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Recovery

from

Binge Eating Disorder:

A Grounded Theory Investigation

By

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A THESIS

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ABSTRACT

Binge eating disorder is a significant issue that affects a large number of individuals, most of whom are women. This disorder can be a chronic problem, and is associated with negative consequences that may reduce the quality of life for the individuals who struggle with it. However, little is known about the recovery process from this disorder.

The purpose of this study was to create a theoretical model for understanding women's experiences of recovery from binge eating disorder.

The participants included six women over the age of 18 who had been recovered from binge eating disorder for at least one year. The participants were each interviewed.

The interviews were analyzed using the grounded theory method. The basic social process uncovered was Self-awakening, a process whereby the individual resolves the issue of disconnection to self. Four phases of recovery also emerged: Self-reflection, Assessing Present Life Situation, Healing/Restoring Oneself, and Creating Balance.

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CHAPTER ONE: INTRODUCTION

> Back in the lounge I ate supper by flashlight. Two Sprites from the machine and a jumbo-sized jar of macadamias. For dessert I had the malted-milk balls and a roll of Oreos. I ate them the way I did back in Easterly: popped off the roof first, then raked two treads through the frosting with my front teeth. Then I filled by mouth with soda and felt the cookie collapse on itself. The ritual both soothed and disappointed me. (Lamb, 1992, p. 179).

Binge eating disorder (BED) is a recently acknowledged eating problem (American Psychological Association, 1994). Due to its relatively new status as a diagnostic category, the research on recovery from BED is limited. For instance, the research on recovery has not yet focused on people's subjective experiences of the recovery process from this particular disorder. In addition, the research has not addressed the strategies used for recovery or the factors that have stimulated or aided recovery.

Since research suggests that eating disorders can be a coping strategy, particularly binge eating (Heffernan, 1994; Katzman & Wolchik,1984; Telch, 1997), it is important to examine how women have come to replace an eating disorder, specifically BED, with healthier strategies for coping.

Nature of the Problem

Both psychological as well as physiological effects have been linked to BED. For instance, the presence of BED has been found to be highly associated with distress (Spitzer et al., 1992). Those who binge eat report feeling guilt, depression, self-condemnation, disgust (Arnow, Kenardy, & Agras, 1992; Leon, Carroll, Chernyk, & Finn, 1985; Loro & Orleans, 1981), feeling fat or overweight, feeling angry towards themselves, and stressed (Lingswiler, Crowther, & Stephens, 1989). Physiological consequences of binge eating include abdominal pain, headaches, dizziness, and fatigue

(Leon et al.; Lingswiler et al.; Loro & Orleans). BED is also linked with obesity, which is itself associated with a number of medical conditions (Romano & Quinn, 1995; Striegel-Moore, 1995).

Significance of the Problem

An understanding the process of recovery from BED is important for several reasons. BED affects a large number of individuals (Spitzer et al., 1992; Spitzer et al., 1993), most of whom are women (Smith, Marcus, & Eldredge, 1994; Spitzer et al, 1992). This disorder is associated with many negative consequences that may reduce the quality of life for the individuals who struggle with it (see Nature of the Problem). As well, BED has been thought to be a chronic problem for many individuals (Spitzer et al., 1993).

The process of recovery needs to be understood as this knowledge can be helpful for those who experience BED and for the therapists who work with these clients. For those who presently have BED, it may be of benefit to learn how others managed to overcome their struggle with BED. Furthermore, because people who currently have the disorder may feel discouraged about their ability to recover, the possibility of learning that there are others who have succeeded in the process of recovery may provide them with some optimism. It is also necessary for therapists to learn what people who have had BED have said about what has been helpful during the process of recovery.

Purpose of the Study

It is important to address the process of recovery from BED with a focus on the strategies used for recovery and the factors that stimulated and aided the recovery process. This study addresses the process of recovery from BED by exploring such

questions as: What is the experience of recovery for women with BED? What replaced the binge eating? And who and what helped along the process of recovery?

In order to obtain a rich understanding of the recovery process an interpretive inquiry approach was used. It is my belief that I would not have been able to reveal the subjective experience of recovery using a quantitative approach. A quantitative approach would have required placing restrictions on the information that I attained from the participants by using a questionnaire or a structured interview. Either of these methods of data collection would not have allowed each woman's unique experience of recovery to freely emerge in her own words. In addition, the purpose of this thesis was not to generalize the findings of the study to all women who have recovered from BED, but to come to one possible way of viewing this phenomenon out of many.

Specific Aims

This thesis had three specific aims. The first aim was to generate a theoretical framework for understanding the process of recovery from BED based on the experiences of the women I interviewed. The second aim was to identify and describe the recovery strategies used by participants throughout the recovery process. And the third aim was to identify and describe the factors that stimulated and aided recovery.

Key Terms

The following terms are defined to ensure a common understanding of the concepts used throughout this study: eating disorders, anorexia nervosa, bulimia nervosa, binge eating disorder, binge eating, and recovery.

Eating disorders are defined as severe disturbances in eating behaviour (American Psychological Association, 1994), which include anorexia nervosa, bulimia nervosa, and binge eating disorder.

Anorexia nervosa is defined as a refusal to maintain minimally normal body weight. Bulimia nervosa is defined as repeated episodes of binge eating followed by inappropriate compensatory behaviour, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications; fasting or excessive exercise (American Psychological Association, 1994).

Binge eating disorder is defined as recurrent episodes of binge eating associated with subjective and behavioral indicators of impaired control over, and significant distress about the binge eating, as well as the absence of the regular use of inappropriate compensatory behaviors that are characteristic of bulimia nervosa (American Psychological Association, 1994). A binge eating episode 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 period 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) (p. 731).

Finally, recovery is defined as the absence of the criteria required for the diagnosis of binge eating disorder, as well as the subjective opinion that one no longer suffers from binge eating disorder.

Reasons for Interest in the Research Topic

I am interested in the recovery from BED for several reasons. I have noticed a tendency for women to use bingeing on food as a way of coping with their problems. On

a personal note, I have observed this behaviour in myself and among some of the women I know. From a sociocultural perspective, this tendency is depicted in various media forms such as television, in movies, and popular literature. The prevalence rates of BED also suggest that more women than men engage in this behaviour (American Psychological Association, 1994). Hence, I have chosen to focus specifically on women in my study.

As a counsellor who works with clients in the area of eating disorders, it is important for me to understand the process of recovery so that I am able to help clients in an effective manner. This is an area of study that needs to be given more attention by health care professionals and researchers.

From my own observations as a clinician, there are helping professionals who have misconceptions about clients with BED. While many counsellors demonstrate compassion for clients who are struggling with anorexia nervosa or bulimia nervosa, they may view clients with BED as having no control, being lazy, and needing to go on a diet. For the reasons given above, a research study on the recovery process is both timely and necessary.

Significance of the Study

I believe this study is significant for the following reasons. Due to the fact that the area of recovery from eating disorders is relatively new, this thesis will further knowledge on the recovery process. Not only will this thesis add to our understanding of recovery from eating disorders in general, but more specifically to our understanding of BED; the factors that stimulate and aid recovery, and the recovery strategies used by those with eating disorders. Thirdly, this study will provide a theory for understanding

the process of recovery based on the experiences of the participants in this study. And finally, the results of this study will have implications for counsellors working with clients who have eating disorders.

Overview

The goal of this study is to learn more about women's recovery process from BED. An additional goal is to attain information concerning the factors that stimulate and aid recovery, and the strategies that women use to facilitate their recoveries. Chapter Two provides a review of the literature that outlines what is currently known about BED and recovery. Chapter Three is a review of the grounded theory method as it applies to this study. Chapter Four is the theory of recovery from BED. And finally, Chapter Five presents a discussion of the theory and its implications for the treatment of BED.

CHAPTER TWO: LITERATURE REVIEW

The following literature review focuses on four areas of research to provide the necessary background information for the study. These areas include literature on the models of binge eating, binge eating disorder, the recovery from eating disorders, and finally theories about the process of change.

Models of Binge Eating

Models of binge eating have been created in order to explain the phenomenon of binge eating. Several of these models are presented here in order to give the reader an overview of theories as to the causes of binge eating. The models that are discussed are based on addictions, affect regulation, escape theory, dieting, biopsychosocial, and feminism. Each of these models are briefly outlined. It is important to note that the majority of these models were originally developed based on people who have bulimia nervosa, but are now also being applied to those with BED. In addition, these models were developed based on women, and therefore we do not know how well they explain the causes of binge eating for men.

The addictions model. This model of binge eating is based on the idea that food is used for tension reduction or regulation, as a sedative, similar to the way that alcohol and drugs are used by people with addictions to those substances (Polivy & Herman, 1993). In this view foods, particularly carbohydrates, are seen as acting as mood-altering drugs by elevating the neurotransmitter serotonin (Wurtman & Wurtman, 1992). It is thought that there are predisposing factors for using food as a substance of abuse such as biochemical, familial, and cultural variables (Polivy & Herman, 1993).

The affect regulation model. This model proposes that binge eating serves affect regulating functions, particularly the reduction of negative affect, which then maintains the binge eating behaviour. Food is thus used to regulate negative emotions by reducing unpleasant affect when consumed. The negative affect reduction reinforces the use of eating in response to aversive feelings, helping to establish a conditioned pattern (Polivy & Herman, 1993).

The escape theory. Heatherton and Baumeister (1991) proposed the escape theory of binge eating. They believe that binge eaters tend to have high standards and expectations for themselves, and are especially sensitive to the perceived demands of others. When binge eaters do not meet these standards, they develop an aversive pattern of high self-awareness, characterized by unflattering views of themselves and concern over how they are perceived by others. These aversive self-perceptions coincide with emotional distress which often includes anxiety and depression. To escape from the unpleasant state, they narrow their focus of attention to their immediate physical surroundings and avoid broadly meaningful thought. The narrowing of attention to the immediate environment disengages normal inhibitions against eating and fosters an uncritical acceptance of irrational beliefs and thoughts.

The dieting model. Another model is based on the contribution that dieting makes to binge eating. Herman and Polivy (1980) suggest that individuals who chose to diet often have low self-esteem and body dissatisfaction, and are choosing diet to improve themselves. However, the dieters soon encounter consequences that arise directly from restricting food intake. The consequences include hunger, frustration, and impaired sensitivity to internal cues that signal satiety. These consequences all contribute to binge

eating. Because the individuals have chosen to binge eat, they must then offset the effects of having consumed many calories during the binge by dieting once again. The failure to lose weight further lowers their self-esteem, and the cycle perpetuates itself.

The biopsychosocial model. This model of binge eating combines biological, genetic, psychological, and socio-environmental explanations. Hsu (1990) suggests that genetic, psychological, biological, personality, and family factors may increase a dieting person's vulnerability to developing an eating disorder. In addition, because adiposity is increasing in North America despite the cultural preference for a slim body type, any deviation from this ideal may cause people to diet in order to conform. Dieting in combination with the above mentioned factors may interact to lead to binge eating and eating disorders.

