. Moreover, it did not specifically examine how long participants had attended OA meetings or how long they had abstained from binge/purge behavior. Nevertheless, it confirmed the notion that OA effectuates positive behavior changes and improvements in quality of life.

In examining the disadvantages of the twelve-step movement, it has been recognized that individual participants could benefit from interventions over and above the twelve-step approach (e.g. psychotropic medications). However, there is no such mechanism within the 12-step approach that enables participants to connect to these resources. Moreover, the emphatic following that is cultivated among many twelve-step groups can also mistakenly assume that there is only one way to recover. This can lead individuals to experience shame and self-doubt should they consider alternative interventions (Johnson & Sansone, 1993).

While Suler and Bartholomew (1986) insist that the physical explanation behind compulsive eating lies in the individual's tendency to secrete insulin upon the sight and smell of food, the evidence supporting this is similarly controversial. For this reason, most OA groups do not focus exclusively on the physical explanations as much as they focus on the psychological and spiritual components of the disorder (Weiner, 1998).

In Yager, Landsverk, and Carole's (1989) comprehensive study on help seeking and satisfaction with care in 641 women with eating disorders, the only negative feedback in terms of OA came from those struggling with Anorexia Nervosa with bulimic features. Anorexics of this subtype described themselves as "unchanged" or "somewhat

worse" with respect to this intervention. In spite of this negative feedback, bulimics (without anorexic features) and binge eaters responded on average to have gotten at least "somewhat better" by OA and other self-help interventions.

A similar study conducted by Rorty, Yager, and Rossotto (1993) examined the subjective appraisal of 40 women recovering from Bulimia Nervosa for a year or more. Thirty-eight percent of their sample had utilized OA in their recovery. Of this sample, satisfaction was equally divided between somewhat or totally dissatisfied and somewhat or totally satisfied.

Yeary (1987) expresses an appreciation for the differences between eating disorders and substance abuse in that the author views food as a complex mixture of chemicals that can affect the body in any number of ways. Given that the stomach and the brain communicate, compulsive eating inevitably disrupts the chemical equilibrium of the body. It is the author's clinical opinion that "recovery from the addictive use of food is in some ways far more difficult than is recovery from psychoactive drug dependence" (p. 305). An anecdotal saying often conveyed in OA meetings is that "when you are addicted to alcohol you put the tiger in the cage to recover; when you are addicted to food you put the tiger in the cage, but take it out three times a day for a walk" (personal communication, Anonymous, May 8, 2001).

Lester's (1999) expressed concern with OA stems from a feminist-cultural perspective on eating disorders. The author contends that the acceptance of "twelve-step truths" (e.g. accepting powerlessness, relying not on self – but on a Higher Power greater than the self, the surrender of one's life over to this Higher Power, etc…) is often incorporated into an individual's belief system over and above overcoming the addictive

behavior. Such a consequence could affect a woman's interpretations of new life experiences. The author cites gender and power as two areas that can negatively impact women who participate in OA.

Van Wormer (1994) challenges how appropriate the 12-step program is to the treatment of women. The author cites Johnson's condemnation of AA and other 12-step programs as male institutions that inevitably accompany "the self-abasing, powerlessness, external focus, and ultimate rejection of responsibility inherent in male religion and politics" (p. 289). Consequently, the author contends that it retains a male perspective that women are forced to accept (1994).

The author further notes that the concepts of powerlessness, surrender and humility are detrimental to women discovering their own power. Moreover, the concept of surrendering one's life to God "invokes images of women passively submitting their lives to male doctors, teachers, and ministers" (Kasl, 1992). Further, Van Wormer (1994) asserts that women would do better to focus on pride than on humility.

Finally, the issue of abstinence has been criticized for its inherent ambiguity. In AA, abstinence was adopted because the alcoholic must abstain entirely from alcohol. The compulsive eater, on the other hand, can construe abstinence as "overly simplistic" (Fallon, Katzman, and Wooley, 1994), demanding rigid adherence from overeating, bingeing, or eating between meals to complete abstention from sugar and white flour. Garner (as cited in Fallon et al., 1994) argues against a black and white definition for abstinence. Instead, the author proposes defining abstinence with the normalizing of food consumption. Otherwise, the value of abstinence may supersede one's ability for moderation, flexibility, and independent thinking.

Disadvantages aside, Suler and Bartholomew (1986) describe OA effectiveness within the context of Antze's (1976) theory that self-help groups serve as a "cognitive antidote" that counters irrational thoughts and beliefs. While its ideology does not cure the illness, it inhibits relapse through a more adaptive system of beliefs. Specifically, recovery begins as the individual stops believing he can control the disease, progresses through an inventory of character defects and wrong doings, and places increased reliance upon a Higher Power.

Suler and Bartholomew (1986) document additional ideological substitutions that were particular to OA. They include:

1. The belief that it is bad to eat, exchanged for the belief that one must eat to live and should not always feel guilty about it
2. The belief that one is simply overweight and needs to lose pounds, exchanged for the belief that one has underlying psychological and interpersonal problems
3. The belief that one must deprecate oneself, deprive oneself, please other people, exchanged for the belief that it is okay to express positive feelings about oneself and take care of one's needs
4. The belief that food is the answer to all problems, the source of solace, exchanged for the belief that psychological and emotional needs should be fulfilled in relationships with people (1986, p. 52).

These more adaptive beliefs substantiate what Suler (1986) recognizes as OA' ideological emphasis on self-awareness and greater interpersonal relationships. Its

overt goals for individual participants to establish abstinence from compulsive eating, dieting, bingeing, and purging are established and maintained as the more in-depth psychological, social, and spiritual issues are addressed. As one OA member claims, “I did not have a problem with eating, I had a problem living life” (Anonymous, personal communication, April 11, 2001).

The outcome of the internalization of the simple program of recovery is stated to be the fulfillment of the “promises” recorded in the Big Book of Alcoholics Anonymous (1976):

> “We are going to learn a new freedom and a new happiness. We will not regret the past nor wish to shut the door on it. We will comprehend the word serenity and we will know peace. No matter how far down the scale we have gone, we will see how our experience can benefit others. That feeling of uselessness and self-pity will disappear. We will lose interest in selfish things and gain interest in our fellows. Self-seeking will slip away. Our whole attitude and outlook upon life will change. Fear of people and economic insecurity will leave us. We will intuitively know how to handle situations that used to baffle us. We will suddenly realize that God is doing for us what we could not do for ourselves“ (p. 84).

Spiegal (1993) prolifically portrays twelve-step programs as “an opportunity for internal, structural, therapeutic change that addresses characterological issues. The meetings, slogans, literature, sponsor, and the 12 steps themselves act as therapeutic

agents" (p. 158). Moreover, the twelve-step program can be viewed as providing a "holding environment," a term coined by the British object relations' theorist, D.W. Winnicott (1975). It was Winnicott's contention that the therapist's office, the therapy session, and the therapist embody a holding environment that is a safe for psychological growth and development. Spiegal (1993) draws the analogy between the inherent structure of the 12-step program with its meetings, steps, traditions, and tools and this holding environment.

Chapter III. Methodology

This chapter is divided into six sections. In section one the researcher delineates the research design used to collect and analyze the data. Sections two and three describe the setting and the sample examined in the study, respectively. Section four discusses the survey instrument developed to answer the research questions; section five, the procedure for executing the study; and section six examines the data analyses procedures.

Research Design

The research design used in this study to collect and analyze the data is a cross-sectional survey research design. According to Grinnell (1993), survey design is an effective means to systematically collect data from selected respondents who represent the larger population of interest to predict human behavior or phenomena. As surveys obtain information needed to describe people's thoughts, opinions, and behaviors, the primary goal of cross-sectional survey research is to identify a representative group of participants to describe the characteristics (Zechmeister, Zechmeister, & Shaughnessy, 1997).

The advantages of utilizing a self-administered survey for this study include its low cost, respondents can read and respond to questions at their own pace, and the visual presentation of the items on the survey can facilitate comprehension. The greatest disadvantage to this kind of approach is that measurement error can occur if the respondents respond in more socially desirable ways in the presence of the researcher (Grinnell, 1993).

Correlational research represents a general approach to research that focuses on assessing the covariation among naturally occurring variables. The primary goal in a correlational research design is to identify predictive relationships between variables (Zechmeister et. al., 1997). The correlational research design used in this study analyzed the relationship between the methods used in OA (e.g. tools) and length of abstinence and frequency of relapse from compulsive eating, bingeing. and purging through continuous scale response choices. A comparison of the impact of the variables on between those with binge-eating disorder and Bulimia Nervosa was also made to differentiate OA's effectiveness between these two populations.

A serious limitation inherent in correlational studies is that they do not provide for causal inferences about the relationship between variables. Therefore, while the researcher may be able to predict that a participant is more likely to obtain abstinence through the use of the OA tools, he/she does not know that the use of the tools is what causes abstinence. Although correlational evidence alone is not sufficient for causal inferences, more sophisticated statistical techniques can help to make causal interpretations from statistical studies (Baron & Kenny, 1986). In this study, multiple regression analyses were utilized to predict the associations between the investigated variables.

Setting

Over one hundred OA meetings are located throughout the Washington metropolitan area, making attendance possible for those able and interested in attending a meeting. The telephone number for the OA Service Center, which connects interested participants to meetings in their locality, is available in all of the local

telephone books. As in Alcoholics Anonymous (AA), meetings are typically held in churches, schools, and community centers. Also, similar to AA are the four general formats of OA meetings: open, closed, discussion, and speaker meetings (Marron, 1993). The present research study surveyed participants in all four of these formats.

The Overeaters Anonymous (OA) meeting

The duration of the typical OA meeting ranges anywhere from one to two hours. Meetings have a leader or speaker(s) that share their experience, strength, and hope with respect to their recovery from compulsive overeating. The leader often shares what he or she was like before coming to OA, what it has been like since she joined the group, and where she is now. The leader who volunteers to facilitate the meeting is familiar with OA's methods and structure. What follows are readings from the OA literature coupled with a reading of the 12 Steps and 12 Traditions of AA, substituting the word food for alcohol.

A call is made by the leader for individuals new to the meeting to introduce themselves. Newcomer greeters are frequently available to answer questions they might have pertaining to the OA program. Medallions are often distributed to those who would like to commit to one day of abstinence, and to those who are celebrating anniversaries ranging from one month to any number of years. Attention is always given to those who are still suffering, as the power of the organization lies in spreading the message that there is recovery from these deadly disorders.

Also common to OA meetings are some discussion and reading from the tools, the Twelve Steps and the Twelve Traditions of Overeaters Anonymous, or the Big Book

of Alcoholics Anonymous. Anonymity is discussed as a critical foundation to the program. Nevertheless, names and telephone numbers of those in the rooms are frequently exchanged for participants to contact one another between meetings. Meetings also include a moment of silence and the Serenity Prayer.

Sample

The OA Intergroup for the District of Columbia, Maryland, and Virginia was chosen from which to select a sample. The selected intergroup was chosen because of the familiarity garnered from this researchers' three years of participation in OA and the resulting relationships established with the participants.

The criteria for participation in the study consisted of the following:

1. Each respondent was of adult age (18 years or over).
2. Each respondent was professionally diagnosed or self-identified with either bulimia or a binge-eating disorder.
3. Each respondent participated in the study voluntarily.

The Virginia and the District of Columbia/Maryland intergroups consist of 55 and 54 OA groups, respectively. The subjects obtained were a sample of convenience of OA participants who attended one of the selected meetings from the April 2001 OA directory. From the list of 109 meetings, 20 meetings were selected for survey distribution across locations in the District of Columbia, Maryland, & northern Virginia ultimately resulting in a sample size of 231 respondents. An equivalent number of morning and evening meetings were chosen from each group to equally distribute the sample group.

Instrumentation

The survey that was designed for this study derived from categories and questions found in the World Service Organizations (1992) and Cash's (1996) surveys of OA. The questionnaire consisted of 30 fixed-alternative and rank ordered items that include baseline data pertaining to demographic information and eating disorder diagnosis. In addressing the research questions, the tools of OA (sponsorship, a food plan, meetings, literature reading, writing, phone calls and service) were also examined.

The survey designed by Cash (1996) addressed the use of a food plan in OA. Cash established face validity for the survey variables through a review and pretesting by a panel of eating disorder and academic professionals. Cronbach's Coefficient alpha was used to determine the internal consistency reliability of the questions pertaining to the utilization of the food plan. The resulting coefficient alpha was r=.90, suggesting that the shared variance of the items was approximately 90%. Hence, it was concluded that the questions pertaining to the use of the food plan in Cash's study measured a single construct. Further modifications to Cash's survey were made on the basis of a pilot study.

The present survey designed by this researcher was constructed as an exploratory instrument to examine the tools of OA and their relationship to abstinence and relapse from binge-eating disorder and Bulimia Nervosa. Moreover, the inclusion of eating disorder diagnosis as a survey item in the current survey allowed for the bulimic and binge eater subgroups to be differentiated. It included only those earlier survey questions pertinent to the research questions being addressed.

Self-reporting as a vehicle for data collection inevitably carries certain methodological liabilities, since the consistency of responses at different times, and the consistency of responses with an outside criterion can be problematic (Katz, 1981). The data in the present study were compared to the national OA study conducted by the Gallup Organization in 1992 to approximate its generalizability to the population at large. Examination of the survey questions by research experts in the field established face validity for the questions prior to their inclusion in the survey. Given that the present survey is assessing continuous scale variables and not attitudes, other measures for determining validity and reliability were inappropriate to the current research approach (as cited in Fischer, 1983).

A pilot study was executed to ascertain any difficulties that might arise with the format, content, and interpretation of the survey questions. Fifteen surveys were emailed to local OA members. As the surveys were returned to this researcher anonymously, confidentiality was guaranteed. Furthermore, feedback was encouraged. Results of the pilot study effectuated the following changes in the survey's format and content:

1. The age range was extended to rule out the inclusion of any participant under the age of 18.
2. "Religion" was changed to "current religious practice" to differentiate between those who were raised in one denomination and practice another.
3. Grade school was eliminated as an educational option as the number of members at this level is insignificant.

4. Living with partner was eliminated as an option choice as several members were sensitive to it, feeling as though it was beyond the appropriate scope of inquiry. The question was rephrased as "Married/Living with partner."
5. "Relapse" was added as an independent variable. It was universally believed to be as significant as abstinence in examining one's recovery program.
6. "Other" was included as a category for those items that members abstain from as several responses noted abstaining from items such as caffeine, wheat, etc…
7. "Weighing and measuring" one's food was included as several members believed this was a critical aspect of their food plan.
8. OA literature was modified to include both AA and OA literature.
9. "What other aspects of your recovery program are helpful…" was included to address the extraneous factors that members independently reported beneficial to their recovery. These responses ranged from exercise to therapy.
10. "Medications used" was added as an additional question in order to examine which pharmacological interventions are being used.
11. Two questions pertaining to the 4th and 9th steps of the program (making an inventory and completing amends) were included in response to member sentiments that working the steps was a critical component of their recovery program. As steps 11 and 12 (prayer and

service) are indirectly ascertained through questions 22 and 23, the only other concrete steps that could be measured by way of standardized survey research included 4 and 9.

12. Feedback regarding the response format for all of the dependent variables was that there were too many options (10 choices). The response format was modified to include only 6 choices ranging from never to daily.