The feminist model. According to this model, the connection between women's relationship to their bodies and the conditions of their lives, is the basis for understanding binge eating. This is in contrast to many of the models presented above which have emerged from a medical perspective. The medical perspective tends to offer asocial, decontextualized, and highly individualized explanations for eating problems (Brown, 1993).

From a feminist perspective eating problems may be seen as "...survival strategies – as sensible acts of self-preservation – in response to myriad injustices including racism, sexism, homophobia, classism, the stress of acculturation, and emotional, physical, and sexual abuse" (Thompson, 1994, p. 1-2). It appears that it is both characteristic and acceptable for women within Western society to displace their

feelings, needs, and dissatisfaction onto their relationship with their eating and their bodies (Brown, 1993).

As Brown (1985) asserts eating problems are a manifestation of a struggle that women are engaging in, both to keep the rules of society (i.e. to be good, beautiful, and valuable in patriarchal terms) and to keep their sanity. Self-feeding or binge eating is a form of self-nurturance for many women, acting as a friend, a support, a tranquilizer, an aesthetic, or as a lover (Brown, 1985). Women often report emotional reasons for bingeing (Brown, 1993). Bingeing can be used to provide a distraction from uncomfortable feelings by numbing emotional pain, but it can also be used to self-punish by causing physical pain.

Summary. Six different models of binge eating were presented in this section, the addiction, affect regulation, escape theory, dieting, biopsychosocial, and feminist models.

Binge Eating Disorder

The behaviour of binge eating has become more common in the past few decades. Since the 1950s, there has been an increase in eating disorders, particularly ones in which binge eating plays a central role, such as bulimia nervosa and BED (Ash & Piazza, 1995; Kassett, Gwirtsman, Kaye, Brandt, & Jimerson, 1988; Kendler et al., 1991). Binge eating without compensatory behaviours was first identified and studied by Stunkard in 1959. Since that time research on this particular eating problem has been scarce and only until recently has research increased. In 1994 the classification of BED was finally included in the DSM-IV (American Psychological Association, 1994). Although BED is currently a diagnosis for further study in the DSM-IV, there appears to be sufficient research evidence to support its use as a diagnosis (Schmidt, 2000).

In order to provide a sufficient understanding of BED the areas of prevalence, age of onset, treatment seeking, comorbidity, associated factors, triggers, coping strategies, risk factors, and predictors of outcome for people with BED are discussed.

Prevalence. BED affects a significant proportion of people. In North America the prevalence in the general population is estimated between 1.8% to 4.6 % (Bruce & Agras, 1992; Spitzer et al., 1992; Spitzer et al., 1993), with prevalence rates as high as 30% in those seeking help for weight loss, and 71.2% in those involved with Overeaters Anonymous (Spitzer et al., 1992). As the high prevalence of BED in the weight loss seeking population suggests, BED occurs more frequently in overweight individuals (Smith, Marcus, & Eldredge, 1994). Approximately 5 to 8 % of obese individuals in the community meet the criteria for the disorder (Bruce & Agras, 1992). However, BED may be experienced by both normal and overweight individuals, and is only found in a subset of the obese population (Spitzer et al., 1992).

BED is not only a North American phenomenon. In France one study found that 8.9 % of participants in a private practice group, 15.2% in a hospital group, and 0.7% of community non-patients met the criteria for BED (Basdevant, et al., 1995). The researchers suggest that the prevalence rate for BED is slightly lower in France than in the United States, but significant nonetheless. Further research on BED outside of North America is needed.

Like both anorexia nervosa and bulimia nervosa, BED also appears to affect more women than men. However, unlike the populations which suffer from anorexia nervosa and bulimia nervosa, a greater percentage of men are included in the population that experiences BED. Several researchers (Smith, Marcus, & Eldredge, 1994; Spitzer et

al.,1992; Spitzer et al., 1993) have found the ratio of proportion for BED in women to men to be 3:2 in weight reducing samples, and approximately equal in community samples.

BED is thought to affect Caucasians and minority groups at similar rates (Smith, Marcus, Lewis, Fitzgibbon, & Schreiner, 1998; Yanovski, Nelson, Dubbert, & Spitzer, 1993). In a biracial population-based study of men and women with BED Smith et al. (1998) found an overall prevalence of 1.5%, with rates of 2.2% among Black women, 2.0% among White women, 1.2% among White men, and 0.4% among Black men. However, a study by Fitzgibbon et al. (1998) which looked at the prevalence rates of BED across Hispanic, White, and Black women, found that Hispanic women showed the highest proportion of BED at 9.6%, followed by Black women at 3.9%, and finally white women at 1.8%. This research suggests that certain minority groups such as Hispanic women, may show a much higher prevalence rate for BED compared to White or Black women.

Not only does BED affect a large number of people, it is suggested to be more common than other eating disorders. For instance, a study using a Norwegian population found BED to have a prevalence two times the rate of bulimia nervosa and five times the frequency of anorexia nervosa (Gotestam & Agras, 1995). In addition, BED appears to have a broader demographic distribution than anorexia nervosa or bulimia nervosa (Telch, Agras, & Rossiter, 1988; Yanovski, Nelson, Dubbert, & Spitzer, 1993; Spitzer, 1993), in terms of age (Wilfley et al., 1993), gender (Yanovski, 1993), and race (Fitzgibbon et al., 1998; Smith et al., 1998; Yanovski et al.). These findings lead to the conclusion that BED is a significant issue for a variety of people.

Age of onset. The age of onset of BED appears to be unclear. Some suggest that the onset typically begins during late adolescence or early adulthood (Santonastaso, Ferrara, & Favaro, 1999; Spitzer et al., 1992; Spitzer et al., 1993; Striegel-Moore, 1995), and that the age of onset is slightly older than that of people with bulimia nervosa (Malkoff, Marcus, Grant, Moulton, & Vayonis, 1993; Wilson, Nonas, & Rosenblum, 1993). However, research by Raymond, Mussell, Mitchell, Crosby, and de Zwaan, (1995) found that women with BED had an earlier age of onset of binge eating (14.3 years) than women with bulimia nervosa (19.8 years). This discrepancy may be explained by the findings of Mussell et al. (1995), who discovered that although the participants in their study began binge eating in adolescence, they did not develop the pattern of binge eating on a regular basis until they were 26 years old.

Treatment seeking. Researchers have suggested that individuals with BED present for treatment at a later age than those with bulimia nervosa, tending to be in their 30s as opposed to in their 20s (Mitchell, 1992; Santonastaso et al., 1999). However, Whitaker et al. (1990) propose that only a small percentage of women who binge eat seek treatment specifically for their eating problem. Wilfley and Cohen (1997) assert that very few individuals who suffer from BED significantly improve or recover without treatment.

Comorbidity. Many studies have found psychological distress and psychopathology in individuals with BED (Castonguay, Eldredge, & Agras, 1995; Grave, Todisco, Oliosi, & Marchi, 1996; Marcus et al., 1990; Romano & Quinn, 1995; Spitzer et al., 1993; Spurrell, Wilfley, Tanofsky, & Brownell, 1997). In a study by Yanovski et al. (1993) obese subjects with BED were found to have a lifetime prevalence of a DSM-III-R axis I or axis II diagnosis. The rates of major depression, panic disorder,

bulimia nervosa, borderline personality disorder, and avoidant personality disorder were all significantly higher for participants with BED.

There appears to be quite a strong association between BED and depression (de Zwaan, Nutzinger, & Schonbeck, 1992; Kuehnel & Wadden, 1994; Marcus et al., 1990; Mussell et al., 1995; Specker, de Zwaan, Raymond, & Mitchell, 1994; Spitzer et al., 1993; Yanovski et al., 1993). Mussel et al. found that half of their sample that presented for treatment for BED reported a history of clinical depression, and for the majority their binge eating behaviour predated the depression. These researchers suggest that BED and obesity, which often is accompanied by BED, may actually contribute to the development of depression.

Associated factors. Overconcern with weight and shape have also been shown to be a significant aspect of clinical presentation of obese clients with BED (Grave et al., 1996; Grilo, Wilfley, Jones, Brownell, & Rodin, 1994; Marcus, Smith, Santelli & Kaye, 1992; Romano & Quinn, 1995; Spitzer et al., 1993). As well, poor self-image or self-esteem (de Zwaan et al., 1994; Goodrick et al., 1999), body disparagement (Goodrick et al.; Romano & Quinn), a sense of ineffectiveness (Grave et al.; Kuehnel & Wadden, 1994), and a drive for thinness are commonly found in people with BED (Goodrick et al.). The factors of body disparagement and drive for thinness are thought to actually potentiate bingeing (Goodrick et al.).

Other factors associated with BED include impairment in work and social functioning, alcohol and/or drug abuse, treatment for emotional problems (Spitzer et al., 1993), a significant amount of adult life spent on diets (de Zwaan et al., 1994; Spitzer et al., 1993), difficulty interpreting hunger and satiety (Grave et al., 1996), using an external

frame of reference in determining self-worth (Kuehnel & Wadden, 1994), low interoceptive awareness (de Zwaan et al.), and emotional stress (French et al., 1997; Greeno & Wing, 1994; Heatherton & Baumeister, 1991; Mussell et al., 1995; Polivy & Herman, 1993),

A lot of research has focused on the association between BED and dieting. Much of the focus has been on the part dieting plays in relation to binge eating. Unlike bulimia nervosa, the onset of binge eating seems to preceed the onset of dieting for the majority of people with BED (Mussell et al., 1995; Spitzer et al., 1993; Spurrell et al., 1997; Wilson et al., 1993). There also appears to be no evidence to suggest that binge eating is a result of dietary restriction for individuals with BED (de Zwaan, 1997). Those with BED tend not to show a relationship between feeling hungry and bingeing (Yanovsky & Sebring, 1994).

Triggers. The reasons or triggers found for binge eating include food cravings (Bruce & Agras, 1992), negative affective states such as boredom, loneliness, depression, hopelessness, stress, emptiness (Arnow, Kenardy, & Agras, 1992; Bruce & Agras; Crowther, Lingswiler, & Stephens, 1984; Davis, Freeman, & Garner, 1988; Eldredge & Agras, 1996; Grave et al., 1996; Lingswiler, Crowther, & Stephens, 1987; Lingswiler, Crowther, & Stephens, 1989; Stickney, Miltenberger, & Wolff, 1999), anxiety, a nonspecific feeling of tension, time of day, type of meal (Arnow et al.), and social situations (Arnow et al.; Grave et al.). When Stickney et al. (1999) asked participants about the function of binge eating, 45% reported relief from negative feelings, 29% said relief from negative thoughts, and 16% cited relief from hunger or food cravings.

Coping strategies. Research which has examined the coping strategies of those with BED has discovered that women with BED appear to binge as a response to stress in place of more adequate coping strategies (Heffernan, 1994). Grilo, Shiffman, and Wing (1989) found that participants who binged were less able to cope behaviourally in emotionally upsetting situations. Another study showed that those who binged tended to cope through avoidance and tended not to share their thoughts and feelings with others (Fitzgibbon & Kirschenbaum, 1991).