Based on the feedback, revisions were made to the survey used in this study. The revised survey used in the study consisted of 30-fixed-alternative or rank ordered items. A fixed alternative asks the respondent to circle the most appropriate answer to a question, such as “My employment status is: 1) Part-Time, 2) Full-Time, 3) Retired, 4) Homemaker, and 5) Student.” A rank order item asks respondents to give numerical values to various responses. Thus, respondents were asked to rank the degree to which he or she utilizes the tools from 1) Daily, 2) 2-5x week, 3) Once a week, 4) 1-3x month, 5) Rarely, to 6) Never. Both the rank order and fixed alternative methods produce responses that were relatively easy to tabulate and typically free of errors caused by semantics or language (Bramer, 1986).

After establishing how long the individual has been attending OA meetings (Item 8), Item 10 directly asks the respondent whether he or she has obtained abstinence (as defined by Overeaters Anonymous). Item 11, “How long have you established continuous abstinence in OA?” is used to measure the length of one’s abstinence. Length was ascertained by way of fixed alternative responses with seven possible ranges from (1) < one month, to (7) 10 years or more. The established category lengths

were designed to reflect meaningful periods of recovery in OA (Cash, 1996). Two categories were added to the period of abstinence from less than one month to one year, since a substantial number of those who attend OA are frequently new members with shorter periods of abstinence. Moreover, a category was added for those with greater than ten years of abstinence.

Item 10 was used as a means to measure the frequency of relapse also by way of a rank order scale. Explanatory wording was added to this questionnaire item to clarify the meaning of relapse to reflect the current usage of words in OA for relapse.

The section addressing the tools used in OA is comprised of 8 items, and the frequencies for items were measured in rank order fashion ranging from (1) daily, to (6) rarely or never, as appropriate. The tools were assessed through the following items:

1. Item 14 asked about the frequency of calling a sponsor.
2. Item 15 asked about the frequency of following a food plan designed for the individual by a qualified professional.
3. Item 18 asked about the frequency of reading twelve-step literature.
4. Item 19 asked about the frequency of writing in one's journal (often as a complement to the literature) to better discern thoughts and feelings.
5. Item 20 asked about the frequency of attending OA meetings.
6. Item 21 asked about the frequency of using the telephone to connect with other OA members.

7. Item 22 asked about the frequency of doing service for OA (e.g. sponsoring another member, assuming a service position, leading meetings, etc…).
8. Item 23 asked how often the individual prays or meditates.

Procedure

The study was submitted and approved by the Institutional Review Board at Virginia Tech. The World Service Organization of Overeaters Anonymous informed this researcher that permission to administer the surveys to OA participants was granted at the local level and individual group level. The Chairperson of the OA Intergroup for the District of Columbia, Maryland, and northern Virginia was subsequently contacted to grant permission to distribute the survey in their respective region with the assumption that completion of the survey was purely voluntary. It was recommended that the researcher follow the specific guidelines for Twelve Step research proposed in an Alcoholics Anonymous document (Appendix D).

Consistent with previous evaluations of OA, the investigator made attempts to contact by telephone the individual service coordinator for each meeting prior to attending whenever possible. Meetings that were without a clear coordinator's name and phone number were not contacted. In this case, permission from the individual group leader was procured prior to the beginning of the meeting. Arrangements were then established for the researcher to announce the study and request for volunteers to participate. The survey (Appendix E) was distributed during the announcement portion of the meeting, to avoid disruption during the meeting. As completion of the survey was completely voluntary, subject consent was assumed upon completion.

As this researcher administered the surveys to OA participants in person, the advantages of face-to-face distribution was also garnered in terms of flexibility and an increased rate of response (Zechmeister, Zeichmeister & Shaughnessy, 1997). Moreover, the researcher was available to clarify questions for the respondents. A folder marked “Surveys” was circulated at the conclusion of the meeting for collection of the surveys. Names were omitted to protect the anonymity of individual members. Once completed, the surveys were stored in a locked file cabinet.

Data Analysis

The Statistical Package for the Social Sciences 9.0 (SPSS) software program was used for data entry and analysis of the survey responses. Descriptive statistics were computed for the demographic characteristics of subjects (gender, age, employment, religion, race, and highest education level completed) and for response categories including the length of abstinence and frequency of relapse or slips.

Pearson product-moment correlation coefficients were calculated to test the relationship between: (1) use of the OA tools and the length of abstinence, and (2) use of the OA tools and the ratio of length of abstinence/time in OA, and (3) use of the OA tools and the frequency of relapse. The length of abstinence/ time in OA ratio was calculated into the correlation’s in order to ascertain how much the length of abstinence is a function of one’s time in OA. The individual tools of OA were independently examined on a continuous scale with respect to the frequency of their use. The tools examined included sponsorship, plan of eating, attending meetings, literature reading and writing, phone calls, performing service work and prayer and meditation.

Extraneous questions pertaining to issues such as therapy, exercise, and psychotropic medication were included for informational purposes only.

An alpha level of .05 was used for these statistical tests, with two-tailed tests used to ascertain the direction of the relationship. It was this researcher's hypothesis that the use of the OA tools would be directly proportional to length of abstinence and inversely related to frequency of relapse. Multiple regression analyses were conducted on the OA population as a whole to predict associations between the type of involvement in these interventions and outcomes.

Lastly, multiple t-tests examined what, if any, differences exist between the bulimic and binge-eater participants in OA. The variables examined between the two groups include length of abstinence, frequency of relapse, and the use of the OA tools.

Chapter IV. Results

This study examined the efficacy of the 'tools' of Overeaters Anonymous (OA) as they relate to length of abstinence and frequency of relapse from binge-eating disorder and Bulimia Nervosa in OA participants. This chapter, which is divided into four sections, discusses the results of this study. The first section addresses a description of the sample being surveyed and describes its generalizability to the population at large. The second section delineates overall demographic data. Moreover, additional variables such as individuals' eating disorder diagnosis, length of abstinence, time in OA, frequency of relapse, and other characteristics pertaining to participants' involvement in OA and utilization of the OA 'tools' are described. The third section examines the studies' hypotheses and the statistical analyses for its corresponding research questions. The fourth section presents a summary of the aforementioned data.

Sample Description

A convenience sample of 269 participants voluntarily agreed to participate in this study. Of the 269 surveys distributed, 231 were complete and therefore analyzed. The remaining 38 surveys were not eligible for inclusion because they had either omitted substantial portions of the survey or because of factors such as age (< 18 years) or length of attendance in OA (< 30 days). The surveys were distributed over a twelve-week period to individuals attending OA meetings in the Washington, D.C., metropolitan area. Response rates across the various meetings ranged from 61% to 95%, with a mean of 78%. Some meetings' response rates were artificially deflated given that some members had already completed the survey in a different OA meeting.

Generalizability of the Sample Findings

As the sample does not represent a random sample from the whole population, its generalizability to OA as a whole is unclear. In order to allay this bias, a comparison population taken from the Overeaters Anonymous Membership Summary of 1992 was identified from which to draw general comparisons regarding the generalizability of the current sample.

In 1991, Overeaters Anonymous commissioned the Gallup Organization to conduct a study of OA members' perceptions and attitudes towards the program. Five thousand surveys were mailed to 400 group secretaries in December 1991, for distribution at their respective meetings. A total of 1,683 surveys were returned from which 1,000 surveys were randomly selected for analysis. Reliability and validity were demonstrated through traditional social science methodology. The demographic variables available for comparison include sex, age, years of OA attendance, and average number of meetings attended each month.

While not analyzed for statistical significance, an overview of the 1992 and 2001 OA populations reveal striking similarities (see Table 1). An examination of the comparison suggests that the current Washington D.C. metropolitan area sample is representative of the national OA population across multiple variables, therefore allowing the results from the current sample to be generalized to the population at large.

For the sake of comparison, several of the demographic variables assessed in the present study that were unavailable in the 1992 national survey were compared to the national membership survey that was commissioned by the national office of Overeaters Anonymous in 1981 by Wolborsky. The sample consisted of 4534

respondents from 501 OA groups with a response rate of 85%. This sample was deemed representative of the national OA population in 1981. The demographic variables involved include race, marital and employment status.

Demographic Data

The demographic questions in the Overeaters Anonymous survey aggregated data about the subjects' gender, age, marital and work status, current religious practice, ethnicity, education level, length of OA attendance, and eating disorder diagnosis. The variables that are available from the national 1992 Membership Summary and from Wolborsky's 1981 survey were both compared to the current sample.

Gender

In the present study (84%) of the participants were females; males represented only 16% of the participants (see Table 1). The ratio of males to females in this study is remarkably consistent with the 1992 Gallup Organization study, which found the national OA membership to be 86% female and 14% male. Previous studies also confirm that the majority of OA participants are female; however, the reasons behind this are yet to be determined (Wolborsky, 1981). It is conceivable that if the cultural pressure surrounding weight, shape and beauty is largely focused on females, then more females would subsequently seek assistance for food-related concerns.

Age

Participants ranged in age from less than eighteen years of age to over sixty years of age. While less than 1% was under the age of eighteen, approximately one-

quarter of the sample population fell into each of the remaining four age ranges (18-34, 35-44, 45-54, >55)(see Table 1). This is comparable to the national membership survey (1992) where less than 1% fell under the age of eighteen, 20% between 18-34 years of age, 28% between 35 and 44 years of age, 25% between the ages of 45 and 55, and 19% over the age of 55 (7% did not respond). Here again, the 1992 and 2001 studies only marginally differ in the age ranges (with the exception of >55 years of age) among which members are distributed within OA.

Ethnicity

The majority of the sample was Caucasian (89%). Seven percent were African American, 2% were Hispanic American, 1% Asian American, and the remaining 1% fell into the "Other" category (see Table 1). This is remarkably consistent with the 1981 national membership survey that observed a Caucasian population of 91%, African American population of 4%, and "Other" population of 5% (see Table 1). In comparing the results of the two surveys, it is surprising that nearly two decades later the ethnic composition of OA has remained so constant. It may be a testament to the level of diversity in the Washington D.C. metropolitan area that allows it to provide a sample so comparable to the population at large. The results also support the notion that eating disorders continue to primarily be a concern for Caucasians over and above other ethnic groups.

Religion

Almost one-half of the sample reported either a Roman Catholic (20%) or Protestant (26%) background. Twenty-three percent self-identified in the 'Other' category as "Spiritual." OA respondents defined 'Spiritual' as not participating in a formal religious practice, but believing in the presence of a Higher Power (Overeaters Anonymous, 1992). Thirteen percent of the sample practice Judaism, 10% are Atheist or Agnostic, 4% are non-denominational Christians, 2% are Buddhist, and the remaining 2% consisted equally of Muslims, Quakers, B'nai, and Greek Orthodox followers (see Table 1). No previous member survey was found to have determined a national sample distribution in terms of religion.

Education

Approximately one-fifth (19%) of the sample has had some college training (up to and including a 2-year degree). Moreover, eighty percent of the surveyed population hold either a four-year college (40%) or a graduate (40%) degree (see Table 1). When the sample education distribution is compared to the national membership's education distribution, it is evident that the OA members in the Washington metropolitan area are, on average, more educated.

Employment Status

Almost three-quarters of the sample is employed in a full-time capacity. Eleven percent work on a part-time basis, 7% are retired, 6% are homemakers, 5% are students and only 1% are unemployed (see Table 1). Since 1981, the sample

distribution differs most noticeably in its percentage of homemakers. Specifically, the OA national membership survey conducted by Wolborsky in 1981 reported 33% of its members as homemakers in contrast to the current 6% (2001). This poignantly reveals the decline of the traditional homemaker in an American society where women have become increasingly involved in the workforce outside of the home.

Marital Status

Slightly less than half (44%) of the population survey is currently married or living with a partner, 33% have never been married while 21% are either separated or divorced. The remaining 2% are widowed. The sample marital status distribution (Table 1) is also markedly different from the 1981 national membership survey in that fewer people are married (70% vs. 44%) and more are separated or divorced (21% vs. 10%).

Eating Disorder Diagnosis

Eighty-four percent of the sample population self-identified as binge eaters; 15% percent as bulimic; and 1% as anorexic (see Table 1). Only those with binge-eating disorder and Bulimia Nervosa were included for statistical analyses and comparison for the purpose of this study.

Spitzer (1992) provided the only available study with any data pertaining to the eating disorder diagnoses represented in OA. However, Spitzer's resulting survey composition varied considerably from the composition of the current sample. Specifically, a greater number of anorexics and bulimics were represented in OA in the

1992 survey. Reasons for this discrepancy may lie in the study's small sample size and lack of group diversity.

Table 1.
Demographic Data for O.A. Participants in 2001 (N=231) as compared to the 1992 & 1982 National Membership Surveys (N=1000)**

		2001		1992	1981
Variables	Category	N	Percentage	Percentage	Percentage
Gender	Female	193	84	86	91
	Male	38	16	14	9
Eating Disorder Diagnosis	Anorexic	2	.9		
	Binge Eater	194	84		
	Bulimic	35	15		
Age	<18	1	<1	<1	
	18-34	22	23	20	
	35-44	70	30.5	28	
	45-54	59	25.5	25	
	55+	50	21	19	
Marital Status	Never Married	77	33		16
	Married/Living with partner	102	44		70
	Separated-Divorced	48	21		10
	Widowed	4	2		4
Employment Status	Part-time	25	11		
	Full-time	163	71		
	Retired	15	7		
	Homemaker	14	6		33
	Student	12	5		<2
	Unemployed	2	1		
Religious Practice	Protestantism	59	26		
	Catholicism	47	20		
	Judaism	31	13		
	Atheist/Agnostic	24	10		
	Spiritual	52	23		
	Nondenominational/ Christian	9	4		
	Buddhist	5	2		
	Other	4	2		

Table 1. (continued)

Demographic Data for O.A. Participants in 2001 (N=231) as compared to the 1992 & 1982 National Membership Surveys (N=1000)**

			2001	1992	1981
Variables	Category	N	Percentage	Percentage	Percentage
Race	Caucasian	205	89		91
	African-American	17	7		4
	Hispanic/Latino	4	2		
	Asian American	2	1		
	Other	3	1		5
Education	High School/GED	3	1		1
	Some College	29	13		19
	2 yr. Degree	13	6		
	4 yr. Degree	92	40		40
	Graduate Degree	93	40		19

Note. Shaded areas are indicative of data that was unavailable.

Time in Overeaters Anonymous

While the mean average for the number of members responding (18%) had been attending OA between 3 and 5 years, two-thirds of the respondents were split between participating in OA from 0 to 2 years or greater than 10 years (see Figure 1). When the average time in OA is compared with national membership's distribution (1992), it appears that the present study has more 'newcomers' and 'old-timers' within its composition. Members in the 1992 survey were more equitably distributed in their respective lengths of time in OA.

Average meetings attended monthly

The majority of the OA population in the Washington D.C. metro area attend between two to five meetings per week (see Figure 2). This is comparable to the national population where fairly proportionate numbers attend one to four meetings per month (34%); five to nine meetings monthly (32%), or are at ten or more meetings monthly (32%)(Overeaters Anonymous, 1992).