As previously mentioned, bingeing on food is suggested to be a response to negative affect for those who have BED. Eldredge and Agras (1996) discovered that participants in their study with BED reported a significantly greater tendency to eat in response to negative mood states than controls and low weight participants diagnosed as having an eating disorder not otherwise specified. Based on the results of this study, the researchers concluded that BED is associated with emotional eating. The tendency to eat in response to emotions has also been linked with the severity of binge eating (Arnow et al., 1995), thus lending support to the connection between these two variables.

Given the functions that binge eating serves, bingeing may be seen as a method for coping with negative events (Katzman & Wolchik, 1984). Some people with binge eating disorder have made the connection between coping, eating, and negative mood on their own. In a study by Telch (1997) participants themselves described their binge eating as a means of coping with negative affective states.

Risk factors. Limited research has been done on the risk factors for BED. However, one study has identified some of the risk factors (Fairburn et al, 1998). The community based, case-controlled study compared women with BED to women with

other psychiatric disorders, bulimia nervosa, and those without an eating disorder. When compared to healthy control subjects, the risk factors identified for BED were certain adverse childhood experiences, parental depression, vulnerability to obesity, and repeated exposure to negative comments about shape, weight, and eating. Compared to women with other psychiatric disorders, the risk factors for BED that emerged were childhood obesity and more exposure to negative comments about shape, weight, and eating. Finally, what distinguished women with BED from those with bulimia nervosa were certain childhood traits and pronounced vulnerability to obesity.

Predictors of outcome. There is also limited research on the factors that may predict the outcome of BED. To date several factors have been identified that predict poor outcome in BED. These factors include the frequency of binge eating episodes (Peterson et al., 2000), the severity of binge eating (Agras et al., 1995; Agras, Telch, Arnow, Eldredge, & Marnell, 1997; Telch, Agras, Rossiter, Wilfley, & Kenardy, 1990), age of onset (Agras et al., 1995), and age at the time of treatment (Agras et al., 1997). However, to my knowledge there are no studies that point to the factors that predict positive outcome in BED.

Summary. BED appears to affect a significant proportion of people including minorities and men. However, the age of onset remains unclear. We do know that people with BED are more likely to suffer from psychological problems, particularly depression. There are also many other factors that are associated with BED, including repeated dieting. Common triggers for binge eating have been identified, and research shows that binge eating is frequently used as a means of coping with negative affect.

Research on the risk factors and predictors of outcome for BED is still relatively unchartered territory.

Recovery

As mentioned earlier, the study of recovery from BED is a relatively new area of research interest. The majority of research on the recovery from eating disorders has focused on either the recovery from anorexia nervosa (Beresin, Gordon, & Herzog, 1989; Garrett, 1997; Hsu, Crisp, & Callender, 1992) and/or bulimia nervosa (Reiss & Johnson-Sabine, 1995; Root, 1990; Rorty, Yager, & Rossotto, 1993; Woodside, Kohn, & Kerr, 1998). Because the literature on recovery from BED is still in its preliminary stages, the review of literature on recovery focuses on the recovery from BED, as well as from other eating problems, to give additional information about how people recover.

Recovery from Binge Eating Disorder

To date there are only two studies that focus on the natural course of BED without treatment (Cachelin et al., 1999; Fairburn et al., 2000) and a number of studies on treatment outcome. The treatment outcome studies have often focused on the outcome of cognitive behaviour therapy (CBT) itself or compared CBT with other treatments such as interpersonal psychotherapy or behavioral weight control (for a review see Wilfley & Cohen, 1997). Because the topic of this thesis is on the recovery process of BED and not on treatment outcome, I have chosen to focus on the studies which examine the natural course of BED.

The first study on the natural course of BED by Cachelin et al. (1999) followed a community sample of women with BED over the period of 6 months. Of an original 31 participants, 21 women completed the study. They were assessed at three points in time:

at baseline, three months, and six months. At the six month follow-up 11 women continued to meet the criteria for BED and 10 appeared to be in partial remission. The binge eating frequency decreased over the follow-up period, particularly for the partial remission group. The partial remission group also showed lower ratings on the importance of weight or shape at follow-up compared to the other group. The two groups did not differ in the likelihood to have sought treatment for the eating problem.

The second study, by Fairburn et al. (2000), compared the course of BED to that of bulimia nervosa. Again this study was community-based using only female participants. The participants included 102 women with bulimia nervosa and 48 with BED. The participants in this study were followed over a five year period and contacted at 15 month intervals. At the five year mark the BED group had a much better outcome than the bulimia nervosa group with only 18% meeting the criteria for a clinical eating disorder compared to 51% of the bulimia nervosa sample. Seventy-eight percent of the BED group had no binge eating episodes over the preceding three months compared to 53% of the bulimia nervosa group.

The relapse rate for the BED sample was quite low. At point three, 10% relapsed, at point four, 4%, and point five, 7%. The BED group also showed a reduction in dietary restraint, a decrease in the level of concern about shape, weight, and eating, as well as a decrease in the level of general psychiatric symptomology. In addition, compared to the bulimia nervosa group, the BED sample's self-esteem improved and they continued to function at a better level of social adjustment. However, the study found that 39% of the BED group met the criteria for obesity at the five year outcome (Fairburn et al., 2000).

Furthermore, the study discovered that compared to the bulimia nervosa group the BED sample showed little flux, with a trend of steady improvement, 50% remitting each year and few relapsing. Despite only 3% of the BED group receiving treatment compared to 28% of the bulimia nervosa group, the majority of the BED sample made a full recovery. The researchers concluded that BED may be an unstable state with the tendency to remit (Fairburn et al., 2000).

Given the results of the two studies discussed, it appears that recovery from BED is attainable and is achieved by many people. However, there is still little known about the recovery from BED, particularly the subjective experience of recovery and details about the process of recovery.

Recovery from Anorexia Nervosa and Bulimia Nervosa

As with the research on the recovery from BED, research on recovery from anorexia nervosa and bulimia nervosa has frequently focused on treatment outcome. However, there has been research on the course and outcome of these eating problems without treatment, as well as on the subjective experiences of individuals who have recovered. This section focuses on the literature that examines the course and/or experiences of those who have recovered from anorexia nervosa and bulimia nervosa respectively. This section finishes with a look at studies that compare recovery from anorexia nervosa and bulimia nervosa, as well as some that include recovery from binge eating/compulsive overeating in the comparison.

Anorexia nervosa

Although anorexia nervosa is thought to have a chronic and persistent course (Fichter & Quadflieg, 1999; Herzog, Schellberg, & Deter, 1997), we do know that there

are people who recover from this eating problem. Several studies have examined how people have recovered from anorexia nervosa and what they felt was helpful to their recoveries.

Factors contributing to recovery. Noordenbos (1989) used a questionnaire and interviews to collect data on the recovery process of four men and 104 women recovered from anorexia nervosa. The study found that the participants felt that admitting to having a problem was important to their recoveries. Ninety-five point two percent said they admitted something was wrong, while 81.9% said that they had felt they could no longer continue their anorexic behaviour and had to do something to change their situation. The motivation for treatment appeared to increase when the participants admitted to having a problem. Seventy-two percent of the participants in the study received treatment. Of those who did receive treatment, psychotherapy and self-help groups were evaluated as most helpful, boosting motivation for change.

Another study by Beresin, Gordon, and Herzog (1989) also used questionnaires and interviews with 13 women who considered themselves to be recovered from anorexia nervosa. When asked what they considered most helpful and harmful to their recoveries 90% said professional help, individual therapy being the highest rated, and 90% said experiences other than therapy. The experiences other than therapy included self-initiated action/personal experience of self, interpersonal relationships, family relationships, and job or school experiences.

The following examples demonstrate some of the experiences other than therapy that the participants found helpful. Recovery was compared to a psychological rebirth, which in part emerged from the participants getting to know themselves better. The

participants enhanced their self-understanding by talking to themselves about their feeling states, desires, and body image. They also found that a critical step to recovery was taking the risk of exposing themselves to others, sharing more of themselves than they had been willing to in the past. Some participants felt that getting away from their families was important. And finally, productivity in school or work was considered beneficial, instilling feelings of power, effectiveness, achievement, and satisfaction (Beresin et al., 1989).

Hsu et al. (1992) also looked at the recovery from anorexia nervosa from the participant's perspective. Six women who had recovered from anorexia nervosa for at least one year were interviewed twenty years after the onset of the disorder. The factors most commonly reported as important to recovery include: finding personal strength and increased self-confidence, getting out of a destructive environment, engaging in therapy, being fed up with the illness, and having faith.

Finally, Garrett (1997), outlined the results of her 1993 study which involved interviewing 32 people at various stages of recovery from anorexia nervosa. There were five elements of recovery that were identified by the participants: abandoning obsession with food and weight, having a sense that their lives were meaningful, believing that they were worthwhile, believing strongly that they would never return to self-starvation, and relying on spirituality as a source of meaning. Activities that were used to facilitate recovery included gardening, swimming, yoga, belly dancing, cycling, walking and running for the pleasure of fitness rather than weight reduction. The participants also discussed recovery as an ongoing process and as a choice between life and death.

Bulimia nervosa

The outcome pattern for bulimia nervosa is thought to be highly variable considering the results of treatment outcome studies (Rorty et al., 1993). However, despite the variable outcome for people with bulimia nervosa, we do know that it is possible for recovery to take place with or without treatment. Several researchers have addressed the issue of recovery without treatment. Studies also exist which examined the factors that are thought to contribute to recovery from bulimia nervosa.

Recovery without treatment. Keel and Mitchell (1997) compared the outcome for people with bulimia nervosa across 88 follow-up and treatment outcome studies. Keel and Mitchell found that the results of the follow-up studies indicate that rates of remission appear to increase over time to meet similar values cited by treatment outcome studies. As well, cases of bulimia nervosa decrease over time in follow-up studies but change very little in treatment outcome studies. And finally follow-up studies found previous treatment interventions to be unassociated with outcome.

A study by Stanton, Rebert, and Zinn, (1986) looked at the likelihood of people recovering from bulimia nervosa without outside help, as well as the factors that were helpful to those who have recovered. Of the 29 undergraduate women in the study who formerly had bulimia nervosa, 42% were considered to have engaged in self-change. They found that it was quite common for participants to have made repeated attempts to change, with nine attempts used on average to stop binge eating, and two attempts used to stop purging, before successful termination.

The desire to improve self-esteem was the most influential factor in initiating a change in binge eating behaviour. In addition, the participants who were considered self-changers most frequently employed helping relationships ("I can be open with at least

one special person about my experiences with my eating habits" p. 919), counter-conditioning ("I do something else instead of binge eating when I need to relax or deal with tension" p. 919), and self-liberation ("I tell myself I am able to quit purging if I want to" p. 919) in order to facilitate recovery. The authors concluded that a number of women appear to be successful at overcoming bulimia nervosa on their own (Stanton et al., 1986).