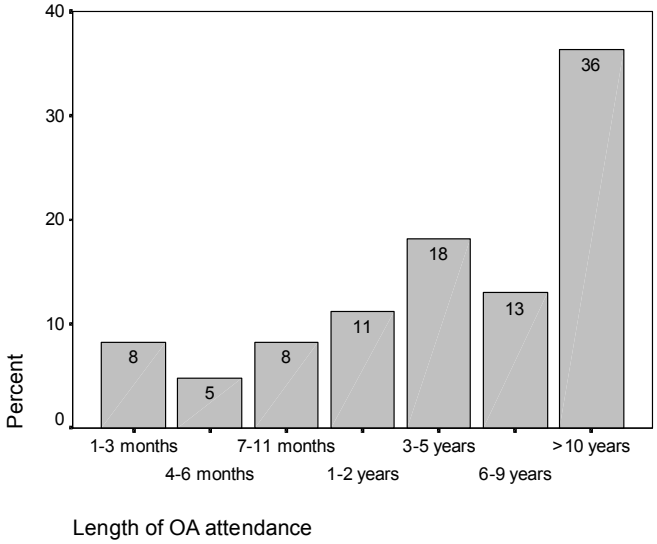

Figure 1. Length of attendance in O.A. (N=231)

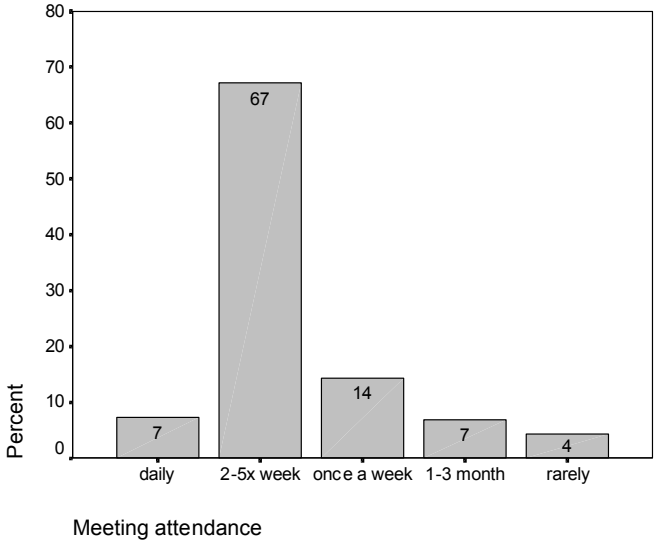

Figure 2. Frequency of attendance at OA meetings (N=231)

Figure 3. Current length of abstinence in O.A. (N=231)

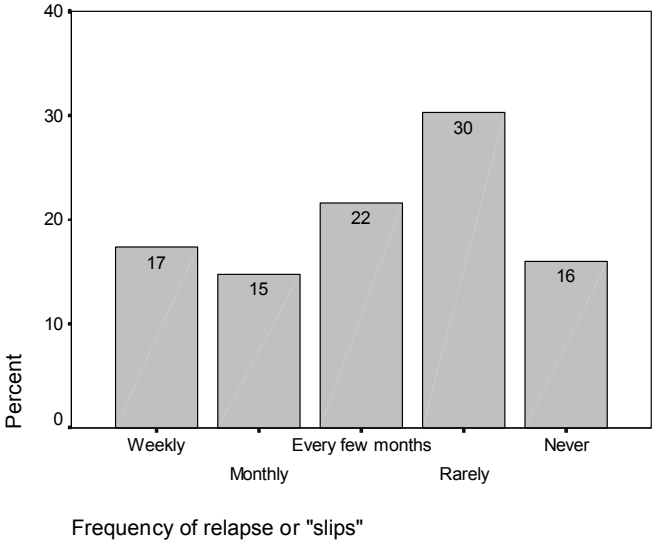

Figure 4. Frequency of relapse and/or "slips" in O.A. (n=162)

Abstinence and Relapse Data

Of the 231 survey participants, 70% (n=162) were abstinent for more than 30 days at the time this survey was distributed. Just over half of those OA participants who were abstinent for more than 30 days had between one month and one year of abstinence. The remaining participants had between one and greater than ten years of abstinence. Figure 3 depicts the frequency distribution for subjects' length of abstinence.

The final dependent variable examined was that of relapse frequency. It appears that of the 70% of the participants who have attained abstinence in excess of 30 days, forty-six percent report never or rarely relapsing. Whereas 54% of those who are abstinent relapse or 'slip' between weekly and every few months. Figure 4 describes the frequency distribution for relapse across survey participants.

Utilization of the OA 'Tools'

Seventy-four percent of the OA participants reported having an OA sponsor. Over half of those surveyed communicate with their sponsor between daily and 2 to 5 times per week; only 13% communicate either weekly or monthly (Figure 5).

The majority of OA participants do state that they adhere to a food plan daily (see Figure 6). Fifteen percent rarely or never adhere to a specified plan. In describing their specific food plan in more detail, most (55%) respondents abstain from both sugar and alcohol; 12% abstain exclusively from sugar, 12% exclusively from alcohol and 25% from wheat. These findings support the notion that simple, refined carbohydrates are what most likely trigger compulsive eating difficulties and are therefore avoided when working the OA program of recovery. In addition, almost half (46%) of those surveyed weigh and measure their food between 75 to 100% of the time (Figure 7). It was noted that this feature of the food plan was a requirement for OA/H.O.W. abstinence.

Most (46%) OA participants surveyed reported reading OA/AA literature daily; 27% did so between two and five times per week; 10% between one to three times per month, and the remaining 10% rarely or never read program literature (see Figure 8). Writing appears to be utilized by almost all OA respondents (96%), with approximately one-third of the sample writing about their thoughts and feelings on a daily basis (Figure 9).

Phone calls between participants, a primary source of communicating with other participants outside of the OA rooms, are made by two-thirds of OA participants between two to five times per week or more. Only twenty-three percent of the OA participants report never or rarely making phone calls (Figure 10).

The preponderance (59%) of those surveyed are committed to one or more permanent or temporary service positions (Figure 11), supporting the notion that the foundation of OA recovery derives from supporting and spreading the message that recovery is possible from compulsive eating.

Lastly, over half (58%) of those surveyed pray or meditate daily, supporting the spiritual nature of this self-help program. Only six percent rarely or never pray, the remaining 36% pray or meditate between one and five times per week (see Figure 12).

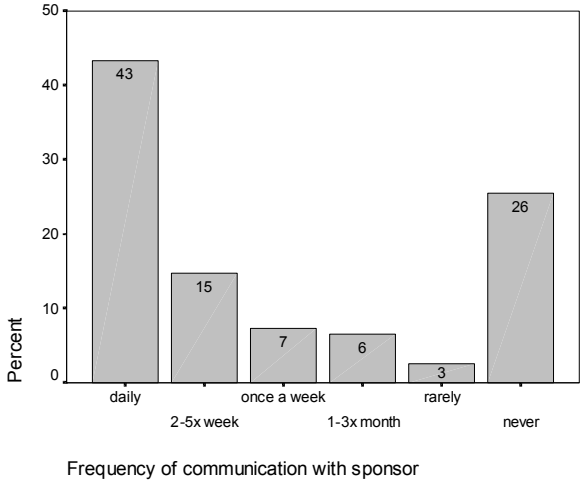

Figure 5. Frequency of communicating with a sponsor (N=231)

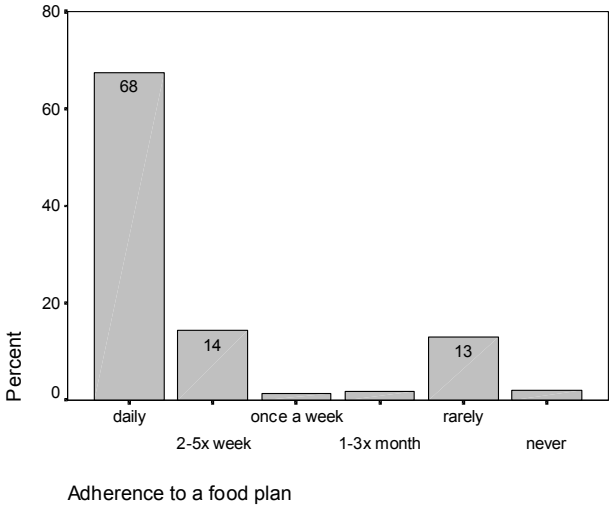

Figure 6. Frequency of adherence to a food plan (N=231)

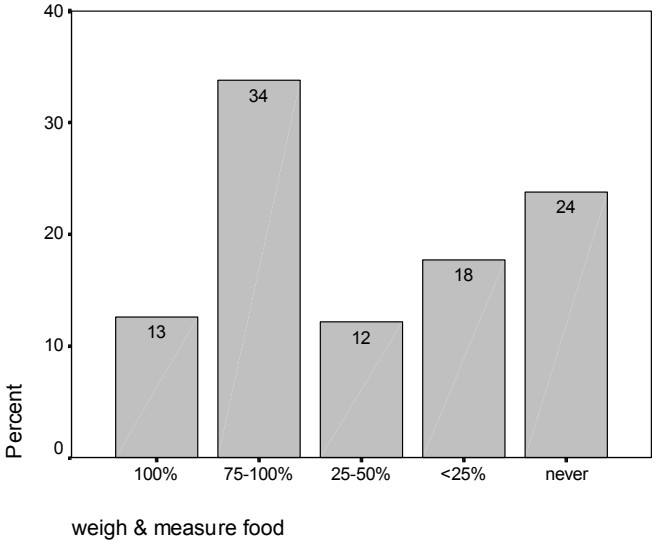

Figure 7. Percent of the time that food is weighed and measured. (N=231)

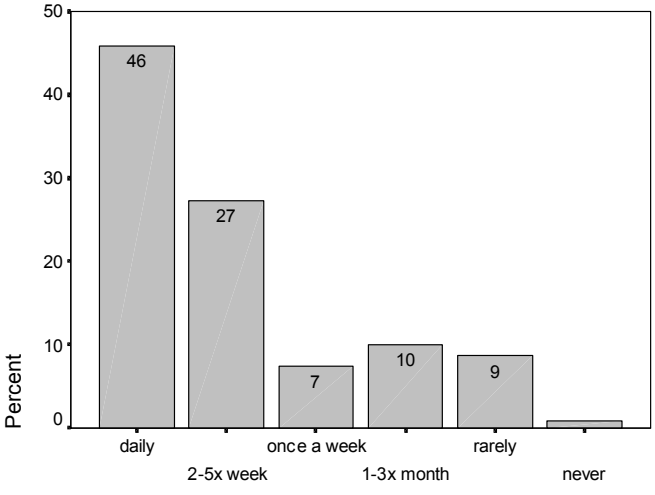

Figure 8. Amount of time spent reading OA/AA literature. (N=231)

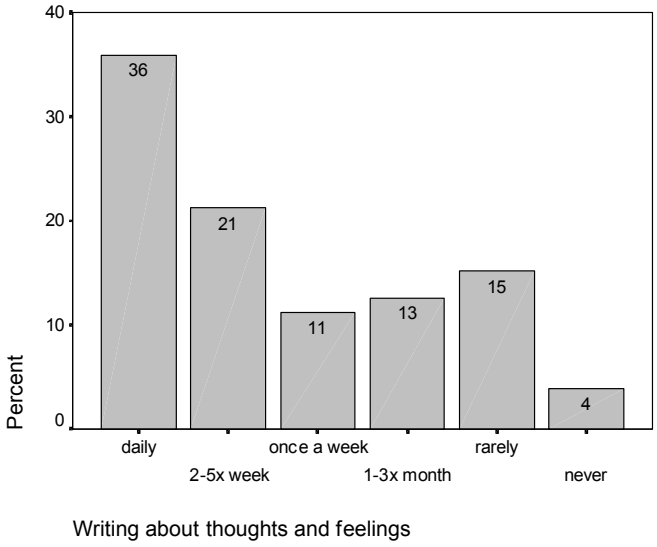

Figure 9. Frequency of time spent writing about thoughts and feelings (N=231)

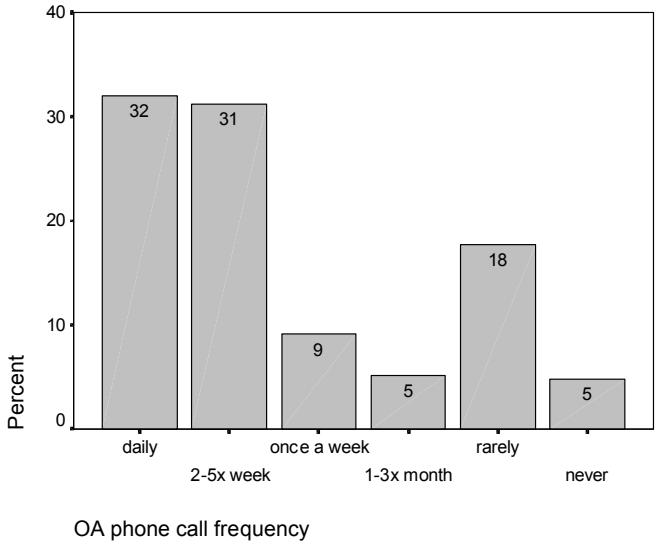

Figure 10. Frequency of phone calls to other O.A members. (N=231)

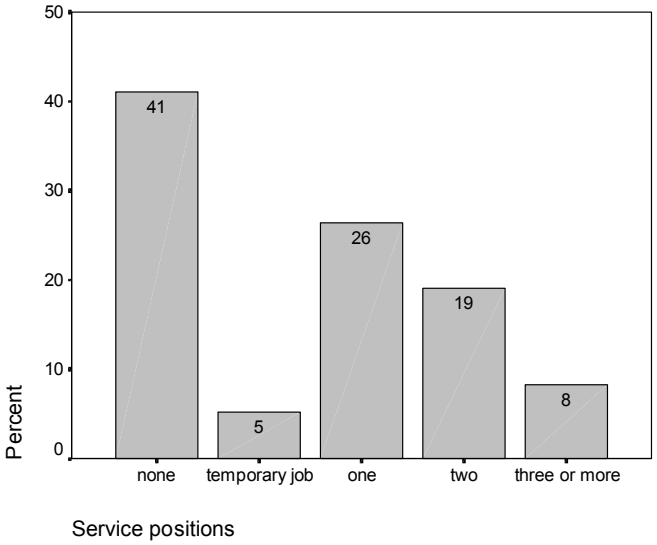

Figure 11. Frequency of O.A. service positions held (N=231)

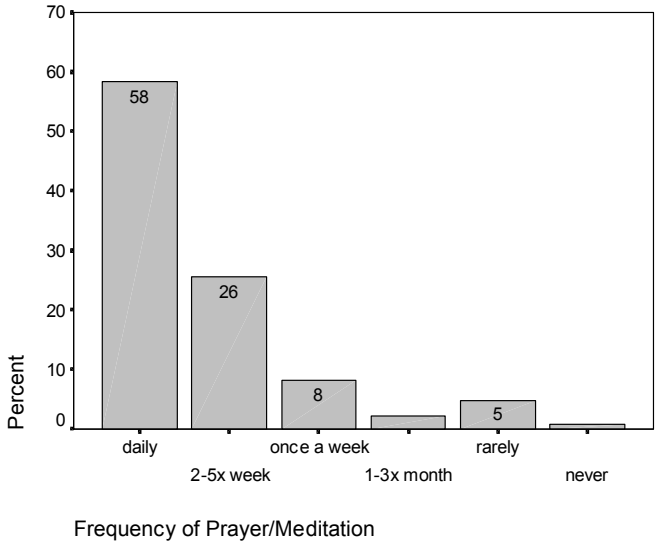

Figure 12. Frequency of prayer and meditation. (N=231)

Other Descriptive Research Data

For the purpose of capturing as much potential pertinent data as possible on OA participants, several additional questions were included that were not specific to the research questions being asked. Figures 13 -18 outlines the frequency statistics for these data.

Specifically, how many participants of OA utilize the Internet as a tool in their recovery program (see Figure 13)? Forty-five percent of those surveyed reported that they do use the Internet as a tool. Of those using the Internet as a recovery tool, OA participants most frequently use email. Moreover, the World Wide Web and the OA website are utilized for recovery purposes by approximately one quarter of the Internet users. Clearly, technology is having its own unique impact on those individuals struggling with compulsive eating disorders.

In terms of other behaviors and tools that participants find useful to their recovery program, a sizable number (39%) attend church, temple or other religious service regularly. Sixty-one percent incorporate exercise into their regimen, and thirty-three percent utilize psychotherapy in their recovery efforts (see Figures 14-16).

Forty-two percent of those completing this OA survey use a psychotropic medication in addition to their OA program (see Figure 17). Antidepressants were the number one medication in use by 39% of the participants (see Figure 18). Selective Serotonin Reuptake Inhibitors (SSRI's), antidepressants specifically directed at increasing the amount of serotonin in the brain, were the most commonly prescribed antidepressants for eating disordered respondents. Those most frequently utilized include Prozac, Celexa, Zoloft, and Paxil.

Lastly, and perhaps most importantly, how much progress have participants made in their work on the Twelve Steps themselves? As several questions already measure those steps that can be assessed quantitatively (e.g. prayer: Step Eleven, service: Step Twelve), the other 'action' steps not yet addressed include Steps Four and Nine. Step Four is the culmination of Steps One, Two, and Three. In this step the individual "Makes a fearless and searching moral inventory of his/her shortcomings" (Overeaters Anonymous, 1992). Over half (62%) of those surveyed reported having completed a fourth step and given it away to another human being. Twenty-three percent have either not begun their fourth step or are currently working on it (15%) (see Figure 19).

Step Nine, which is culmination of Step Six, Seven, and Eight, is where the individual "makes direct amends to such people wherever possible except when to do so would injure them or others." Most (42%) of the participants reported having made at least one ninth step amend; 21% have completed making their amends; and the remaining 37% have not yet made any ninth step amends (see Figure 20).

The final survey question asks participants to identify what other behaviors or tools not previously mentioned have contributed the most to their recovery. The tools that were most frequently noted include faith, honesty, and relationships with other program participants. Other related tools/behaviors noted, albeit less frequently, ranged from working the twelve steps, applying positive thinking, remaining involved with family members, and participating in other twelve-step programs.

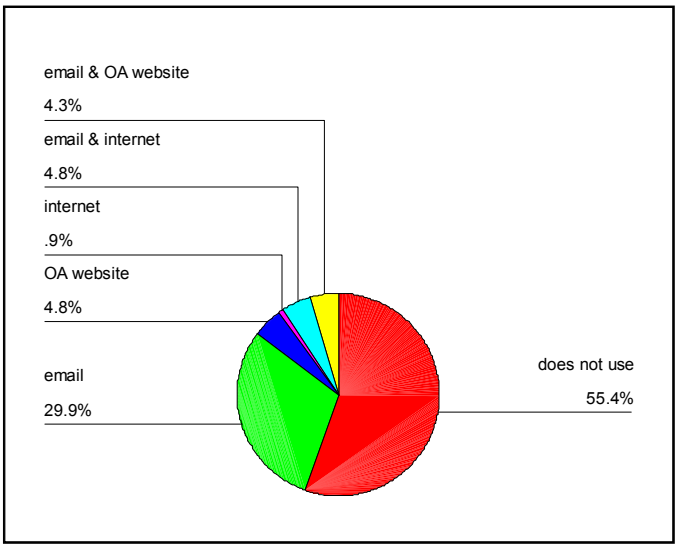

Figure 13. How respondents spend their time on the Internet (N=231) regularly

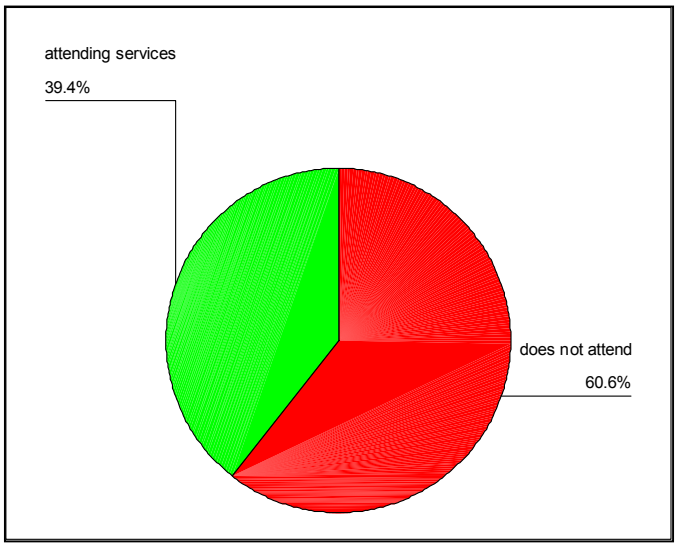

Figure 14. Percentage of O.A. members that attend religious services (N=231)

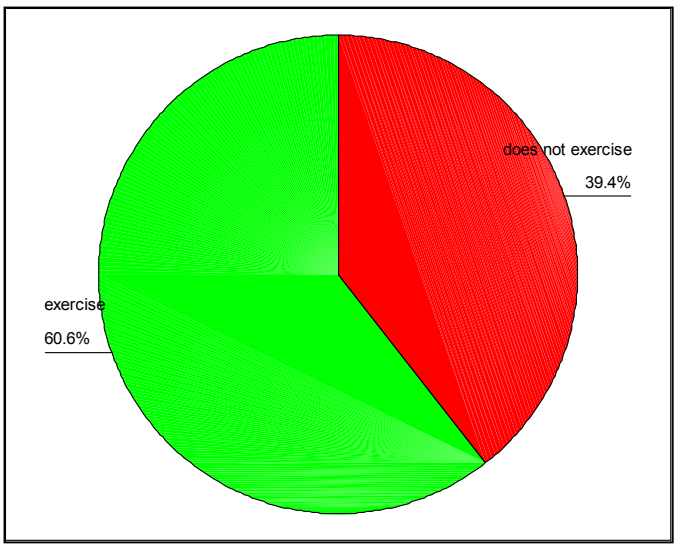

Figure 15. Percentage of O.A. members that exercise regularly (N=231)

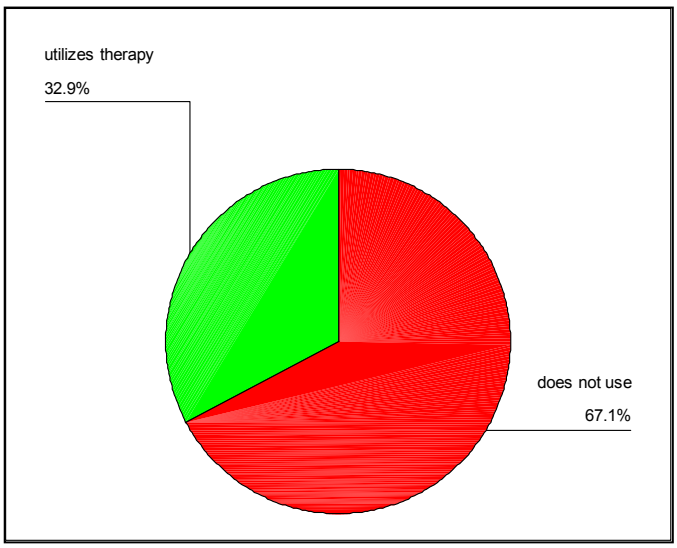

Figure 16. Percentage of O.A. members that participate in therapy (N=231)

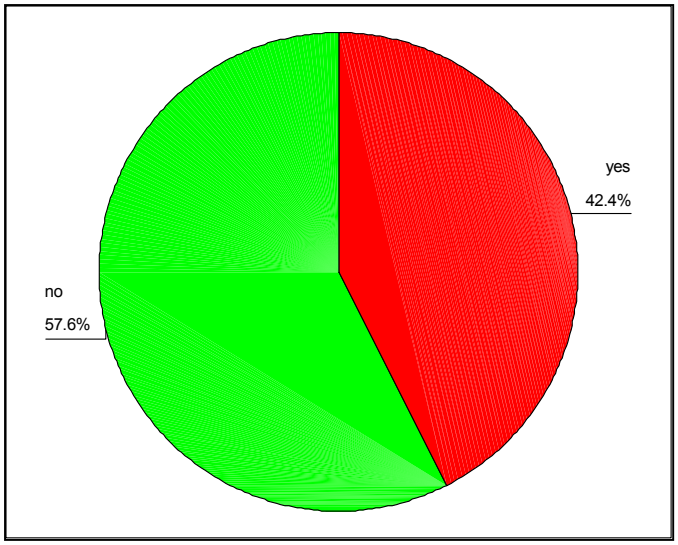

Figure 17. Percentage of O.A. members taking psychotropic medication (N=231)

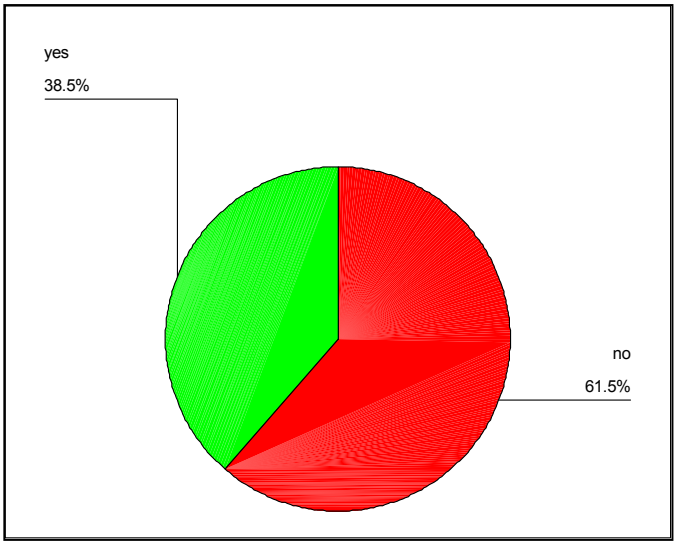

Figure 18. Percentage of O.A. members taking antidepressants (N=231)

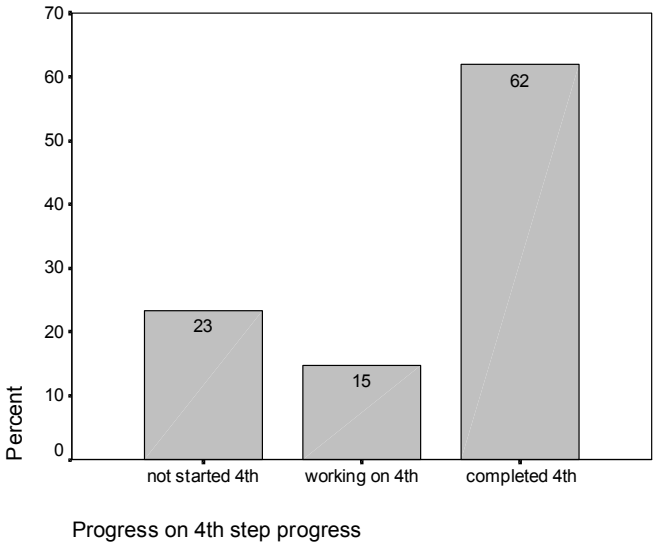

Figure 19. Frequency data for progress on the fourth step (N=231)

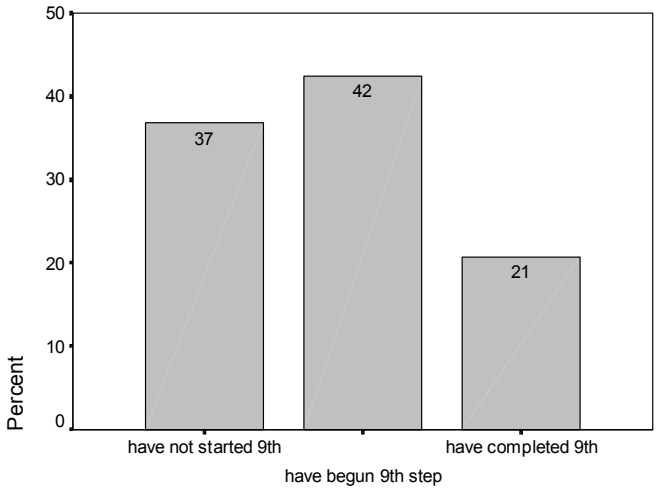

Figure 20. Frequency data for progress on the ninth step (N=231)

Study Hypotheses

The study was designed to investigate whether the use of the OA tools relate to abstinence and relapse from compulsive eating for those with Bulimia Nervosa and binge-eating disorder. Moreover, do statistically significant differences exist between the

use of the OA tools by the bulimic and binge-eater participants in OA? The results of the statistical analysis behind each research question with a sample of OA participants (N=231) were as follows:

Research Question 1: Is the use of the OA 'tools' associated with individuals' length of abstinence?

As previously mentioned, the length of abstinence was adjusted for time in OA. Therefore, a member with one to two years of abstinence who has been in the program for one to two years would receive a ratio score of one. In contrast, a member who has been in program between four and six months and has been abstinent one and three months would receive a ratio score of .5. This method of computation eliminated statistical bias towards those who have or have not been in OA for a lengthy period of time.

The length of abstinence ratio did correlate significantly with the use of several of the OA 'tools' and demographic variables among subjects. The respective variables and their correlation to the abstinence ratio can be seen in Table 2. Specifically, frequency of relapse, adherence to a food plan, weighing and measuring food, making phone calls to other participants, prayer and meditation, and performing service work all correlate positively with the length of abstinence ratio at the .01 level. Completing a fourth and ninth step similarly correlated to the abstinence ratio at the .01 level. Writing about thoughts and feelings, attending 12-step meetings, frequency of communication with a sponsor, education level, eating disorder diagnosis, and using the Internet as a recovery tool also correlated positively with abstinence at the .05 level. The only variables that

did not correlate at some level of significance include length of OA attendance and regularly reading AA/OA literature. A comprehensive correlational matrix for all of the variables analyzed can be seen at the conclusion of Chapter four (see Table 6).

The correlational coefficient between the abstinence ratio and the independent variables combined r^2 =.39, which translates to 39% of variance shared by the variables. The square root of the R^2 was .63, representing a large effect size according to Cohen (1988).

Multiple regression equations were run to determine, which, if any, variables make a significant addition to the prediction of increasing an individual's length of abstinence (relative to their time of involvement in the OA program). Decreased frequency of relapse, longer lengths of OA attendance, holding a service position, increased frequency of attending meetings and making progress on the 9th step were all significant predictors of longer lengths of abstinence relative to time in OA at the .05 level (see Table 3).

Research Question 2: Is the use of the OA 'tools' associated with individuals' frequency of relapse or 'slips'?

Several of the OA variables assessed (calling a sponsor, adhering to a food plan, weighing and measuring food, reading, writing, phone calls, and completion of the fourth and ninth steps) inversely correlated to relapse/'slip" frequency at the .01 level. Albeit not a formal tool, the use of the Internet similarly inversely correlated to relapse/'slip' frequency at the .05 level, as did prayer and meditation. Only the length of OA attendance, number of meetings attended weekly, and the eating disorder diagnosis did

not correlate with the frequency of relapse. The individual correlations for the aforementioned relationships can be seen in detail in Table 2.