Factors contributing to recovery. Studies have also looked at what people who have recovered from bulimia nervosa have said about the process of recovery. Rorty et al. (1993) interviewed 40 women who were recovered from bulimia nervosa for a year or more. When asked what stimulated the recovery process, answers such as the desire for a better life, "hitting rock bottom," negative medical, social, or professional consequences, increased self-esteem, or having an important person take a stand were given. In addition, 60% of the participants recalled experiencing a significant life transition, such as the transition to university or to the work world, while 40% perceived that nothing out of the ordinary was happening at the time that the recovery process began. As well, 90% of the participants sought treatment of some kind, including psychotropic medication, professional treatment, non-professional care such as Overeaters Anonymous, self-help groups, and books. The level of satisfaction with the type of care varied. The study also found that the support provided by friends, family, or romantic partner was generally considered to be helpful, whereas the support provided by parents was not.

Peters and Fallon (1994) conducted a study using semi-structured interviews to discuss any treatment experiences and what recovery meant with 30 women recovered from bulimia nervosa. Using the grounded theory method three continua regarding the

recovery process emerged from the interviews: "denial to reality," "alienation to connection," and "passivity to personal power." "Denial to reality" represents the women moving from concealing from others and lying to themselves about their eating problem to accepting the reality of it. "Alienation to connection" describes the shift of the women from isolation to connection with other people. And "passivity to personal power" is the change the women went through from "feeling lost" and not knowing what they wanted out of life to taking control of their lives. The study also revealed that recovery is a multidimensional process which involves a progression of changes in relation to one's self, one's body, one's family, and one's culture.

Two studies that compared people who recovered from bulimia nervosa with those who still engaged in the bulimic behaviours found important differences. Rossotto, Rorty-Greenfield, and Yager (1996) discovered that recovered women believed that a lack of self-acceptance or low self-esteem were factors in the development of their eating problem. However, women still struggling with bulimia nervosa believed that feelings of power, control, or escape kept the problem going. Recovered women described recovery as learning to forgive oneself, coming to a point of surrender, and being on one's own side rather than being one's own worst enemy.

The authors (Rossotto et al., 1996) believe that in order to overcome bulimia nervosa the person must acknowledge the harmful impact of low self-worth and begin to accept themselves despite struggling with the problem. The authors suggest that while working towards recovery people may come to realize that weight loss or failed diets were actually superficial causes of the problem and that other causes provide a more meaningful explanation.

The second study comparing recovered and non-recovered women with bulimia nervosa found that women who had recovered had significantly more friendship supports available to them than non-recovered women (Rorty, Yager, Buckwalter, & Rossotto, 1999). In addition, the comparison group and recovered women both had more family available to provide emotional support and had higher levels of satisfaction with emotional support from family than non-recovered women. Compared to the recovered women, non-recovered women showed significant social impairment. The authors speculate that building solid relationships with friends may be critical to recovery from bulimia nervosa.

Anorexia Nervosa, Bulimia Nervosa, and Binge Eating

Several studies have compared the recoveries of people with different eating problems. Often the recoveries of people with anorexia nervosa and bulimia nervosa have been compared and contrasted. However, some researchers have looked at recovery from eating problems, including binge eating or compulsive overeating, without distinguishing the recoveries by type of eating problem. As well, there have been studies that have compared the recoveries of people with addictions, such as alcoholism and gambling, to those with eating problems, specifically binge eating. Finally, there have been authors who have written about recovery from eating problems based on professional and/or personal experiences. All four types of studies will be discussed in this section.

Comparing recovery from bulimia nervosa and anorexia nervosa. Herzog et al. (1999) conducted a 7.5 year follow-up study examining the recovery and relapse rate of 246 women with either anorexia nervosa or bulimia nervosa. They found that the

majority of women reported periods of substantial symptomatic improvement over the course of the 7.5 years. A large majority of the participants attained partial recovery by follow-up. The rates of full recovery were found to increase slightly between the five and 7.5 year follow-up intervals. This suggests that a small number of the women continued to recover past the five year mark. However, the women with anorexia nervosa were less likely to achieve full recovery, and women with bulimia nervosa appeared to recovery more rapidly.

Yager, Landsverk, Edelstein, and Jarvik (1988) also conducted a follow-up study with 628 women over a 20 month period. The women in this study were divided into groups based on their eating problems, which included anorexia nervosa, bulimia nervosa, and sub-diagnostic eating disorders. The study found that there was a modest tendency for the women with anorexia nervosa and bulimia nervosa to improve. The improvements found were in criterion symptoms, associated health status, and associated psychological symptoms, and they occurred regardless of whether treatment had been sought in the community.

Although the improvements that the participants made in the study by Yager et al. (1988) were not as significant as those found in the study by Herzog et al. (1999), the difference in findings may be due to the contrast in the length of the follow-up periods. The tendency to recover from an eating problem may improve over time, although this remains unclear.

The following study looked at the factors that influence recovery from eating problems. Hesse-Biber, Marino, and Watts-Roy (1999) followed 21 women across a six year period, starting from their sophomore year in college to two years post-college. The

women who participated in this study were considered in the "gray zone" of eating disorders, meaning they did not quite meet the criteria for anorexia nervosa or bulimia nervosa. However, the results of this study contribute to our understanding of recovery nonetheless.

Of the 21 women followed, only 11 got better while 10 women remained at risk of developing an eating disorder meeting DSM-IV criteria. Those who did get better showed that both their relational and autonomous aspects of self were balanced and intact. They were found to value both relationships and independence, as opposed to the at risk group who valued independence over relationships. The group that got better also demonstrated having developed healthier means of coping with difficulties in their lives. In addition, the at-risk group showed diminished self-esteem and self-doubt compared to the group that got better who demonstrated self-confidence. Finally, the at risk group were more likely to grow up in a family that emphasized physical appearance, have conflict with their mothers and problematic relationships with their fathers. The group that got better was found to have supportive mothers (Hesse-Biber et al., 1999).

Comparing recovery from a variety of eating problems. As mentioned previously, there are studies which have examined the recoveries of people with eating problems without separating the analysis by type of eating problem. Thompson (1994) interviewed 18 women about their recoveries from a variety of eating problems including compulsive overeating, dieting, anorexia nervosa, and bulimia nervosa. The participants varied in terms of ethnicity, sexuality, age, religion, and length of time recovered. Thompson did not distinguish between the women's recoveries by the type of eating problem they had, but rather looked for the similarities between their experiences.

The participants in this study considered recovery or healing as being able to enjoy eating, believing they have the right to eat, and learning to stop eating when they were full. It was common for the participants to make many attempts at recovery and try many approaches to recovery, stumbling on a successful approach after several tries. All of the participants used a combination of strategies to recover. The healing process was considered by many of the participants to be very slow and was described as two steps forward and one step back (Thompson, 1994).

The author (Thompson, 1994) found that major life crises, that were either positive or negative, motivated several women to seek help for their eating problems. For example, the death of a parent, the birth of a child, or a failed relationship. Only a few who were compelled to seek help sought traditional medical or therapeutic help. Self-help programs such as Overeaters Anonymous were the most common method of healing. Of the women who did attend counselling, many found that counselling helped to change their eating patterns although none of them went to therapy for that reason.

Another important finding of this study was that many of the women found it helpful to identify how painful emotions fueled their eating problems. This began when the women started to notice what they were feeling when they most wanted to binge or deny themselves food. Many women felt that the first step of their healing was deciding against severe diets. Instead the participants took steps to acknowledge trauma and learn new methods of coping with pain (Thompson, 1994).

Comparing recovery from addictions and binge eating. There have been two studies which compare the recovery process from various addictions, and included in the comparison is binge eating (Hanninen & Koski-Jannes, 1999; Koski-Jannes & Turner,

1999). Only the aspects of recovery from binge eating from these studies are considered. It is important to note that these two studies do not state the criteria by which they determined binge eating. Although the two studies use the term "binge eating" interchangeably with the term "bulimia" (no definitions of bulimia or binge eating were offered), it is impossible to know whether the participants were experiencing bulimia nervosa, BED, or both.

Koski-Jannes and Turner (1999) studied the factors influencing recovery from binge eating and different addictions. The addictions included alcohol, multiple drugs, smoking, sex, and gambling. The participants included 38 men and 38 women. When the participants were asked what contributed to recovery, participants most frequently responded "tiring out," God, a self-help group, and "hitting bottom."

The recovery from binge eating was particularly facilitated by an intimate relationship, but also with therapy, children, and mutual support groups. Forty-one percent of all the participants in the study changed their behaviour without formal treatment or self-help groups. It was found that the majority of binge eaters and smokers quit on their own. The maintenance techniques most often used by the binge eaters were distraction, will power, and thinking of the negative consequences of bingeing. Fifty-five percent of the binge eaters resolved their problem without treatment. The study found that people with different addictions vary in their receptivity to different emotional incentives. For example, love and caring in the case of binge eaters, social support and spirituality with polydrug users, and health concerns with smokers (Koski-Jannes & Turner, 1999).

The second study comparing recovery from different addictions also compared people who binge eat and people with addictions to alcohol, smoking, sex, multiple drugs, and gambling (Hanninen & Koski-Jannes, 1999). This study focused on the narratives of recovery given by these different groups. Twenty-two men and 29 women participated in this research. Five different story types emerged: the AA story, the growth story, the co-dependence story, the love story, and the mastery story. Each story type that emerged was told predominantly by a group of people having a particular gender and addiction. The "love story" was told mostly by women who had recovered from binge eating. The key to recovery in the "love story" was seen as receiving love and care. Binge eating was thought to be used to compensate for the lack of love, and the cure for binge eating was thought to be receiving love.

Based on the results of this study, the authors concluded that due to the profound differences in the recovery stories, addiction can stem from various kinds of problems and they believe there are many routes to recovery (Hanninen & Koski-Jannes, 1999). Koski-Jannes & Turner (1999) also suggest that there are differing routes to recovery for different addictions.

Ideas about recovery based on personal and/or professional experience. Literature on the recovery from eating problems is also available based on personal and/or professional experience. In an article by Epston, Morris, and Maisel (1995), four steps to recovery from anorexia nervosa and bulimia nervosa are outlined based on the authors' clinical experiences. The first step is "breaking the spell of anorexia/bulimia" and involves the person becoming more aware of the physical, emotional, spiritual, and relationship costs of what the authors call "an allegiance to an anorexia/bulimia lifestyle."

At this stage the person's life may feel unendurable and the person may feel required to choose between self-exhaustion or commitment to fighting the eating problem. The second step involves "turning against anorexia/bulimia." The individual starts to move in the direction of self-acceptance and away from self-denial and self-punishment.

The third step in the recovery process is described as "reclaiming a life and making an appearance in it." A number of events occur in this stage. The person recognizes and feels an entitlement to feelings, appetites, desires, opinions, and thoughts. Previously forbidden emotions return. Existing relationships often come up against challenges, and many are ended, deferred, or revised. The relationships that are being revised may be re-described as abusive or one-sided. And finally the person starts reclaiming their future visions and dreams and also feels considerable grief for what has been lost. The last and fourth step in this process is "post-liberation." The person has started to separate from the eating problem and begins to enjoy their new lifestyle without the problem. At this stage self-appreciation replaces self-hatred and punishment (Epston et al., 1995).