The correlational coefficient between the frequency of relapse and/or 'slips' and the independent variables was $\underline{r^2}$ =.40, which translates to 40% of variance shared by the variables. The square root of the $\underline{R^2}$ was .63 representing a large effect according to Cohen (1988).

Multiple regression equations were run to determine, which, if any, variables make a significant addition to the prediction of decreasing the frequency of relapse or "slips." Length of abstinence and OA attendance, adherence to a food plan, frequency of phone calls, and more frequent writing about thoughts and feelings were all significant predictors of a decrease in the frequency of relapse at the .05 level (see Table 4).

It is of interest to note that the frequency of relapse and the length of abstinence correlate most with each other. While it is intuitively comprehensible that this is so, their strong collinearity statistically demonstrates this assertion.

Table 2.

Correlation Matrix for Abstinence & Relapse (N=231)

Tools & Steps of OA/A	**Increase in Abstinen Ratio**	Decreased Frequency of Relapse
Higher education level	.15*	.13*
Longer length of abstinence	.56**	.51**
More frequent communication with sponsor	.14*	.2**
Greater adherence to a food plan	.29**	.34**
More frequent weighing & measuring of food	.21**	.23**
Increased frequency of phone calls to members	.25**	.29**
Number of service positions held	.26**	.3**
Using the Internet as a recovery tool	.15*	.25**
Increased prayer/meditation	.2**	.16*
Progress on 4th Step	.26**	.30**
Progress on 9th Step	.26**	.24**
Increased time spent writing about thoughts & feelings	.16*	.29**
Decreased frequency of relapse	.55**	1.00
Primary Eating Disorder Diagnosis (1: Bulimic; 2: Binge Eater)	-.13*	-.11
Increased time reading OA/AA literature	.09	.2**
Increased length of OA attendance	-.05	.08
Increased meeting attendance	.14*	.12

Note. Significance: * = .05 ** = .01
All shaded areas denote some level of correlational significance

Table 3.

Multiple Regression Analysis of the Abstinence Ratio on Variables within OA (N=231)

I.	B	**Beta**	Standard	Significance
Decreased frequency of relapse	.88	.46	.10	.000
Increased length of OA attendance	.22	.17	.08	.000
Number of service positions held	.28	.15	.10	.01
Increased meeting attendance	.34	.12	.15	.03
Progress on 9th Step	.45	.13	.21	.03
More frequent communication with sponsor	.05	.06	-	-
Greater adherence to a food plan	-.10	- .11	-	-
Increased time spent reading OA/AA literature	.08	.09	-	-
Increased time writing about feelings	.03	.04	-	-
Increased frequency of phone calls	-.10	-.11	-	-
More frequent weighing & measuring of food	-.04	-.04	-	-
Increased prayer & meditation	.09	.10	-	-
Progress on 4th Step	.06	.05	-	-
F=30.26	DF=230		R =.39	

- = statistically insignificant

Table 4.

Multiple Regression Analysis for Relapse Frequency on Variables within OA (N=231)

I.	B	**Beta**	Standard	Significance
Longer Length of Abstinence	.26	.48	.03	.000
Greater Adherence to a Food Plan	-.17	-.19	.05	.001
Increased Frequency of Phone Calls	-.18	-.15	.06	.005
Increased Time Spent Writing about feelings	-.11	-.14	.05	.01
Increased Length of OA Involvement	-.08	-.11	.04	.04
Increased Frequency of communication with sponsor	-.05	-.05	-	-
Increased Weighing & Measuring Food	-.01	-.01	-	-
Increased Time Spent Reading OA/AA literature	-.02	-.02	-	-
Increased meeting attendance	-.04	-.05	-	-
Increased Frequency of Phone Calls	-.01	-.01	-	-
Number of Service Positions	.09	.11	-	-
Progress on 4th Step	.13	.12	-	-
Progress on 9th Step	.05	.05	-	-
F=30.29	DF=230		R =.40	

Note. - = statistically insignificant

Research Question 3: Are there statistically significant differences between the bulimic and binge eaters length of abstinence, frequency of relapse, and utilization of the OA steps and tools?

Calculation of an Independent Samples t-test revealed that the average length of abstinence for bulimic respondents (M= 3.63, SD= 2.77) was significantly higher than the average length of abstinence for binge eaters (M = 2.60, SD = 2.46), t (227) = 2.24, p= .03. The difference in abstinence ratios (length of abstinence/ time in OA) for the two populations was also significant t (227) = 2.2, p = .03.

The average ratio for bulimic respondents was .69 (SD = .64) whereas the binge eater's average ratio was .48 (SD = .50). This indicates that the average bulimic's length of abstinence is greater than that of the average binge eater when their length of time in OA is accounted for.

The strength of the relationship between the eating disorder diagnosis and the length of abstinence in OA was determined by assessing the size of the effect. This was calculated by finding the difference between the means (1.02) divided by the pooled standard deviation (3.12). Thus, for length of abstinence, d was .33, which is a medium effect size. Complete data comparing bulimics with binge eaters is outlined in Table 5.

The effect size for the abstinence ratio (length of abstinence over time in OA) was d = .35, demonstrating that the strength of the relationship between eating disorder diagnosis and the abstinence ratio is also moderately strong.

With respect to the frequency of relapse, the Independent Sample t-test revealed that the mean frequency for bulimic respondents (M= 3.49, SD = 1.34) closely approximates that for binge eaters (M = 3.06, SD = 1.33). The difference in the

frequency of relapse or ‘slips’ between the populations was not significant t (227) = 1.73, p = .08.

Table 5.

Independent Sample T-Test Comparisons Between Bulimic (n=35) and Binge-Eating Participants (n=194) in O.A.

Variables	Eating Disorder Diagnosis	Mean	Std. Deviation	t	Significance (two-tailed)
> Length of Abstinence	Bulimic	3.63	2.77	2.24	.03*
	Binge Eater	2.60	2.46		
Abstinence Ratio	Bulimic	.69	.64	2.20	.03*
	Binge Eater	.48	.50		
Decreased Frequency of Relapse	Bulimic	3.49	1.34	1.73	.08
	Binge Eater	3.06	1.33		
Increased Communication with a Sponsor	Bulimic	3.00	2.09	.38	.71
	Binge Eater	2.86	2.10		
Greater Adherence to a Food Plan	Bulimic	1.86	1.63	-.15	.88
	Binge Eater	1.85	1.50		
Increased Weighing and Measuring of Food	Bulimic	3.00	1.31	-.30	.77
	Binge Eater	3.08	1.43		
Increased Time Reading OA/AA Literature	Bulimic	1.97	1.42	-.63	.53
	Binge Eater	2.13	1.35		
Increased Time Writing about feelings	Bulimic	2.23	1.44	-1.73	.09
	Binge Eater	2.70	1.64		
Increased Meeting Attendance	Bulimic	2.11	.72	-1.94	.06
	Binge Eater	2.38	.90		
Increased Frequency of phone calls	Bulimic	2.20	1.55	-1.56	.12
	Binge Eater	2.67	1.63		
Holding a service position	Bulimic	2.69	1.47	.92	.36
	Binge Eater	2.45	1.39		
Increased Prayer and Meditation	Bulimic	1.54	.70	-1.44	.15
	Binge Eater	1.75	1.18		
Progress on 4th Step	Bulimic	2.40	.88	.09	.93
	Binge Eater	2.39	.83		
Progress on 9th Step	Bulimic	1.86	.73	.12	.90
	Binge Eater	1.84	.75		

Note. Significance indicated by * = .05 ** = .01

Summary

The cumulative findings of this study include the demographic and descriptive characteristics of the participating OA participants in the Washington metropolitan area and the results pertaining to the three research questions.

Most of the OA participants (N=231) surveyed were female (84%), between the ages of 34 and 44 (30%), married or living with a partner (44%), and employed full-time (71%). Most (89%) were also Caucasian, likely to consider herself to be either Protestant (26%) or 'spiritual' (20%), and has a college degree (80%).

Other descriptive characteristics of the sample indicated that 84% were binge eaters. Attendance at OA meetings was skewed towards those with less than two years in attendance (32%) and those who have been attending more than ten years in total (36%). Seventy percent of the sample claimed to be abstinent for more than 30 days at the time this survey was distributed, while 30% have between 0 to 30 days of abstinence from their eating disordered symptoms.

Calculation of Pearson product-moment correlation's, Independent Samples t-tests, and multiple regression equations analyzed the three research questions. The results were as follows:

The length of abstinence ratio did correlate significantly with the implementation of several of the OA 'tools' among participating participants. Specifically, greater adherence to a food plan, increased frequency in weighing and measuring of food, making phone calls to other participants, more time spent engaging in prayer and meditation, and performing service work all correlated with the length of abstinence ratio at the .01 level. Progress on the fourth and ninth steps also correlated to the abstinence

ratio at the .01 level of significance. Variables corresponding to the abstinence ratio at the .05 level of significance are also displayed in Table 2. The shared variance between the length of abstinence ratio and the use of the 'tools' was 39%, representing a substantial degree of overlap or confounding between the variables. Moreover, multiple regression analysis revealed increased lengths of OA involvement, a decrease in the frequency of relapse or 'slips', holding a service position, greater attendance at meetings, and progress on the ninth steps to be significant predictors of abstinence at the .05 level.

A decrease in the frequency of relapse or 'slips' also correlated significantly with the implementation of several of the OA 'tools' among participating participants. Specifically, calling a sponsor, adhering to a food plan, weighing and measuring of food, making phone calls to other participants, reading, writing, performing service work, and progressing on the fourth and ninth steps all inversely correlated with increasing frequency of relapse at the .01 level. The shared variance between the length of frequency of relapse or 'slips' and the use of the 'tools' was 40%, representing a large degree of overlap. Lastly, multiple regression analysis revealed that longer lengths of abstinence and involvement in OA, greater adherence to a food plan, increased frequency of phone calls to other members, and more time spent writing about one's thoughts and feelings were all significant predictors of decreasing relapse frequency at the .05 level.

With respect to the third research question, Independent Sample T-tests revealed significant differences between bulimics and binge eaters in terms of their mean lengths of abstinence and abstinence ratios. In short, bulimic respondents have

significantly longer periods of abstinence in OA, whether or not their length of time in the program was accounted for. Moreover, the effect size for both the length of abstinence (d = .33) and the abstinence ratio (d = .35) was moderately strong. Conversely, bulimic participants attended less meetings (M = 2.11, SD = .72) than did the population of binge eaters (M = 2.38, SD = .90) t = -1.94 (55.42), p = .057. Moreover, the frequency of relapse or 'slips' between the two populations was not significant, suggesting that both bulimics and binge eaters have a comparable likelihood to relapse or slip into eating disordered symptoms.

Table 6.

Correlational Matrix: Variables of OA Involvement (N=231)

	Higher Educational Level	> Length of OA Attendance	EDiagnosis 1:Bulimic 2:Binger	< Frequency of Relapse	> Length of Abstinence	Abstinence Ratio	> Frequent Comm. With a Sponsor	> Adherence to a Food Plan	> Frequent Weighing & Measuring
Higher Education Level	-	-	-	-	-	-	-	-	-
Increased Length of OA Attendance	.07	-	-	-	-	-	-	-	-
ED Diagnosis (1: Bulimic; 2: Binge eater)	-.01	.01	-	-	-	-	-	-	-
Decreased Frequency of relapse	.13*	.08	-.11	-	-	-	-	-	-
Longer Length of Abstinence	.06	.31**	-.13	.54**	-	-	-	-	-
Abstinence Ratio	.15*	-.05	-.13*	.55**	.57**	-	-	-	-
More Frequent Communication with Sponsor	.05	-.12	-.01	-.21**	-.08	-.14*	-	-	-
Greater Adherence to a Food Plan	-.10	-.09	.01	-.39**	-.30**	-.31**	.40**	-	-
More Frequent Weighing & Measuring	.02	-.17**	.02	-.23**	-.20**	-.21**	.53**	.39**	-
Increased Time Spent Reading OA Literature	.07	.02	.03	-.20**	-.02	-.09	.44**	.32**	.45**

Table 6. (continued)

	Higher Educational Level	Increased Length of OA Attendance	ED Diagnosis 1:Bulimic 2:Binger	Decreased Frequency of Relapse	Longer Lengths of Abstinence	Abstinence Ratio	More Frequent Comm. With a Sponsor	Greater Adherence to a Food Plan	More Frequent Weighing & Measuring
> Writing	-.06	-.12	.12	-.29**	-.16*	-.16*	.47**	.30**	.50**
> Meetings	-.05	-.05	.11	-.14*	.02	-.13*	.31**	.22**	.18**
> Phone Calls	-.07	-.22**	.08	-.29**	-.29**	-.25**	.53**	.38**	.57**
> Service	.04	.23**	-.04	.31**	.34**	.26**	-.28**	-.21**	-.27**
> Prayer & Meditation	.02	-.08	.07	-.25**	-.09	-.20**	.06	.18**	.05
Fourth Step	.16*	.62**	.01	.30**	.38**	.27**	-.19**	-.27**	-.16*
Ninth Step	.05	.49	.01	.24**	.35**	.26**	-.01	-.15*	-.12

	Increased time reading Literature	Increased time spent Writing	Increased Meeting Attendance	Increased Frequency: Phone Calls	More Service Positions	Increased Prayer & Meditation
> Time Reading Literature	-	-	-	-	-	-
> Time Writing	.49	-	-	-	-	-
> Meeting	.40	.24	-	-	-	-
> Phone Calls	.47	.53	.32	-	-	-
> Service Positions	-.23	-.25	-.24	-.36	-	-
> Prayer & Meditation	.23	.24	.20	.16	-.14	-
Fourth Step	-.11	-.17	-.08	-.24	.29	-.27
Ninth Step	-.05	-.14	-.06	-.19	.25	-.27

Note. Significance indicated by * = .05 ** = .0

Chapter V. Discussion

Summary of Results

The first research question was to delineate a profile of the typical OA member in the Washington metropolitan area. The results of the survey demographics were remarkably consistent with the National Membership Survey that was conducted in 1992 by the Gallup Organization. The majority of OA participants continue to be women (84%), supporting the American Psychiatric Association's assessment that the male to female ratio of those with eating disorders ranges anywhere from 1:6 to 1:10 (2001). It also appears to be consistent with the message from the media, primarily aimed at females, conveying the message that thinness is a prerequisite to be attractive, popular and healthy (Flood, 1989).

The percentage of males in the organization has increased from 9% in 1981 to 16% in 2001. Flood (1989) draws attention to the fact that the media has also begun to target men with advertisements suggesting that without "lean, well-muscled bodies, their achievements was be meaningless." Consequently, they, too, have responded with an increased obsession with food and fitness (p. 46).

Respondents were largely Caucasian, highly educated, and married or single. They ranged in age from 18 years of age to greater than 55 years. The absence of much racial diversity in this sample was comparable to previous OA membership surveys. This was referenced in the literature as possibly the result of different cultural perceptions on obesity. The media has historically tended to portray the thin, attractive female as Caucasian. Nevertheless, it is noted that as racial diversity is increasingly

embraced and promoted by the media, so, too, have eating disorders begin to increase in their rate of occurrence among minorities.

A variety of religious practices were embraced, although Protestantism, Catholicism, and those who claim a more generic “spirituality” were practiced by approximately 70% of the participants. The concept of ‘Spiritual’ as a category evolved through the large number of respondents placing it in the “Other” category for religious practice. Albeit not a formal religion, it was described as believing in the presence of a Higher Power. Given the ‘spiritual’ nature of the program, it is consistent with the steps practiced by those in all 12-step programs.

The original 12-step literature made frequent reference to God. As the concept of God made some participants uncomfortable, the term “Higher Power” began to be embraced. This allows participants the freedom to choose their own higher power, which could apply to the individual’s 12-step group, therapist, or “God-like deity” (Johnson & Sansone, 1993). The group sanctions accommodation rather than orthodoxy. Nonetheless, in spite of the absence of a specific definition of God, the focus in the first three steps does remain on spirituality. The fact that a large percentage of 12-step participants embrace ‘Spirituality’ rather than a formalized religion is therefore not surprising.

Suler and Bartholomew acknowledge that yielding to a higher power may often satisfy religious needs in the member’s life that have otherwise been neglected (1986). It is their belief that while the surrender of control can be explained in purely psychological terms, the spiritual benefits cannot be denied. Many of the participants they surveyed in their examination of OA further attest that they experienced “a

rejuvenation of their religious convictions and activities" (p. 53). This may also serve to explain the large number of participants practicing a more formalized religion.

The majority of the participants surveyed were binge eaters (84%); however a fairly sizeable percentage of bulimics (15%) and a few anorexics (1%) also frequented the meetings. This in sharp contrast to the OA that originated in 1960, that was designed strictly for the compulsive overeater. It is clear that as the American creed, "one can never be too rich or too thin" has continued, coupled with the media's promotion of an ultra-slim image, eating disorders have and was continue to proliferate. In turn, those with other variations of eating disorders are increasingly utilizing self-help groups like OA.

In reflecting upon the variety of eating disorders represented, Malenbaum et al. (1988) documented the experience of women with eating disorders in OA. Their results revealed that in addition to the binge eaters, those with normal weight bulimia also tended to find the experience helpful. In contrast, the only negative experiences were reported by the anorexic population, who described themselves as "unchanged" or even "somewhat worse" as the result of the program (Yager, Landsverk, and Edelstein, 1989). The dearth of anorexic participants participating in OA may be indicative of this difficulty. A major concern with the 12-step approach for anorexics is that it is not sufficiently equipped to deal with the substantial medical and psychiatric problems associated with Anorexia Nervosa. Moreover, it would be inappropriate for an anorexic to be encouraged to refrain from particular foods (e.g. white flour or sugar) given the active deprivation already characteristic of this disease.

The typical OA member surveyed works in a full-time capacity. Homemakers only comprise 6% of the population, in contrast to 30% of those surveyed in 1981. This vividly reflects the trend in our society for increasing numbers of females to be employed outside of the home. Further, 80% of today's participants have attained a college degree, far surpassing the 59% of those attaining the degree in 1981. Another noteworthy change is reflected in the percentage of those divorced or separated. This number has risen from 10% in 1981 to 21% in 2001. It is apparent that greater gender equality over the last twenty years has significantly contributed to myriad demographic changes, yielding both positive and negative consequences.

The second research question addressed whether the steps and 'tools' of OA correlate with individual's lengths of abstinence. As previously mentioned, an abstinence ratio was created that adjusted the individual's length of abstinence to their time spent in OA. Correlations were then assessed between this ratio and the dependent variables.

The majority of the tools and steps of the program demonstrated a strong correlation with an individual's abstinence. Specifically, increased adherence to a food plan, the weighing and measuring of food, the frequency of telephone calls, the attainment of service positions, time spent in prayer and meditation, and progressing through the fourth and ninth steps all correlate with abstinence across OA respondents at the .01 level of significance. Moreover, greater educational status, more communication with a sponsor, writing about thoughts and feelings, and meeting attendance all correlate with the attainment of abstinence at the .05 level.

In a similar fashion, the results of the third research question, assessing the relationships of the frequency of relapse across the OA population to these same variables, also produced several significant correlations. Adherence to a food plan, weighing and measuring of food, reading OA/AA literature, writing, making phone calls, holding a service position, and progressing through the fourth and ninth steps all relate to a decrease in the frequency of relapse at the .01 level.

Multiple regression analyses conducted on the OA population enabled specific predictions between the type of involvement in these interventions and their outcomes to be made. Attending meetings, progressing on the ninth step, doing service, minimizing relapses or 'slips,' and remaining involved in the OA program all predict an increase in abstinence at the .05 level of significance or better. Furthermore, the length of attendance in OA, writing about thoughts and feelings, making telephone calls to other participants, adhering to a food plan, and sustained abstinence all predict a decrease in the frequency of relapses or 'slips' at the .05 level of significance or better.

It was concluded then, that the application of the steps and the tools of OA might directly promote abstinence and reduce the frequency of relapse in those with binge-eating disorder and Bulimia Nervosa. Previous research supports this contention. Convergent findings include Ferster, Nurnberger, and Levitt's (1962) earliest behavioral approach to the treatment of eating disorders. They demonstrated positive effects from self-monitoring of food intake and stimulus control techniques pertaining to the environmental cues associated with compulsive eating. Such techniques parallel the tools that enforce the weighing and measuring of food, communicating with a sponsor

(where food is frequently 'turned over'), the daily writing of thoughts and feelings, and the support of making phone calls to other participants.

Ferster, Nurnberger, & Levitt's (1962) approach did, however, differ from that promulgated in OA in that they de-emphasized any strict adherence to one food plan. Smith, Wasiam, Bray, & Ryan (1999) confirmed this idea through research that demonstrated how flexible dieting strategies were associated with an absence of overeating, lower body mass and lower levels of depression and anxiety. This may help to explain that while adherence to a food plan correlates with abstinence, it does not predict it with any degree of certainty. It is possible that too rigid adherence to any one food plan could, in fact, have the reverse of the desired effect of increasing one's abstinence. It might also explain the disproportionately small number of anorexics in program. As previously mentioned, with an anorexic patient who already wrestles with requiring control, the too rigid adherence to any one of the program's tools (e.g. adherence to a food plan) would only serve to underscore the maladaptive thought patterns already intact.

The strong correlations and regression between length of abstinence and frequency of relapse with the variables assessed demonstrate the efficacy of the first three steps in OA. In summary, through acknowledgement of one's powerlessness (Step One), acceptance that something greater than the self can promote change (Step Two), and the surrender to that power that results in the wasingness to engage in new behaviors (Step Three), a new way of life (e.g. abstinence) is established. A comprehensive table delineating the 12 Steps with an interpretation of each step from a conventional psychotherapeutic perspective can be found in Appendix F.

This occurs not because the taking of the first three steps “cures” the problem; rather it inhibits the relapse process by urging participants to adopt more adaptive attitudes (Antze, 1976). For example, Antze described how alcoholism is perpetuated by the alcoholics’ belief that they could stop drinking if they wanted to. Unfortunately, the failure to stop at that “last drink” results in guilt, self-blame, and further binges to escape those feelings. The 12-step ideology impedes this insidious cycle by encouraging its participants to relinquish their “omnipotent attitude by accepting the addiction as a disease beyond their control, by confessing their inadequacies and guilt (Steps Four and Nine), and by relying on their higher power and the strength of the group to change (Steps Two and Three) (as cited in Suler and Bartholomew, 1986)

The resulting behavioral changes further mimics those seen through cognitive-behavioral approaches. The difference between the Twelve-step approach and cognitive-behavioral therapy lies in its acceptance of a Higher Power and reinforced interpersonal reliance (through sponsoring, etc…). One large study, known as Project MATCH, compared a Twelve Step facilitated therapy approach with cognitive-behavioral therapy and motivational enhancement therapy in alcohol abusers (Humphreys, 1999). Besides increasing the participant’s involvement in A.A./N.A. related activities, the Twelve Step intervention was more effective in promoting abstinence. For example, after one year of treatment, 45% of those involved in Twelve Step programs reported abstinence from alcohol and other drugs compared to 36% of those treated in the cognitive behavioral program. With this research in mind, it can be surmised that the benefits of utilizing the OA tools and steps could minimally serve as an adjunct to more traditional forms of therapy for eating disorders.

Given Wilson and Fairburn's (1998) assumption that cognitive-behavioral therapy is the most effective treatment for Bulimia Nervosa, the behavioral components of this program coupled with the cognitive adaptations that result from working the Twelve Steps could provide bulimics in particular with a viable alternative to more costly forms of treatments. Wilson's (1999) opposition to this approach stems from those groups that press for rigid dietary restrictions (e.g. white flour or sugar) in their definition of abstinence. It should be noted, however, that OA does not promote abstention of any food groups per se; rather, participants are encouraged to avoid their 'binge foods.' It is at the disgression of individual groups whether or not to endorse a blanket recommendation that all participants should abstain from sugar or white flour. For this reason, the newcomer to OA is encouraged to 'shop-around' to find groups that are compatible with their individual needs.

The predictive relationship between the number of meetings attended and abstinence support Allon's (1975) allegation that the structured activities for self-disclosing and sharing parallel those of psychotherapy groups. However, OA is unlike group therapy in that it does not allow its participants to express their feelings about and directly to each other. OA meetings provide a forum for the expression of experience, strength and hope. Participants can stay in touch with the disease and simultaneously seek and receive support from those who have recovery.

While opponents to 12-step meetings point to participants that become enmeshed in extreme subcults within the program that can be a destructive influence, the majority of 12-step organizations emphasize a balance between "isolation and integration" outside of the group (Suler and Bartholomew, 1986). The slogan "principles

before personalities" belies the need to place the group's ideology before personal desires. Ardent support for anonymity outside of the fellowship is a universally established principle. Furthermore, participants are always encouraged to reach out to other participants in trouble. All of these forces exemplify "The social force that channels energy into group solidarity and identity" (1986).

Nevertheless, "these forces that shape the group as a substitute or supplemental family are counterbalanced by the group's acknowledging and supporting individual's participation in familial, recreational, and occupational groups outside of OA" (p. 50, 1986). As one member described recovery, "the goal is to utilize the program to actively live life, rather than make the program one's life."

The fact that involvement in service positions within the organization portends abstinence from the disease ($t = 2.67$ (231), $p = .01$) supports the utility of the 12th step. Specifically, "Having had a spiritual awakening as the result of these steps, we tried to carry this message to other compulsive eaters and to practice these principles in all of our affairs" (Overeaters Anonymous, 1992). Suler and Bartholomew's statement that "people can be therapeutically transformed by helping others" (p. 50) similarly upholds this principle.

In a 31-week post-treatment study, Miller and Verinis (1995) found that although attendance at AA meetings was not predictive of abstinence, involvement in AA meetings (e.g. service) and related activities did predict more favorable results with respect to abstinence.

A comparable study completed by Humphreys in 1997 followed 628 alcoholics post-treatment over eight years. The number of meetings attended predicted

abstinence, lower depression, and better relationships at the 8-year follow-up. Involvement in the program also predicted better relationships after only one year. In summary, several studies have demonstrated that attendance at meetings and performing service for the group presage auspicious outcomes in decreasing addictive behaviors.

Lastly, the predictive relationship between progression on the 4th and 9th steps and length of abstinence and frequency of relapse presage the value of confession and penitence in the process of change. Foucault's early writings on Christianity attempt to explain how confession and penitence "produces intrinsic modifications in the person who articulated it; it exonerates, redeems, purifies him; it unburdens him of his wrongs, liberates him and promises him salvation" (p. 151, as cited in Lester, 1999). The 4th and 9th steps mimic the actions of confession and penitence and are therefore the concrete action steps that 12-step participants take to change their interior lives.

The fact that the steps are integrally related to long-term abstinence from both binge-eating disorder and Bulimia Nervosa demonstrate the multifaceted nature of these disorders. The goal is not to merely abstain from compulsive eating; rather it is to transform one's life on the inside so that the 'sick' self is abdicated in favor of a healthier self, both mentally, physically, and spiritually.

The remaining research question addresses what differences, if any, exist between those with binge-eating disorder and Bulimia Nervosa. T-test analyses reveal significant differences between the two populations on variables assessing the member's length of abstinence and number of meetings attended. Bulimic participants prove able to maintain longer periods of abstinence in OA, even when their time in OA

is accounted for (via the abstinence ratio) (M = 3.63, SD = 2.77 vs. M = 2.6, SD = 2.46) t (227) = 2.24, p = .03. Conversely, they attend less meetings than do binge eaters (M = 2.11, SD = .72 vs. M = 2.4, SD = .90) t (55.42) = -1.94, p = .057. Their commitment to write on their thoughts and feelings on a daily basis is also somewhat less than those with binge-eating disorder (means: 2.11 vs. 2.38; p = .09).

These differences may be explained by the nature of the bulimic cycle. Flood (1989) describes it as a predictable experience, one that is in sharp contrast to many of the families' relationships that bulimics were raised in. The chaotic environment prevents the bulimic from relaxing, as the rules are continually changing. The routine of the binge-purge cycle becomes important for through it she is able to control (e.g. anesthetize) her feelings and predict her experience. Attending meetings and the disciplined nature inherent in the OA program provide the bulimic with a structured and concrete action plan. The bulimic member can begin at Step One and progress forward. Furthermore, meetings are replete with rituals from opening and closing readings to ceremonies to mark a member's transitions into recovery. It may be the ability to work well within such structure that leads bulimics who participate in the OA program to attain longer periods of abstinence.

Conversely, the bulimic's predisposition towards control may also lead to an "all-or-nothing" comprehension of recovery and subsequent relapse if any changes occur (Riley, 1991, p. 722). For this reason, many clinicians do not approve of the term relapse because it implies a failure. Those struggling with eating disorders need to expect some variability in their diet without the harsh self-deprecation that comes from viewing an occasional slip as a failure. This type of perfectionistic thinking only serves to

perpetuate the bulimic cycle once a slip has occurred. This may also serve to explain why in Rorty, Yager, and Rossotto's (1993) appraisal of women recovering from Bulimia Nervosa, the thirty-eight percent of their sample that utilized OA were nearly equally split between somewhat or totally satisfied and somewhat or totally dissatisfied with the program. Such research may indicate that the bulimics who remain in the OA rooms (e.g. those surveyed) are limited to those who are satisfied with the 12-step approach. Those who do not find OA beneficial may be absent due to voluntary attrition.

The fact that bulimics procure longer periods of abstinence in OA is surprising from the vantage point that Fairburn et al. (2000) concluded that the prognosis for those with binge-eating disorder was better than for those with Bulimia Nervosa. In a 5-year community-based study, only 18% of those with binge-eating disorder had an eating disorder of clinical severity in contrast to 51% of the bulimics. A high degree of flux was noted in the bulimic sample. Each year approximately a third remitted and another third relapsed. Instability was also noted in Keller et al's (1992) prospective study of the course of Bulimia Nervosa. There was significantly less instability in the binge-eating disorder group. Rather, they tended to gradually improve, with about 50% remitting annually. Such research paradoxically supports the notion that bulimia, rather than binge-eating disorder, is the more recalcitrant disorder. As the present study is limited to a one-time sample design, it is possible that repeat assessments could convey different treatment outcomes.

In summarizing the results of the extraneous interventions that are utilized by OA participants, it is clear that the majority of the participants that were surveyed exercise regularly, attend religious services, and use the Internet as part of their recovery

program. Moreover, one-third of those participants engage in individual psychotherapy and are being prescribed antidepressants. This is encouraging in light of concerns that a potential disadvantage of 12-step programs may be that participants are precluded from other therapeutic interventions outside of the 12-step approach (Johnson and Sansone, 1993).