Goldkopf-Woodtke (2001) wrote an article based on her own experience of recovery from anorexia nervosa and her professional experience working with clients with eating problems. She believes that there are four ingredients that are necessary in order for recovery to occur. These include: the acceptance that a problem exists, the desire to get well, inner strength, and hope. She also suggests that the acceptance that a problem exists needs to take place at two levels of understanding: recognition that one has a problem, and admitting that one cannot deal with the problem alone.

When discussing her own recovery she mentions several important aspects of the experience: appreciating and accepting herself; learning to tolerate uncomfortable feelings and painful emotions; saying good-bye to symptoms and grieving their loss; getting over obsession with weight and food; learning to tolerate uncertainty; having support from others; and the commitment to her own well-being (Goldkopf-Woodtke, 2001).

Summary. To date the research on the recovery from BED is limited with only two studies on its course and none on the subjective experiences of recovery. However, research on the course of BED shows promising results suggesting that BED may be an unstable state with a tendency to remit (Fairburn et al., 2000). Literature on the recovery from anorexia nervosa, bulimia nervosa, and binge eating offer us more information about what individuals have said about their recovery experiences, as well as what professionals have discovered from working with clients who have eating problems.

The Process of Change

Several researchers have studied and written about how people change. This information may help our understanding of the recovery process of BED. First, research on people who have made successful changes is discussed. Second, two theories of change are outlined, Virginia Satir's theory of change and the transtheoretical model of change developed by Prochaska and DiClemente (1982). Studies evaluating the application of the transtheoretical model to people with eating disorders is also reviewed.

Successful changers

Research has shown that it is possible for people to make successful change without professional help. Schachter (1982) found that 60% of people in two community

studies made changes on their own by quitting smoking or losing weight. It has also been found that situational changes such as losing one's job, changing schools, moving to a new location, or the death of a parent serve as powerful triggers for change (Bakker, 1975).

Gross (1987, as cited in Gross, 1994) examined literature on people who have made intentional changes. He found that people who are successful in making lifestyle changes have: tried several times to change before they succeeded; worked at making change harder and longer; discovered more creative and flexible ways to make the change than those who relapsed; concentrated on what they could do for themselves instead of what others could do for them; maintained a strong commitment to making change; had a clear picture of their change target; made a public commitment to make a change; kept a clear picture of the "how" of change and their change target; felt some social pressure and/or social support to make the change; believed they deserved to make the change and believed in their ability to make the change.

Making change has been found to be a struggle and not to be a linear process. It is erratic and there are many lapses and relapses. Some changes have been found to require "letting go" of the attempt to control the process and allowing change to happen as and how it will (Gross, 1994).

Models of Change

Satir's Model of Change

Virginia Satir's model of change is thoroughly outlined by Gross (1994) and involves six stages. The first stage is labeled "status quo." At this stage there is little thought by the individual that things should be different. Life remains predictable and is

maintained by self-reinforcing repetition. In the second stage, "the foreign element," the status quo is disrupted by the entry of something external to the system. The foreign element may be a new experience, a loss, social pressure or support from significant others, situational events involving shifts in social roles, maturational or developmental events, and physical or emotional pain from an accident or illness. "The tension between the impulse to remain the same on the one hand and the impulse to change on the other, is heightened by the foreign element to set up chaos—the third stage..." (p. 99).

Stage three, chaos, is a stage of flux and involves the eruption of the tension to both resist and move toward a change. What was previously known and predictable becomes disarranged. In this stage the person may experience fear about the loss of security, anger over an imposed change, or sadness over the loss of an imagined future. Next comes implementation, stage four. Feelings that once seemed intolerable become tolerable, assertion replaces submissiveness, healthier lifestyle choices are made, and risks are now taken. Stage five is relapse, an arbitrary stage which could occur at any point between the third and sixth stages. Relapse is considered a return to the status quo. Finally stage six is the development of a new status quo. During this stage the problems of integrating the new into the old system of actions, thoughts, and feelings have been solved and the strange or new has become familiar. At this stage the support from others is essential (Gross, 1994).

The Transtheoretical Model of Change

The next theory of change, the transtheoretical model, has five stages (Prochaska & Norcross, 1999). The stages represent the various constellations of intentions and behaviours that individuals pass through as they move from having a problem to doing

something about it. The first stage is precontemplation, when the individual has no intention to change their behaviour in the foreseeable future. Contemplation, the second stage, occurs when the person is aware that they have a problem and are seriously thinking about overcoming it, but have not made a commitment to take any action. The third stage is preparation. The person at this stage is intending to take action immediately and starts to show some small behavioural changes. The fourth stage is the action stage. The individual is modifying their behaviour, experiences, and/or environment in order to overcome their problems. Maintenance is the fifth and final stage. It is the stage at which the person is working to prevent any relapses and consolidate the progress made during the action stage.

It is rare that people who are trying to make changes in their lives successfully maintain their gains with the first try (Prochaska & Norcross, 1999). Schachter (1982) found that self-changing smokers who were successful made on average three to four attempts to quit smoking before they became long-term maintainers. In addition, although linear progression through the stages is possible it is very rare, particularly with addictions. Usually change occurs in a spiral pattern (Prochaska & Norcross), with people regressing, relapsing, and recycling through the stages (DiClemente, 1999). However, people who relapse do not regress back to where they started in the beginning. Instead, each time a person relapses and goes through the stages again, they may learn from their previous mistakes and can try something new the next time (DiClemente et al., 1991).

The utility of the transtheoretical model for eating disorders. Several studies have researched the utility of the transtheoretical model of change with eating problems

(Blake, Turnbull, & Treasure, 1997; Levy, 1997; Treasure et al., 1999). This type of research is important. If the transtheoretical model is applicable to people with eating problems, therapists will be able to assess what stage their clients are in to tailor therapy to the level of readiness the client has for change (Levy, 1997).

Levy's (1997) study's results support the utility of the transtheoretical model of change for people with bulimia nervosa. Levy found that individuals in the precontemplation stage used significantly less change processes than individuals in any other stage of change (processes of change, of which there are 10, are types of coping strategies). The processes of change employed also varied depending upon the stage of change the participants were in. For example, women in the action stage used the process of change called "stimulus control," avoiding or countering stimuli that elicit problem behaviours, more frequently than participants in any other stage. Prochaska, DiClemente, and Norcross (1992) suggest that people spontaneously use different processes of change depending on their stage of change.

Blake, Turnbull, and Treasure (1997) had similar findings to Levy (1997). When comparing 51 women with anorexia nervosa with 58 women with bulimia nervosa, they found that there was an increase in the number processes of change used from the stages of precontemplation to action.

Treasure et al. (1999) also found support for the use of the transtheoretical model of change for women with bulimia nervosa. Their study showed that women who were in the action stage at the beginning of treatment improved in terms of their eating behaviours more than those in precontemplation. However, they suggest that the current

instruments that are used to measure the readiness of change may need to be modified for use with women who have eating disorders.

Summary. Research on how people change may add to our understanding about how people with BED recover. Literature on the process of change has provided information about people who have successfully changed, as well as models for understanding how people change. The transtheoretical model of change has received some support when applied to people with eating problems.

Chapter Summary

This chapter provided information on four areas of research. First, models of binge eating were presented, with preference stated for the feminist model. Second, an overview of the literature on BED was given to provide an understanding of the eating problem that was overcome by the participants in this study. Third, research on the recovery from BED, bulimia nervosa, and anorexia nervosa was presented with a focus on research highlighting the subjective experiences of those recovered. Fourthly, the process of change was discussed and two models of change were presented.

CHAPTER THREE: METHOD OF INQUIRY

The purpose of this chapter is to introduce grounded theory, provide a rationale for its use in this study, a description of the method, its application, and to evaluate its use in this research.

Introduction to Grounded Theory

The grounded theory method emerged from symbolic interaction theory, which is similar to phenomenology. Both symbolic interaction theory and phenomenology are "...concerned with the study of inner or "experiential" aspects of human behavior, that is, how people define events or reality and how they act in relation to their beliefs" (Chenitz & Swanson, 1986, p. 4). Therefore, grounded theory places importance on having the researcher understand the behaviour as the participant understands it, which is done by examining participants' self-definitions and shared meanings.

The purpose of grounded theory methodology is to generate explanatory theory (Strauss & Corbin, 1990) about social or psychological phenomena (Chenitz & Swanson, 1986). A systematic set of procedures is used to develop the inductively derived grounded theory about a phenomenon (Strauss & Corbin, 1990). The theory then serves to interpret, or explain and predict, the phenomenon under investigation. A new perspective or viewpoint of a phenomenon is created through the theory which allows us to understand behavior in new or different ways (Chenitz & Swanson, 1986).

Grounded theory is valuable in several regards. For instance, the new theory developed using this methodology can be useful in advancing already existing theory (Glaser & Strauss, 1967). One way this is accomplished is by allowing the researcher to gain a fresh perspective in a familiar situation (Stern, 1980). In addition, the grounded

theory can generate useful practical applications (Glaser & Strauss, 1967). Because the resulting theory emerges as an entirely new way of understanding the observations from which it is generated, this new understanding permits the development of relevant interventions in the social environment under consideration (Hutchinson, 1986). As well, grounded theory can guide and provide a style for research on particular areas of study (Glaser & Strauss, 1967).

Grounded theory is particularly useful in preliminary, exploratory, and descriptive studies (Glaser & Strauss, 1966). If little is known about a topic and few adequate theories exist to explain or predict a group's behaviour, it is impossible to test existing theory or utilize identified existing variables. In order to find out what is going on in the area under study, use of grounded theory is appropriate in discovering the problems that exist in the social context, and how persons involved handle them. Hypotheses regarding previously unexamined situations are allowed to emerge from the data using grounded theory (Stern, 1980). Grounded theory can then also be a precursor for further investigation in an area of study (Chenitz & Swanson, 1986).

However, in order to be useful, the theory must "fit" the situation being researched, have "grab," and "work" when put into use (Glaser & Strauss, 1967). In other words, in order to "fit," the categories that are generated must be indicated by and applicable to the data. To have "grab," the theory must speak to, or be relevant to the social or practical world, and to the persons in that world. And finally, to "work," the theory must have relevance or usefulness to explain, interpret, and predict the phenomenon under study.

Rationale for Using Grounded Theory

A grounded theory methodology was chosen to study women's experiences of recovery from BED for the following reasons.

Grounded theory methodology allows for the analysis of social processes (Fagerhaugh, 1986). This method is appropriate when one is looking to account for change in the social phenomenon being studied over time. Grounded theory allowed me to capture women's experiences of recovery from BED over the period of recovery, which was one of the purposes of this study.

As well, the research questions used in grounded theory studies tend to be oriented towards action and process (Strauss & Corbin, 1990). The question I posed at the beginning of each interview, "How were you able to recover from binge eating?," allowed participants to speak to their recovery experience, from the time in their lives when they were actively engaging in binge eating, until their present recovery.