When asked what other practices they found paramount to their recovery a sizeable number of participants responded with 'honesty.' Indeed, Chappel and Dupont (1999) comment on how most people are amazed by the level of honesty at 12-step meetings. Working the steps reinforces this quality in participants' daily lives. A 12-step meeting is a unique forum in which people genuinely reveal not only their strengths, but also their weaknesses and character defects.

Conclusions

Based on the findings from this study, it can be concluded that the abstinence from binge-eating disorder and Bulimia Nervosa can be significantly increased by performing service within the group, attending meetings, progressing through the 12 Steps, and by increasing one's time of participation in OA. It can also be concluded that the longer one is abstinent from either disorder, the less likely relapse is to occur.

Relapse or 'slip' frequency can be significantly decreased by way of adherence to a food plan, frequent telephone calls to other participants, regular writing down of one's thoughts and feelings, and by increasing one's time of involvement in OA. It can also be concluded that the less an individual relapses or 'slips,' the more likely he or she was attain longer periods of abstinence.

Finally, significant differences between the two populations were apparent in their respective lengths of abstinence and number of meetings attended. As a group, bulimic respondents were likely to attend fewer meetings yet attain longer periods of abstinence than binge eaters.

Limitations

An inherent limitation to the present study design exists in the potential variability of the term abstinence. While the OA definition for abstinence was explicated at each meeting, it was noted that some groups embraced variations of this definition. It is possible that multiple variations of the meaning for abstinence may have been applied in responding to the survey given these different interpretations. For example, H.O.W. abstinence required that a member have no slips or relapses. Other OA groups interpret abstinence to strictly mean the absence of a relapse. This discrepancy may have influenced the level of association between which abstinence and relapse related to the variables assessed. Future research into individual perceptions of the term abstinence is necessary to fully clarify these distinctions.

A second limitation exists in the nature of the OA sample responding to the survey. The current survey is limited to those presently participating in OA. Former participants were not assessed for their perceptions of the OA tools and practices. Surveying both present and former participants of the OA organization could serve beneficial in gleaming which aspects of the OA program, if any, might be detrimental to recovery from an eating disorder. It also could delineate which facets of the 12-step approach persuaded them to abandon the program.

Should these results be compared to outcomes from more conventional treatment centers, the characteristics of the OA participants surveyed, who appear to be well-educated and voluntary participants, could provide an alternative explanation for their success. Subjects from more conventional treatment programs might also differ in the severity of their eating disorders, feasibly making the attainment of abstinence a more arduous task.

Additional differences between those groups studied in OA versus conventional treatment programs may be invalid due to the outcome measures utilized. In the present study, outcomes were assessed by way of an individual's length of abstinence and frequency of relapse. Particularly with binge-eating disorder, other research studies typically apply weight loss as a primary criterion for success.

Results comparing those with Bulimia Nervosa to those with binge-eating disorder also need to be interpreted with caution given the smaller number of bulimics in the present survey (34 bulimics vs.197 binge-eater respondents). It is conceivable that differences could be minimized or possibly augmented by a larger sample size of bulimic participants.

Lastly, the fact that the 12-step approach is a spiritually based program makes a comprehensive statistical examination of the program inherently difficult. Incorporating a valid and reliable measure that correlates an individual's spirituality with the variables already being examined could help in determining how much of participants' success is attributable to their spiritual well being.

Implications of Research Findings

In light of the positive associations demonstrated between length of abstinence and frequency of relapse and the length of OA involvement, meeting attendance, adherence to a food plan, the making of phone calls to other participants, performing service, writing, and progressing through the steps, it can reasonably be assumed that any or all of these interventions may be useful to those who work with eating disordered individuals. Further, all of the variables assessed in the study positively correlated with either an increase in abstinence or a decrease in relapse.

The number of variables that were predictive of positive outcomes supports Riley's (1991) contention that "to be effective in working with eating disorders, we must be open to working with an eclectic model of treatment" (p. 725). Despite a number of "remarkable recoveries" that have been documented using OA and the 12-step model (Johnson and Sansone, 1993), opponents do exist who argue against an addictions treatment model for eating disorders. Their opposition arises primarily from possessing more of a physiological perspective of addiction and from issues pertaining to issues of gender and power. Other concerns specific to those with Anorexia Nervosa and Bulimia Nervosa regarding nutritional and medical considerations that are not addressed in a 12-step program are also worthy of consideration.

Rather than debating the advantages and disadvantages of the 12-step approach to eating disorders, it would be more beneficial for professionals to acquire a working knowledge of how OA works and how it can be of use to those with Bulimia Nervosa and binge-eating disorder. Riley (1991) advocates for "the integration of the 12-step approach into an overall treatment program to make the best use of both programs and

decrease the competition usually inherent between health care providers and self-help groups" (p. 725). For example, the very nature of the need for adherence to a food plan facilitates OA participants to obtain consultation with a nutritionist or doctor as part of their recovery program.

As evident from varying definitions among groups concerning the definition of abstinence, there is substantial variability in the beliefs, attitudes and practices from group to group and from sponsor to sponsor about eating disorder recovery in OA. For this reason, it is incumbent upon the newcomer to OA to seek out groups that are effective for them.

Johnson and Sansone (1993) point to the universal availability of the 12-step support network, a feature that tradition psychotherapy cannot provide. Those working with eating disordered individuals can encourage their clients to make use of this resource. In the Washington D.C. metropolitan area and other large metropolitan areas in the United States and abroad, there are meetings seven days a week from early morning through late into the evening. For those with limited financial resources, it is also important to note that the meetings are free.

Humphreys (1999) made reference to the powerful influence that clinicians can have in encouraging clients to affiliate with 12-step programs. In studies where clients were encouraged to attend meetings, find a sponsor, and become involved in AA/NA related behaviors, clients were more likely to be involved in self-help groups outside of treatment (Miller and McCrady, 1993). This is contrary to the opinion that participation in 12-step programs rests entirely on client motivation. Rather, the professionals that work with these clients can and do exert influence. Assuming the clinician monitors the

client's experience in OA, and should OA prove to be effective in remediating the client's symptoms, treatment gains can continue beyond the termination of professional intervention.

Given what many professionals claim is the addictive nature of eating disorders; Wilson (1999) advises those who work with eating disorders to regularly screen their clients for the presence of alcohol or drug problems. Besides documenting high rates of substance abuse in the family of those with eating disorders, rates of substance abuse are consistently higher in those with Bulimia Nervosa. An increased rate of substance abuse among binge eaters has not been reliably demonstrated (Yanovski, 1993).

Based on the variables in the present study that demonstrated strong associations with length of abstinence and frequency of relapse through regression analyses, professionals may assist their eating disordered clients by encouraging the following recovery tasks:

1. Going to meetings - this provides a powerful recovering support network. It is also a forum to identify and express feelings, and acquire a telephone list of other participants.
2. If the meetings meet the clients' needs, support the client to keep showing up. Length of OA involvement was the one variable predictive of both an increase in the length of abstinence and a decrease in the frequency of relapse.
3. Use the telephone list circulated at meetings to create a list of participants that have or are working on their recovery who are available to receive calls. Making calls to other participants decreases isolation and fosters

interpersonal relationships in which participants learn to give and receive help.

4. Keep a journal and write in it regularly. Journaling provides another outlet for the "hard to handle highs and lows that we all experience" (Overeaters Anonymous, 1992). It also provides insight into one's actions and reactions.
5. Obtain a food plan from a registered nutritionist or doctor and follow it regularly. This takes the guesswork out of how much or how little one really needs.
6. Perform service, either through a formal service position or through smaller tasks such as getting to a meeting early to help set up. Carrying the message to those who are still struggling is the basic purpose of the fellowship. No matter how small, it is through acts of service that this is accomplished. Of significance in the present research is the association between the number of service positions held by OA participants and an increased length of abstinence.
7. Lastly, and perhaps most importantly, work the 12 Steps of the OA/AA program, particularly through 9th step. While the 9th step loaded most heavily upon the abstinence ratio, Steps 1 – 8 must be worked through first given the stepwise progression of the work. Progression through the steps facilitates the inner psychic change (emotional and spiritual) that can serve as the foundation for a new identity and long-term recovery.

Chappel and Dupont (1999) liken dependence on a 12-step program in the early stages of recovery “to dependence on a cast or crutches while a fracture is healing.” They further the analogy to continued dependence on education and exercise. Like these activities, 12-step programs promote “health and continued growth and development… The work of recovery in 12-step programs complements and enhances, it does not compete with psychiatric treatment” (p. 439). OA is not intended to be an exclusive treatment alternative for binge-eating disorder and Bulimia Nervosa. Rather, it is an adjunct to more conventional forms of treatment that is often helpful in the initial phases of treatment or in preventing subsequent relapses for some individuals with eating disorders.

Suggestions for Future Research

1. To increase reliability and validity, the present research would benefit by an enlarged sample size and one that spans a broader geographic range. With the surge of Internet and e-mail use among OA participants, a survey could feasibly be disseminated across the United States and beyond.
2. Additional insights could be gleaned from analyzing whether or not the supplemental interventions (e.g. exercise, therapy, psychotropic medication, attending religious services, etc…) correlate with participants’ length of abstinence and frequency of relapse.
3. It would be beneficial to utilize a repeated measures design, thereby assessing participants at multiple points in time. Follow-up studies ranging anywhere from 6 months to 3 years and beyond would make this research more

comparable to research on formal treatment programs. It would also provide additional information pertaining to the long-term efficacy of participation in OA.

4. Future research using the length of abstinence as a predictor for recovery should address the potential variations in the meaning of the term between OA groups. More unbending measures for abstinence such as BMI (body mass index) or frequency of purging related behaviors before and after participation in OA would further increase the predictive validity of the variables being assessed.

5. Anecdotally, more concentrated numbers of participants with long-term abstinence appeared to cluster in the chapter of OA referred to as H.O.W. (Honesty, Open-mindedness, and Wasingness). Given that this program reinforces a more structured and disciplined approach to working the OA program, a survey question discriminating which group the respondent belongs to (e.g. OA or OA/H.O.W.) would allow for a comparison of outcomes between the two groups.

6. Increasing the composition of the sample to include both current and former participants of OA could provide valuable information pertaining to attrition within the program. What types of eating disorders and for what reasons do some participants dropout because they find the OA program unsatisfactory? Or, do some participants leave merely because their personal goals were accomplished or their needs were met? Examination of both present and past participants would provide answers to these questions.

7. Lastly, as the inherent nature of this program is a spiritually based, a measure to gauge participants' level of spiritual well being and its relationship to

length of abstinence and frequency of relapse from binge-eating disorder and Bulimia Nervosa would provide insight into the role of spirituality in the recovery process.

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Appendix A.

The Twelve Steps of Overeaters Anonymous

1. We admitted we were powerless over food that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our was and our lives over to the care of God as we understood God.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked God to remove our shortcomings.

8. Made a list of all persons we had harmed, and became wasing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong, promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to compulsive overeaters and to practice these principles in all our affairs.

Appendix B.

The Twelve Traditions

1. Our common welfare should come first; personal recovery depends upon OA unity.
2. For our group purpose there is but one ultimate authority-a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for OA membership is a desire to stop eating compulsively.
4. Each group should be autonomous except in matters affecting other groups or OA as a whole.
5. Each group has but one primary purpose-to carry its message to the compulsive overeater who still suffers.
6. An OA group ought never endorse, finance or lend the OA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.
7. Every OA group ought to be fully self-supporting, declining outside contributions. Overeaters Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
8. OA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
9. Overeaters Anonymous has no opinion on outside issues; hence the OA name ought never be drawn into public controversy.
10. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, films, television, and other public media of communication.
11. Anonymity is the spiritual foundation of all these traditions, ever reminding us to place principles before personalities.

Appendix C.

DSM-IV Definitions

Table C1.

Diagnostic Criteria for Bulimia Nervosa (307.51):

1. Recurrent episodes of binge eating

2. Recurrent inappropriate compensatory behavior to prevent weight gain such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

3. These behaviors occur at least ≥2 times per week for 3 months.

4. Self-evaluation unduly influenced by body shape and weight.

5. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Bulimia Nervosa: Subtypes

1. Purging Type: during current episode of Bulimia Nervosa, person regularly engages in purging behavior.
2. Nonpurging Type: during current episode of Bulimia Nervosa, person has used inappropriate compensatory behaviors such as fasting and excessive exercise, but not purging.

Table C2.

Proposed Diagnostic Criteria for Binge-Eating Disorder:

A. Recurrent episodes of binge eating

B. Binge eating associated with 3 of the following:

1. Eating more rapidly than normal
2. Eating until feeling uncomfortably full
3. Eating large amounts of food when not physically hungry
4. Eating alone because of embarrassment
5. Feeling disgusted with oneself/depressed
6. Marked distress regarding binge eating
7. Binge eating $\geq$ 2 days per week for 6 months

C. Binge eating is not associated with regular use of inappropriate compensatory behavior.

Appendix E

Memo on Participation of Alcoholics Anonymous Members in Research and Other Non-A.A. Surveys

Since the early days of our fellowship, the participation of A.A. members in research and surveys has been sought and has occurred. In recent years there has been an escalation of concerns about alcoholism in all parts of our society. As a result, A.A. can expect that requests for participation in research may increase.

In general, within A.A. there is a favorable attitude toward research. As Bill W. wrote, “Today the vast majority of us welcome any new light that can be thrown on the alcoholics’s mysterious and baffling malady. We welcome new and valuable knowledge, whether it be issues from a test tube, from a psychiatrist’s coach or from revealing social studies.” Historically, participation has been worked out on a case by base basis. Some of the attempts to cooperate have led to strained relationships while more have been successful, mutually satisfying, and produced new insights.

How A.A. members might cooperate with research has been discussed by the trustees’ Committee on Cooperation with the Professional Community. At the suggestion of the committee, we offer this memo both to those who would solicit the participation of A.A. members in research and to those A.A. members who will be approached about such requests.

1. The best research between A.A. members and researchers have been those in which the researcher has become thoroughly familiar with the fellowship before making inquiry about participation. At the same time, the A.A. members would be involved have gotten to know the researcher so that they trusted him or

her, and have been convinced of the researcher's commitment, competence, integrity, and respect for the Traditions of A.A. The investigator has been forthright in giving the A.A. members all the information about his or her research which they needed in order to make an informed decision about it.

2. For A.A. members, cooperating with a researcher and being part of a research program raises most of the same problems as cooperating with any other non-A.A. profession; or engaging in any other non-A.A. undertaking. The problems are amenable to the same kind of solutions. See "How A.A. Members Cooperate With Other Community Efforts to Help Alcoholics" and the C.P.C. Workbook. As long as there is frank communication and attitudes of open-mindedness and flexibility, it has proved possible to work out ways of participating in research which does not require A.A. members to compromise A.A.'s Traditions and which permit the researcher to arrive at valid findings.

3. The researcher should be aware that central offices in A.A. cannot offer the kinds of assistance he or she may be used to from the headquarters of other organizations, e.g. access to records, endorsements, etc. However, the researcher may receive some help from the General Service Office, intergroup offices, and local office of other kinds.

(1) Individuals in these offices may be willing to give the researcher their opinion about the project and about its feasibility.

(2) Literature can be provided which will prove helpful to the researcher in understanding A.A. members, what is is, what it can and cannot do, as well as on how A.A. members cooperate with non-A.A. undertakings.

(3) A copy of this memo can be provided.

4. Decisions about whether or not to cooperate in research are always made at the local level where the research will occur. Almost always the request for participation has been made to individual A.A. members who have then sought the cooperation of other members. In rare instances the request has been made to a group. When A.A. members have decided to cooperate, it has been in their capacity as private citizens.