Grounded theory is also an appropriate method for use in an area that is being explored for the first time (Glaser & Strauss, 1966). Because the study of the strategies and factors helpful to the recovery from BED, or the recovery process itself, has not been previously explored, this method was well suited for this area of investigation. In addition, grounded theory allowed for the development of a theory to give meaning to the participants' experiences, another purpose of this study.

Finally, the grounded theory method stresses that the meaning of the experience must be understood from the perspective of the participant (Chenitz, 1986). This aligns with my own values. I believe it is important to understand experiences from the participant's point of view, instead of studying them and making judgements about their

experiences, without asking for their feedback. It is also my opinion that it is necessary for researchers to verify that participants are in agreement with the results that emerge from the study, rather than for researchers to theorize about what they have learned, and assume that the results of the study are true to the participants' experiences. Verification of the participants' experiences was used in this study in order to substantiate that the theory I created was true to the spirit of their recovery stories. The method of this verification is further elaborated later in this chapter.

Grounded Theory Methodology

Grounded theory methodology uses a constant comparative method of analysis, with comparisons made continuously throughout the research process. Comparisons are made between the interviews to check for similarities and differences, as well as with the literature, which is also considered a source of data (Chenitz & Swanson, 1986). There is a continual interplay between analysis and data collection. The researcher moves back and forth between collecting data and data analysis (Glaser & Strauss, 1967). The data are also compared and contrasted again and again to provide a check on their trustworthiness (Hutchinson, 1986). The theory that emerges from this process is grounded in the data, rather than in the expectations of the researcher (Glaser & Strauss, 1967).

In addition to the constant comparative method of analysis, grounded theory methodology also employs a particular approach to theoretical sensitivity, sampling, and data analysis.

Theoretical Sensitivity

Theoretical sensitivity refers to a personal quality of the researcher, and indicates an awareness of the subtleties of meaning of the data (Strauss & Corbin, 1990). Despite the level of theoretical sensitivity of the researcher, it is important that throughout the research process the researcher maintains an attitude of skepticism. The researcher may ask herself questions such as "What is going on here? Does what I think I see fit the reality of the data?" This is done in order for the researcher to challenge herself and her assumptions about what is emerging in the data.

Theoretical sensitivity comes from and can be developed by the researcher through various sources. These sources include literature, professional experience, personal experience, and the analytic process.

Literature. Theoretical sensitivity can be developed by reading literature, such as theory, research, or documents. From reading literature in an area of research, the investigator may become "sensitized" to what is occurring with the phenomenon they are studying (Strauss & Corbin, 1990).

However, Glaser & Strauss (1967) warn against the investigator becoming too familiar with the research in the area under study. In fact, they suggest that the researcher literally ignore the literature at first so that the emergence of categories will not be contaminated by concepts more suited to different areas. Later, similarities and convergences with the literature can be established after the analytic core of categories has emerged.

While working on this research I had to balance my use of the literature as a source for theoretical sensitivity. At the start of the research it was necessary that I become somewhat familiar with the literature in order to establish whether there was a

need for this research. Once that was demonstrated, I ignored the literature while interviewing participants and developing the grounded theory so as not to influence the findings. Once the grounded theory had been established, I went back to the literature in order to substantiate the theory.

Professional experience. Knowledge which comes from working in a particular field may help the researcher understand events and actions they observe. A researcher may also reach an understanding more quickly than someone who does not have any experience in the field or may be prevented from seeing more obvious themes (Strauss & Corbin, 1990).

As a counsellor who works with clients with BED, I am aware of the struggles that are involved in recovery. Overall, my professional experience was an asset as it helped me to interpret that data more easily. At the same time, I was mindful of the need to look for themes that were grounded in the data. I frequently reviewed the data in order to look for missing information. I also consulted with my supervisor, who encouraged me to continually reflect upon my interpretation of the data and provided me with alternative viewpoints.

Personal experience. Drawing upon personal experience may give the researcher a basis for making comparisons that help stimulate the generation of potentially relevant concepts, and the relationships of the concepts in regard to the topic of study (Strauss & Corbin, 1990). Sensitivity is enhanced from personal experience as long as the researcher is open to others' experiences being different and unique from their own.

As I mentioned in the introduction, I have had my own experience with binge eating. Although I have never met the DSM-IV criteria for BED, I was able to relate to

some of the experiences of the women I interviewed. Despite the assumptions I have developed about recovery from my personal and professional experience, I believe that I remained open to the data (these assumptions are outlined further on in the chapter). Some of the women I interviewed experienced recovery in a way that was different from what I expected. However, I was conscious of the need to include every participant's experience in the grounded theory.

Analytic process. The process of analyzing the data may increase the researchers insight and understanding about the phenomenon of study. From collecting and asking questions about the data, making comparisons, thinking about what they are seeing, making hypotheses, developing small theoretical frameworks about concepts and their relationships, researchers may expand upon their theoretical sensitivity. Throughout the research process the researcher's ideas and insights will likely build upon each other, giving meaning to data which previously appeared to have no meaning (Strauss & Corbin, 1990).

Theoretical Sampling

Sampling decisions are not predetermined but are guided by the emergence of the grounded theory (Glaser & Strauss, 1967). Theoretical sampling, the selection strategy used in grounded theory, is accomplished by moving from one participant to the next while developing categories and building theory (Corbin, 1986). This sampling strategy is based on the need to collect more data to examine categories and their relationships, and to assure that representativeness of the categories exist (Chenitz & Swanson, 1986).

Due to the manner in which theoretical sampling proceeds, it is necessary for the researcher to simultaneously collect, code, and analyze the data. Hypothetical

connections are developed by the researcher who then substantiates these by reviewing the data, field notes, literature, or by consulting with the participants. The emerging hypotheses then guide further sampling directions (Chenitz & Swanson, 1986).

The selection process in this study occurred as outlined above. Participants were selected if thought they would be able to illuminate the phenomena under study, i.e. the recovery process from BED (Sandelowski, 1986). After the first four participants were selected and interviewed, a working theory of recovery was developed. In order to provide more variation to the theory, the next participants who were selected for the study had to be different from the previous participants in some way. For example, participants who had been recovered for a longer period of time than the others, or participants might be those who struggled with binge eating for a longer period of time.

Sampling occurs until theoretical saturation of each category is reached (Glaser & Strauss, 1967). A researcher will know that saturation has been reached when the following occur: no new or relevant data emerge regarding a category; the category development is dense, such that all of the paradigm elements are accounted for, along with variation and process; the relationships between categories are well established and validated (Strauss & Corbin, 1990). In this study, selection continued until saturation was reached with a total of six participants.

Selection of Participants

Recruitment of participants for this study was done by word of mouth, through posters placed across the University of Calgary campus and at various locations in the community, and by contacting Overeaters Anonymous (OA).

The posters used in recruitment explained that participants should be women over the age of 18 who have recovered from binge eating for a minimum of six months (Appendix A). Those who were interested in participating were able to contact me by telephone at the number provided on the poster or by email.

Contact made with Overeaters Anonymous (OA) was done by telephone. I spoke with a contact person for that organization and explained my research as well as the requirements for participation. This information was passed on to members of OA along with my phone number.

Once I was contacted by a potential participant, I explained the nature of the study and the time commitment involved. If the woman agreed to participate I administered a screening questionnaire over the telephone to make sure she was an appropriate participant for the study (Appendix B). Criteria included that she must be over 18, have at one time met the DSM-IV (American Psychological Association, 1994) criteria for BED, and be recovered for a minimum of six months. If she qualified for the study, we then agreed on a time to meet for the interview at a mutually agreed upon location.

However, if the potential participant did not qualify for the study, she was informed that she did not meet the criteria for participation. She was then thanked for her interest and her time.

In total nine women contacted me about participating in this study. Six women qualified for and participated in this study. Three women were not appropriate because they did not meet the criteria for BED. One woman's past eating problem met the criteria for anorexia nervosa. I conducted an interview with this woman thinking she may have at one time met the criteria for this study; however, she did not. The interview was not

used as data. The two other women who did not qualify met the criteria for bulimia nervosa, one was not yet recovered while the other was.

The selection of participants and interviewing took place over the period of one year, March 2000 to February 2001.

Table 1: Participant Demographics

Participant (Pseudonym)	Present Age	Age of Approximate Onset Of Binge Eating	Length of Recovery (Years)
Jasmine	32	11-12	4
Marie	32	10	2-3
Lisa	26	12	3
Elizabeth	30	22	1-2
Danielle	32	8	12
Catherine	46	4-5	10

Data Collection

The Interview Process

Two interviews were conducted with the majority of participants. The first interview was unstructured, which is the most commonly used type of interview when employing the grounded theory method (Swanson, 1986). This interview format allowed the participants to describe their experiences of recovery in their own words.

At the outset of the first interview participants were given a cover letter (Appendix C) to read, as well as two copies of a consent form (Appendix D) to sign before the interview took place. Each participant was asked to provide a pseudonym for

confidentiality purposes. Next she was asked the open question: "How were you able to recover from binge eating disorder?" (see Appendix E for the interview guide).

The second interview that took place was more structured and narrow in focus (Swanson, 1986) to address any missing information. To facilitate the process before the second interview took place, a transcript of the first interview was given to the participant for her review. The participant had the opportunity to read the transcript and to make any corrections or clarify any misinterpretations in the transcript.

Two interviews were conducted with four of the six participants for a total of 10 interviews. Two participants did not feel they had anything to add or change to the first interview.

The length of the interviews ranged from 1 hour to an hour and 45 minutes. On average, the interviews were approximately 1 hour and 20 minutes in length.

After the interviewing process was completed with all of the participants, I sent them each a copy of the emerging theory for review. I asked the participants for feedback in order to ensure the trustworthiness of the developing theory. I received feedback on the phone, or via email. I then made notes to record any necessary corrections to the transcripts, categories, and theory.

Data Transcription

Each interview was audiotaped with the permission of the participants. After each interview, the audio recordings were transcribed by the researcher. This allowed me to constantly compare each interview throughout the research process as is required when using the grounded theory method.

Copies of the transcripts were stored in the following way: one copy on a computer disk and one printed copy both stored in my home filing cabinet. The audiotapes were also stored in my home filing cabinet. My home filing cabinet was kept locked at all times, accessible only to myself.

Compliance with Ethical Standards

The following section outlines the measures that were taken in order to ensure compliance with ethical standards. The measures were taken to ensure that participants provided informed consent to participate in the study, that their confidentiality was protected, and they were aware of the risks and benefits of participating.

All participants were given an explanation of the purpose and nature of the study in the form of a cover letter (Appendix C) prior to their involvement in the study and prior to signing a letter of consent (Appendix D). Participants were informed of their right to withdraw from the study at any time. Furthermore, participants were informed of the risks and benefits involved in the study. They were given the option to terminate the interview at any point if they became overly distressed. Participants were also provided with a number to a distress line that they could call 24 hours a day if they felt the need, and I informed them that I would arrange for psychological services if required. In addition, I was available to address any questions or concerns of the participants if they so chose.

Confidentiality was maintained by having the participants choose a pseudonym at the beginning of the study. No identifying information of the participants was shared with anyone and no identifiable information will be used for teaching, publication, or any other scientific purpose. All interviews were audiotaped with the participants' consent.

All participants were informed of the risks and benefits of participating in the research (Appendix C). As mentioned previously, participants were told that discussing their recovery stories might put them at risk for emotional upset and distress. They were also informed of the potential benefits of participating in this study. The benefits included developing new insights into their experience of recovery, possibly experiencing catharsis, making their stories available to women who are currently struggling with BED, and contributing information which may be useful to counsellors working with people who have BED.

Data Analysis

Data analysis during the grounded theory research process occurs in a non-linear fashion. Several research processes are in operation at once (Stern, 1980). According to Maxwell and Maxwell (1980), these research processes include: the collection of empirical data, concept formation, concept development, concept modification and integration, and the production of the research report.

Almost from the beginning of the study, data are examined as they arrive. The data is coded, categorized, conceptualized, and thoughts concerning the research are written down in the form of memos (Stern, 1980). The data collection and analysis continue to proceed simultaneously, and the theory is constructed from the data itself (Charmaz, 1983).

The procedures for the grounded theory method outlined by Strauss and Corbin (1990) were followed for this study. The next section elaborates on the coding procedures, as well as memo and journal writing used in the development of the grounded theory of recovery from BED.

Coding

Three different types of coding occur during the data analysis of the grounded theory method: open coding, axial coding, and selective coding (Strauss & Corbin, 1990).

Open coding. The first step of analysis was coding data and writing memos about the concepts that recur in the data (Corbin, 1986). Coding of the data at this stage is called open coding, although open coding continues to take place throughout the data analysis process. Open coding is the naming and categorizing of the phenomena through close examination of the data (Strauss & Corbin, 1990). Questions such as "What do I see going on here?" "What are people doing?" "What is happening?" were asked during this stage (Charmaz, 1983).

To start the analysis process the data were broken down into concepts, which are the basic units of analysis (Strauss & Corbin, 1990). All identified concepts were cut from the transcripts. These concepts were then grouped into substantive codes, which reflected the substance of what participants had said (Glaser & Strauss, 1967). The substantive codes were organized with labeled envelopes. For example, any comment that participants made about starting to eat food that they had previously considered forbidden, was given the substantive code name "incorporating forbidden food" and put into the same envelope. Substantive codes based only on the data aids in the prevention of the researcher from imposing preconceived impressions on the data (Hutchinson, 1986).

Next the codes were compared, similar codes were clustered and given an initial label, and categories were formed (Chenitz & Swanson, 1986). Categories were then given conceptual names, which were more abstract then the names given to concepts

(Strauss & Corbin, 1990). For instance, the substantive code of "incorporating forbidden food" was grouped with other substantive codes that were related to the food strategies women used in order to facilitate recovery from binge eating. Codes such as "stopping all diets," "not eating when emotional," and "eating when hungry," were grouped under the category name "changing relationship to food."

Following the formation of categories, the emerging categories were then compared with each other to ensure that they were mutually exclusive and covered behavioural variations (Hutchinson, 1986). Categories were also developed in terms of their properties, which could then be dimensionalized. Once identified the properties or the specifying features of the category became the categories' sub-categories (Strauss & Corbin, 1999). For example, the category of "distress" had many properties. One of these properties or sub-categories was "experiencing fear." A dimension of "experiencing fear" was the degree of fear felt by the participants. This category development formed the basis for making relationships between categories, subcategories, and between major categories (major categories are discussed in the following section).

Axial Coding. Axial coding is the process of putting data back together in new ways by making connections between a category and its subcategories (Strauss & Corbin, 1990). This process leads to the development of what eventually become the main categories, as well as helping to develop these categories beyond their properties and dimensions.

The manner in which the categories were developed further was by using the paradigm model (Strauss & Corbin, 1990). The paradigm model helped to link

subcategories to a category and categories to major categories in a set of relationships. These relationships denote causal conditions, phenomenon, context, intervening conditions, action/interactional strategies, and consequences. This paradigm model was used by focusing on "...specifying a category (phenomenon) in terms of the conditions that give rise to it; the context in which it is embedded; the action/interactional strategies by which it is handled, managed, carried out; and the consequences of those strategies" (p. 97).

To illustrate the process of applying the paradigm model, the following description of linking categories to major categories is provided using examples from this study. It is important to note that the development of the major categories occurs at the same time that categories are being compared to the paradigm model.

First each category was compared to the paradigm model, finding the best fit between the categories and the paradigm model. For example, regarding the category "attempting to recover" I asked myself whether it was a context, an intervening condition that facilitated or constrained strategies in a specific context, a strategy carried out under a specific set of perceived conditions, or a consequence of strategies (Strauss & Corbin, 1990). I determined that "attempting to recover" was in fact a strategy influenced by the condition of "distress."

While comparing the categories to the paradigm model I remained conscious of how the categories grouped together into phases of recovery (the major categories). When four phases emerged after comparing the categories to the paradigm model, each phase was given an abstract label to capture the process that was occurring in that phase. For instance, the categories of "dissatisfaction" (context), "wanting something better for

self" (intervening conditions), "seeking information" (strategies), and "gaining awareness" (consequences), were included in the major category labeled "assessing present life situation."

However, I continued to question how the categories related to each other, as well as to the major categories. Necessary changes continued to be made, such as moving a category to another phase or re-labeling a category in terms of the paradigm model. For example, I re-labeled the category "learning" as a context rather than a condition of the third phase.

Selective coding. Selective coding is the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development (Strauss & Corbin, 1990). At this stage the primary task is the integration of the categories to form a theory.

The core category is the central phenomenon or basic social process around which all the other categories are integrated. Therefore, the core category must be abstract enough to encompass all that is described in the theory (Strauss & Corbin, 1990). The theory should also be explained by the core category. In addition, the core category should solve or process the problem that is being addressed, and explain as much variation in behaviour as possible, and use the fewest number of concepts possible (Fagerhaugh, 1986).

The core category in this study was identified by asking several questions about the data. Questions included: "What seems to be the main story line, the main pattern or theme that I see happening over and over again?" "What category do all the other categories seem to be leading up to or pointing to?" "Which category seems to be of a

higher level of abstraction than the others?" (Corbin, 1986, p.99). Asking myself these questions led to the discovery of the core category "self-awakening." The core category or basic social process of "self-awakening" that emerged in this study will be discussed further in the next chapter.

The integration process of the categories at the selective coding stage was similar to that of axial coding; however, it was done at a higher, more abstract level of analysis. There were five steps involved in the integration process which were not meant to be followed in a linear fashion, but rather used when needed. These steps included: explicating the story line; relating subsidiary categories around the core category by means of the paradigm; relating categories at the dimensional level; validating those relationships against the data; and filling in the categories that needed further refinement and/or development (Strauss & Corbin, 1990).

Further data collection and analysis then produced more categories. At each phase of the grounded theory, hypotheses were generated about the categories, their relationships and interrelationships, and these hypotheses were tested with the data (Chenitz & Swanson, 1986). Hypotheses were discarded if they were not found to be accurate. As well, I remained on the lookout for any contradictory data. This meant investigating unusual circumstances or occurrences of data which did not fit with what had already been found. Any contradictory data that surfaced was kept to add to the richness of the theory as it progressed (Hutchinson, 1986).

The data collection continued until the categories became saturated (Corbin, 1986). Relationships between the categories continued to be developed until a pattern among relationships emerged. Analysis focused on the interrelationships between

categories, and a theory about the relationships was produced (Chenitz & Swanson, 1986).

Memos

Writing was done throughout the research process and was recorded in the form of memos. Memos are the written capsules of analysis which serve to store the ideas generated about the data. The process of memo writing and sorting allows the researcher to identify areas for further clarification, refinement, and verification, as well as to lead to further data collection (Chenitz & Swanson, 1986). The memos show the theory being developed step by step, and allow the researcher to keep a record of and order the results of analysis (Corbin, 1986).

While writing memos, I asked myself what relationship one code or category had to another. I asked questions such as "Are they separate codes? Is one code a property or a phase of another? Is one event the cause of another or the consequence? What are the conditions that influence the codes?" (Hutchinson, 1986, p. 123). This questioning allowed for repetitive examination of the data and elaboration of ideas about the data and the coded categories (Charmaz, 1983).

The sorting of memos was also an important step in the development of the theory. The object of sorting is to put fractured data into a coherent and workable whole (Hutchinson, 1986). The sorting of the memos provided an opportunity to cluster concepts (Stern, 1980). Memos which discussed the same category were put together in order to clarify its dimensions and to distinguish it from other categories.

Memos were also sorted into phases of the process under study (Charmaz, 1983). This facilitated the generation of a theoretical outline that integrated the main ideas of the

theory (Hutchinson, 1986). The piles of sorted memos facilitated the writing of the theory. Once the piles were sorted I was able to describe in writing the contents of the memos, which had been organized in such a way that the best integration of the theory was achieved (Stern, 1980). These memos formed the core of the paper and often reflected the ordering of experiences the data represented (Charmaz, 1983).

It is important to note that both during and after the initial writing of the theory I continued to memo and reconceptualize parts of the theory.

Journalling

It is recommended that researchers keep a journal throughout the research process (Hutchinson, 1986). Keeping a journal provides a place for the researcher to express personal feelings and reflections to help to sustain a heightened level of awareness. As Hutchinson points out, "...one must become aware of personal preconceptions, values, and beliefs. Only through self-awareness of mind-set can the researcher begin to search out and understand another's world. Such understanding is vital to the world of research" (p. 115).

Throughout the research process I kept a journal to record my personal preconceptions, feelings, and reflections. This journalling process was helpful in that it enabled me to remain aware of the biases that may have been influencing the way I viewed and interpreted the data.

The following section outlines my personal preconceptions.

Personal Preconceptions

My personal preconceptions are the result of being a therapist who works with clients with BED, as well as from my own experience with binge eating. As a

consequence of journalling during the research process I became aware of several of my preconceptions.

It is my belief that binge eating develops as a way to cope with emotions and the difficulties that a person may encounter in life. I think that in order to recover, it is important for people who binge eat to find other ways of coping. As well, for some people it may be necessary to address any personal issues that they may be trying to cope with, such as abuse issues or problems in family relationships.

It has also been my belief that in order to recover from binge eating, the individual has to have the desire to recover. While working with my clients who have BED, I have found that the clients who really want to recover have been more successful than those who are ambivalent. As well, I think that the desire to recover stems from binge eating no longer serving its purpose, i.e. creating more problems in the person's life than it is helping.

Furthermore, I think there is a connection between binge eating and low self-esteem. I have noticed that people with BED do not feel very positive about themselves. I feel that addressing self-esteem issues is important to the recovery process.

Finally, I believe that the way people view recovery from BED likely changes the longer they have been recovered. For instance, people who have recently recovered may be more worried about relapse than those who have been recovered for a number of years.

Evaluation of Trustworthiness

Quantitative and qualitative research are based on different underlying assumptions. The underlying assumption of quantitative research is that there is one

reality or truth, and through systematic observation and scientific methods, it is possible to discover this reality or truth (Usher, 1996). On the other hand, qualitative research is based on the assumption that there are multiple socially constructed realities (Mertens, 1998).