5. Those individuals approached about cooperation will want to make an informed judgment about whether to participate and about whether to seek the participation of others. Indeed, with the increased requests for research cooperation, it is necessary that selection take place. Some of the questions the individual might have are: what is being studies, by whom, why and how; who will carry out the research at the local level; what will cooperation involve, e.g. interviews, questionnaires, amount of time; who will evaluate the findings; who will use the findings for what purpose; in light of A.A. traditions, is cooperation possible; what arrangements are made to ensure anonymity, etc.

6. A.A. is concerned solely with the personal recovery and continued sobriety of alcoholics who turn to the Fellowship for help. Meetings are devoted exclusively to the A.A. program. No research which could interfere with this goal could be tolerated. Some groups have permitted questionnaires or interviews to occur after meetings provided that participation is on a purely, voluntary basis. Some members look upon research participation as one way of pursuing the above mentioned goal, as using their experience to contribute to log-term

solutions for alcoholism. Many more will define it as a distraction from Twelfth Step work, which they define in immediate personal terms.

7. A.A. and its members are particularly concerned with anonymity. While most researchers are skilled at ensuring anonymity to subjects, A.A.'s concerns may raise some unique issues. For example, as no one A.A. can break the anonymity of another, there may be some ticklish issues in soliciting cooperation from others. Some research procedures may also require extra precautions to be taken, e.g. when data are stored in computers, when granting agencies require consent to participate forms, etc.

And, a final note from Bill W. about cooperation with non-Alcoholics working to resolve the problems of alcoholism, "So let us work alongside all these projects of promise to hasten the recovery of those millions who have not yet found their way out. These varied labors do not need our special endorsement, they need only a helping hand when, as individuals, we can possible give it."

We welcome additional information from researchers and from members of A.A. who have our experience to share or comments to make.

APPENDIX E

Overeaters Anonymous Survey

This survey is for part of a dissertation about Overeaters Anonymous. PLEASE DO NOT WRITE YOUR NAME ON THIS SURVEY. Thank you for your time!

1. Sex: ☐ Female ☐ Male

2. Age: ☐ < 18 yrs. ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55 or older

3. Marital Status: (choose only one)

☐ Never Married ☐ Married/Living with partner ☐ Separated/Divorced ☐ Widowed

4. Which best describes your employment situation? (includes volunteer work)

☐ Part-time ☐ Full-time ☐ Retired ☐ Homemaker ☐ Student

5. Current Religious Practice:

☐ Protestantism ☐ Catholicism ☐ Judaism ☐ Atheist/Agnostic

☐ Other (please specify): _____

6. Race:

☐ Caucasian ☐ African-American ☐ Hispanic/Latino

☐ Asian American ☐ Native American ☐ Other (please specify): _____

7. Highest Education Level Completed:

☐ High School / GED ☐ Some College ☐ 2 yr. Degree ☐ 4 yr. Degree ☐ Graduate Degree

8. How long have you been attending Overeaters Anonymous meetings?

☐ 1-3 months ☐ 4-6 months ☐ 7-11 months

☐ 1-2 years ☐ 3-5 years ☐ 6-9 years ☐ 10+ years

9. Which word best describes your primary problem with food? (Choose the **best** answer)

☐ Anorexic ☐ Bulimic ☐ Compulsive Overeater (Binge-eater)

10. Since beginning OA, have you experienced relapses or "slips"?

☐ A few times a week ☐ A few times a month ☐ Every few months ☐ Rarely ☐ Never

11. Are you currently abstinent from compulsive eating (includes binging, purging, and starving)?

☐ Yes ☐ No (If no, skip to question #13)

12. If abstinent, how long is your current abstinence in Overeaters Anonymous?

☐ 1-3 months ☐ 4-6 months ☐ 7-11 months

☐ 1-2 years ☐ 3-5 years ☐ 6-9 years ☐ 10 years or more

The OA Tools

13. Do you have an OA sponsor? ☐ Yes ☐ No (If no, skip to question #15)

14. How often do you communicate with your OA sponsor (telephone, e-mail)?

☐ Daily ☐ 2-5x week ☐ Once a week ☐ 1-3x month ☐ Rarely ☐ Never

15. Do you adhere to a food plan?

☐ Daily ☐ 2-5x week ☐ Once a week ☐ 1-3x month ☐ Rarely ☐ Never

16. Do you abstain from either of the following? ☐ Sugar ☐ Alcohol ☐ Other (please specify): _____

17. How much of the time do you weigh and/or measure your food?

☐ 100% ☐ 75-100% ☐ 25-50% ☐ <25% ☐ Never

18. Do you read OA/AA literature?

☐ Daily ☐ 2-5x week ☐ Once a week ☐ 1-3x month ☐ Rarely ☐ Never

19. Do you write about your thoughts and feelings?

☐ Daily ☐ 2-5x week ☐ Once a week ☐ 1-3x month ☐ Rarely ☐ Never

20. Do you attend 12 step meetings (includes OA, AA, Al-Anon, etc…)?

☐ Daily ☐ 2-5x week ☐ Once a week ☐ 1-3x month ☐ Rarely ☐ Never

21. Do you make phone calls to other OA members other than your sponsor/s?

☐ Daily ☐ 2-5x week ☐ Once a week ☐ 1-3x month ☐ Rarely ☐ Never

22. How many regular service positions are you committed to? (This question refers to regular service commitments to OA such as sponsoring, treasurer, intergroup rep., etc…)

☐ None ☐ Temporary Job ☐ One ☐ Two ☐ Three or more

23. How often do you pray and/or meditate?

☐ Daily ☐ 2-5x week ☐ Once a week ☐ 1-3x month ☐ Rarely ☐ Never

24. Do you use the Internet as a tool in your recovery program? ☐ Yes ☐ No

25. If so, which aspects of the Internet do you utilize (e-mail, OA websites…)? _____

26. What other behaviors/tools do you consistently engage in that could be helpful to your OA program?

☐ regular attendance at church/temple or other religious service

☐ exercise ☐ medication ☐ therapy ☐ Other: _____

27. Which medications, if any, have you used on a consistent basis during your time in OA?

Please specify: _____

28. How much progress have you made on a fourth step inventory?

☐ have not started one ☐ am working on one

☐ have completed one and have given it away to another human being

29. How much progress have you made on ninth-step amends?

☐ have not made any ninth-step amends ☐ have made at least one ninth-step amend

☐ have completed making my amends

30. Are there any other behaviors/tools that play a significant role in your recovery?

Appendix F.

The Original Twelve Steps and their corresponding interpretation from a more conventional psychotherapeutic perspective

1. We admitted we were powerless over alcohol that our lives had become unmanageable. (A)	1. Confront denial.
2. Came to believe that a Power greater than ourselves could restore us to sanity. (B)	2. Establish hope and faith.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.	3. Confront grandiosity / omnipotence; push to establish dependency away from substance and into relational sphere.
4. Made a searching and fearless moral inventory of ourselves.	4. Challenge to begin process of introspection.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.	5-7. Confession and catharsis.
6. Were entirely ready to have God remove all these defects of character.	
7. Humbly asked Him to remove our shortcomings.	
8. Made a list of all persons we had harmed, and became willing to make amends to them all.	
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.	8-9. Making amends (penance and undoing) in a nonselfish manner.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.	10. A mechanism to continue catharsis and undoing.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.	11. Continuing confirmation of a new image of oneself.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to compulsive overeaters and to practice these principles in all our affairs.	12. Giving back through helping others and recruiting new members, redirection of energy through altruism and sublimation.

(A) Overeaters Anonymous substitutes food for alcohol.
(B) Some groups substitute the word "Higher Power."

Note. From "Integrating the Twelve-Step Approach with the Treatment of Eating Disorders," by C.L. Johnson & R.A. Sansone, 1993, International Journal of Eating Disorders,14(2), p.121.

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EDUCATION

Doctor of Philosophy in Counselor Education: Virginia Polytechnic Institute and State University – Falls Church, VA. Fall 1999 – May 2002. GPA 3.96

Educational Specialist in School Psychology: The College of William and Mary (NASP Approved Program) - Williamsburg, VA. May 1998. GPA 3.6

Master of Education in School Psychology: The College of William and Mary - Williamsburg, VA. May 1996. GPA: 3.8

Bachelor of Arts, Psychology: Brown University - Providence, R.I. December 1993. GPA 3.6

PROFESSIONAL EXPERIENCE

School Psychologist

Fairfax County Public Schools – Area II; Fairfax, VA. Fall 1999 – present

Fall 2001 - present: Psychologist for the ED/LD programs at McLean & Centreville High Schools. Provide direct clinical services for special education students with emotional disabilities and their families including counseling, crisis intervention, and behavioral intervention planning. Conduct psychological evaluations for students in need of emotional disabilities support services and provided training of and consulting with staff with respect to mental health issues. Also serve as a liason with community agencies and mental-health providers when appropriate.

Fall 1999 – Summer 2000: Psychologist for Bonnie Brae & Terra Centre Elementary schools Responsible for designing and utilizing both individual and group intervention techniques to meet the individual needs of students in the K-12 grade range. Participated in meetings (eligibility, Local Screening, 504, etc…) and provided case management skills pertaining to the special education and regular education populations. Routinely made use of crisis intervention and consultation skills to communicate effectively with parents and support staff within the school (counselors, administrators, teachers, etc…). Served as the liason between school staff and outside private practitioners with regard to students' health and welfare. Utilized diagnostic and assessment expertise to partake in test selection, administration, and interpretation.

Doctoral Teaching Assistant

Virginia Polytechnic Institute and State University – Falls Church, VA. August 1998 – May 1999.

Supervised Masters' level Counseling students completing internships in schools and community agencies under the direction of Dr. Richard Paritzky. Assisted counseling faculty in teaching graduate-level classes that included DSM-IV and Appraisal in Counseling.

Clinical Psychologist intern

Catholic Charities – Arlington, VA. September 1998 - January 1999

Provided clinical psychological services for adolescents and adults. Participated in team case review meetings and received consultative supervision from the staff psychiatrist and psychologists.

School Psychologist – Center for Gifted Education

The College of William and Mary - Williamsburg, VA. August 1996 - August 1998.

Performed psychological screenings in the Center for Gifted Education under Dr. Joyce Van Tassel-Baska. Administered, scored, and interpreted individual cognitive, achievement, and nonverbal problem solving measures for preschool and elementary aged children referred to the Center. Consulted with parents and children on the social-emotional and developmental needs of the gifted child.

School Psychologist (full-time); School Counseling internship (part-time)

Norfolk City Public Schools: Maury High School - Norfolk, VA. August 1997 to June 1998.

Responsible for designing and utilizing both individual and group intervention techniques to meet the individual needs of students in the K-12 grade range. Applied group and individual counseling skills with students of diverse backgrounds and handicapping conditions. Conducted groups on topics ranging from teen pregnancy and anger management to eating disorders and study skills. Actively participated in career counseling secondary students preparing for entrance into college and/or vocational positions. Routinely made use of crisis intervention and consultation skills to communicate effectively with parents and school personnel. Utilized diagnostic and assessment expertise to partake in test selection, administration, and interpretation.

Psychology Instructor **(William and Mary Summer Enrichment Program - sessions I & II)**

College of William & Mary - Williamsburg, VA. Summer 1997 & Fall 1998.

Instructed gifted middle school students in psychological concepts including the basic principles of learning, intelligence, creativity, and motivation. Introduced the Myers Briggs Personality Type Inventory to focus students on achieving greater self-awareness of their individual personality and learning styles.

School Psychology Practicum **(10-16 hours per week)**

Hampton City Public Schools - Hampton, VA. September 1996 to May 1997.

Conducted psychological evaluations at the preschool, elementary, middle, and high school levels. Participated in Child Study and Eligibility meetings. Developed Curriculum Based Assessments for individual students in consultation with teachers. Exercised counseling skills with individuals and groups addressing a number of school-related problems such as learning disabilities and attention deficit disorder. Acquired experience in peer mediation program development and techniques.

Group Counselor/Coleader **(5-10 hours per week):**

The College of William and Mary - Williamsburg, VA. January 1996 - May 1996.

Planned and implemented an on-campus eating disorder support group. Responsible for running meetings, increasing community awareness, and providing literature and resources for those suffering from eating disorders.

Residential Counselor **(20-40 hours per week):**

Trudeau Residential Center - Warwick, R.I. September 1992 - September 1993.

Planned and implemented recreational and educational activities for adults 18+ with mental retardation, multiple handicaps, and severe/profound disabilities. Developed and updated individual treatment plans and administered medications and treatments. Supervised the adult residents and communicated with parents as needed.

PAPERS AND PRESENTATIONS

The Secret Life of Teenage Girls: Interviewed and quoted by Brooke Foster in November, 2000 issue of the Washingtonian.

Ethical Decision Making: Presented a workshop at the American Counseling Association's national conference with Dr. Richard Paritzky; San Diego, CA. April, 2000.

Analysis of Stability and Patterns of Precocity in Preschoolers: 44th Annual Convention of the National Association for Gifted Children; Little Rock, AR. November, 1997.

National Mental Health and Education Center for Children and Families Conference: Presentation on the Norfolk Interagency Consortium program with John Brinkman, Norfolk School Psychologist; Washington, D.C. September 1997.

Psychological Assessment of Gifted Children - In-service seminar for faculty and staff at the Center for Gifted Education at the College of William and Mary; Williamsburg, VA. November, 1996.

Eating Disorders in the Male Population: A Comparison With Female Patients: with Dr. Brian Hayden. Presented for Independent Study Research Project - Brown University; Providence, R.I., December 1992.

WORKSHOPS/CONFERENCES ATTENDED

Teaching about the Arab World and Islam: Sponsored by the Middle East Policy Council. McLean, VA. – March 2002.

National Association of School Psychologists – National Convention: Washington, D.C. – May 2001.

Academy for Eating Disorders – Ninth International Conference: New York, NY. – May 2000.

American Counseling Association: National Convention: San Diego, CA. – April 1999.

AVSAP (Association of Virginia Student Assistance Professionals): Cultural Attitudes and Solutions Around Alcohol, Tobacco, and Other Drug Use: Fredericksburg, VA. – October 1999.

Prince William County Public Schools: Suicide Prevention/Crisis Intervention workshop: Manassas, VA. – August 1999.

Virginia Academy of School Psychologists – State Convention: Winchester, VA. – October 1997.
- "It's Child's Play: Facilitating Children's Emotional Growth Through Play"
- "The IDEA Amendments and the Delivery of Psychological Services through Special Education"
- "The Wechsler Adult Intelligence – III"

Awakening the Soul... A Journey Toward Enlightenment: Sponsored by the Diocese of Southern Virginia. Williamsburg, VA. - September 1996.

BASC Workshop with Randy Kamphaus: Norfolk, VA. - October 1996.

Child Development Resources - Caring for Children with Special Needs: Williamsburg, VA. - November, 1996.

Executive in Residence Program - School Restructuring with Dr. Gordon Cawelti: Williamsburg, VA. - November 1996.

National Association of School Psychologists: National Convention: Atlanta, GA. - March 1996.

PROFESSIONAL AFFILIATIONS

American Counseling Association
National Association of School Counselors
National Association of School Psychologists
Virginia Association of School Psychologists
Virginia Certified School Psychologist
Virginia Certified School Counselor: (K-12)
Chi Sigma Iota: International Honor Society for Counselors (candidate)
Advisory Board: George Washington University's School Counseling Program