Due to the fact that quantitative and qualitative research are based on different assumptions, it is necessary to evaluate these two paradigms using different criteria in order to fit with these underlying assumptions (Guba, 1981). Strauss and Corbin (1990) propose that although grounded theorists believe that the usual canons of "good science" should be kept, they require redefinition in order to fit the realities of qualitative research, and the complexities of social phenomenon under investigation.

The methods of evaluation of quantitative research have been adapted by qualitative researchers to better fit with the assumptions of the qualitative paradigm. Trustworthiness is evaluated in qualitative research through credibility, transferability, dependability, and confirmability, instead of the quantitative evaluation methods of internal validity, external validity, reliability, and objectivity (Guba, 1981). Each of these qualitative methods for evaluation of trustworthiness is explained and discussed in relation to this study.

Credibility

A qualitative research study is thought to be credible when it presents faithful descriptions or interpretations of a human experience. The descriptions or interpretations should be recognizable to the people who have had those experiences and that they recognize them as their own experiences (Sandelowski, 1986).

The testing of credibility in qualitative research is often referred to as doing "member checks." In other words, testing the data with members of the group who are being studied (Guba, 1981). In this study, I consulted with the participants about the accuracy of their transcripts and also about how well the emerging theory fit with their experiences. This allowed me to confirm that both the interviews and the theory I developed were true to the information that the participants shared with me.

To establish credibility, the researcher can also demonstrate referential adequacy. This was done by testing the analysis and interpretation of the data against literature that was collected for this purpose. It is assumed that the researcher will have collected referential adequacy materials during the study (Guba, 1981). This aspect of credibility is an important part of the grounded theory method itself. Throughout this study the constant comparison method was employed which lends credit to the findings of the research. The evolving theory was not only compared with the literature, but also with the data.

Prolonged engagement with participants is another tool suggested to enhance credibility (Guba, 1981; Sandelowski, 1986). Contact between myself and the participants included at least two phone conversations (in order to complete the screening questionnaire and set up meeting times), and one to two interviews. This period of contact allowed a rapport to be built between myself and the participants, which I feel allowed for an open and honest sharing of personal information.

Transferability

In contrast to quantitative researchers, qualitative researchers do not support the concept of generalizability. The reason is based on the idea that all social/behavioural

phenomena are context-bound, and therefore it is not possible to develop truth statements that have general applicability (Guba, 1981). Instead there are only statements that are descriptive or interpretative of a given context. Therefore, the term generalizability is not used by qualitative researchers, but rather transferability.

A study is considered to have met the criteria for transferability when its findings can fit into contexts outside the study situation, and when its audience views its findings as meaningful and applicable in terms of their own experiences (Guba & Lincoln, 1981). To ensure transferability researchers may use theoretical or purposive sampling and collect thick descriptive data (Guba, 1981).

Theoretical sampling, which is an integral aspect of the grounded theory method, was discussed earlier in this chapter in relation to this study. Participants who were thought to be able to contribute to the theory of recovery from BED were selected, as well as participants who could add variation to the theory (Sandelowski, 1986). The participants all had unique experiences of recovery. Both their differences and similarities in experience likely helped to establish transferability to other women who have recovered from BED. In order to ensure transferability of the theory, the findings must be "well grounded in the life experiences studied and reflect their typical and atypical elements" (Sandelowski, p. 32).

Collecting thick descriptive data was also a method used in this research (Guba, 1981). The interviews were unstructured and open ended questions were used to allow the participants to freely share their experiences. In most cases, two interviews were conducted in order to gather any missing information. This allowed for rich description of the grounded theory, lending corroboration to the transferability of this study.

Dependability

Dependability refers to the stability of the data. The researcher must take into account the apparent instabilities which may arise either because different realities are being tapped, or because of instrumental shifts which stem from developing insights on the part of the investigator-as-instrument (Guba, 1981).

In order to establish dependability several methods can be used. Some of these methods include using multiple data sources and observers (Hall & Stevens, 1991), as well as a leaving a clear "decision" or audit trail (Guba & Lincoln, 1981).

A number of data sources, as well as observers were used in this study. The interviews with six participants and a large pool of literature were taken as sources of data. There were also several people, including the participants and my supervisor, who were consulted in regard to the developing theory.

In addition, an audit trail was developed while generating the theory of recovery. An audit trail takes the form of documentation, such as interview notes, and a running account of the process, such as the researcher's journal (Guba, 1981). This allows an external auditor to examine the processes in which the data were collected, analyzed, and interpreted. As mentioned earlier, I kept a journal as well as wrote memos throughout the research process. This allowed me to keep track of the theory as it developed step by step, and to leave a clear trail concerning my decisions about the study from beginning to end (Guba & Lincoln, 1981).

Confirmability

In qualitative research, researchers do not accept the idea of investigator objectivity as quantitative researchers do (Guba, 1981). Instead there is the concept of

data and interpretational confirmability. Confirmability can be achieved through practicing reflexivity.

Practicing reflexivity is to "intentionally reveal to his [or her] audience the underlying epistemological assumptions which cause him [or her] to formulate a set of questions in a particular way, and finally to present his [or her] findings in a particular way" (Ruby, 1980). Reinharz (1979) also recommends that the researcher discuss personal assumptions, and document shifts and changes in orientation. One way this can be done is by means of journalling. As previously discussed, I kept a journal throughout the research process to record my own assumptions, as well as to monitor my thoughts regarding data and the evolving theory. My preconceptions or assumptions were outlined earlier in the chapter. Memos were also kept which documented the changes made to the theory as it shifted.

Summary

This chapter provided an overview of the grounded theory method. The rationale for using this method was given, as well as how the grounded theory method was applied in this study. The approaches to theoretical sensitivity, sampling, and data analysis particular to grounded theory were outlined, as well as compliance with ethical standards and my personal preconceptions. Evaluation of trustworthiness was also discussed, with a focus on this specific project.

CHAPTER FOUR: A GROUNDED THEORY OF RECOVERY FROM BINGE EATING DISORDER

This chapter outlines the grounded theory of recovery from BED. The theory is divided into four phases and each phase is introduced in turn. Once the theory is explained, the process of recovery is commented upon, the core category is presented, and a discussion of how the core category is related to the theory follows.

The Grounded Theory of Recovery

The theory of recovery from BED was derived from the interviews of six women. In some cases the words of the participants were used to name the phases, categories, and codes; in others, the names were chosen based upon my experience with the data.

The categories of each phase are organized by use of the paradigm model (Strauss & Corbin, 1990). As discussed in the previous chapter, the paradigm model was employed to show connection and denote relationships between the categories. This model is comprised of the following: causal conditions, phenomenon, context, action/interactional strategies, intervening conditions, and consequences. Only the relationships that were applicable to the theory of recovery were used.

Although the phases of recovery are presented in a linear fashion, it is important to note that the phases are not meant to be taken as such. In fact, the phases of recovery occur in more of a spiral manner. Even though it is possible for a person to go through the phases in a linear direction, the majority of women I interviewed did not experience recovery in this way. The women moved back and forth between the phases a number of times, and for various periods of time. There is no one way to assume that recovery takes place.

Phase I: Self-reflecting

During this phase of recovery, the participants reflected on themselves and what was happening in their lives. This self-reflection helped get the recovery process started by initiating self-analysis of the women's life situations. The self-analysis set the stage for the possibility of recovery to follow. See Table 2 for a summary of Phase I.

Context

There were two main contexts affecting the women's lives at this stage. These contexts were **life changes/transitions** and **disapproval from others**.

Life Changes/Transitions

The participants experienced life changes or transitions in their lives at the time their recoveries began. The **life changes/transitions** took several different forms. These changes included moving, the death of a loved one, the ending of a relationship, starting a new job or school, and having a birthday. Some of the participants experienced more than one of the above listed life changes or transitions. As well, at least one woman experienced some of these **life changes/transitions** at different times in her life which encouraged a number of attempts to recover. However, not all of these attempts were met with success, and she remained in this first phase of recovery for a number of years.

Moving. Moving occurred in various forms. For instance, some women moved to a new city, while others started living on their own for the first time in their lives. A couple of the participants experienced both. Another participant moved into a new home.

The death of a loved one. One participant experienced the death of a close family member. As Marie explained,

Table 2

Phase I: Self-reflection

Paradigm model	Categories	Sub-Categories
Context	Life changes/Transitions	
	Disapproval from others	
Condition	Distress	Experiencing fear Experiencing negative feelings about self Experiencing a low point Experiencing isolation Experiencing physical discomfort Experiencing obsession Feeling out of control Feeling unaccepted by others Practicing self-punishment
Strategies	Attempting to Recover	Seeking help Focusing on weight loss
Consequences	Contemplating	Noticing a lack of change Wondering what is going on
	Desperation	

> I think it all came to a head when my dad passed away. And my dad, he did a lot of things right, but the one thing that he could never get a hold of was that I was his fat daughter, so he would reinforce that I was fat. So I think that him dying was probably, like I didn't have anyone to be mad at anymore about it...I had no one else to blame for who I was and how I was...

The ending of a relationship. Ending relationships was common, some of which were described as abusive.

Starting a new job or school. Some participants started a new job during this phase of recovery, or began University. As Catherine described,

> I had just started working in a business that I really enjoyed, work that I really loved doing. I had moved into my own brand new condominium, new everything, it was wonderful. I had a really nice severance package from this oil company I used to work for, and life was just wonderful, and I was eating my face off...I can remember sitting there at this table and looking at myself in this mirror...I was absolutely loaded on this carbohydrate high, thinking "What the hell is going on? I'm supposedly happy right?"...And that's when I really, really had to look at my real recovery, and for me it really took off at that point.

Having a birthday. One participant felt that her 30th birthday was a significant transition affecting her recovery experience.

Disapproval from Others

Several of the participants felt that they received disapproving messages from those around them. The disapproving messages were often about the amount of food that they were eating or about their body size. The women were either directly told these messages, or indirectly told by use of jokes or body language. The messages came from family members or family friends, members of the opposite sex, or even from strangers. The women discussed these experiences: "Having family members sit around and make fun of your weight and you just laugh along, even though it hurts."

> It was brought to my attention by men...like "Look at how much you're eating, isn't that a lot? Isn't that kind of piggish?" And it didn't even dawn on me that

there was something wrong with that. It was because that's what I'd always done. I'd always just thought I just had a big appetite.

Intervening Conditions

Distress

In this phase of recovery the women appeared to be in **distress**. This **distress** took several forms which included experiencing fear, negative feelings about self, a low point, isolation, physical discomfort, obsession with weight and food, feeling out of control, feeling unaccepted by others, and practicing self-punishment.

Experiencing fear. The fear that the participants talked about had several sources. Some women were afraid of getting larger, others were afraid of their lack of control over food, and some were fearful of the effect of binge eating on their physical health. The following comments illustrate their fears:

> ...I realized I couldn't control my eating. It was a scare for me. I went deeper and deeper into diet to diet to diet, because I wanted to keep myself thin. But at the same time I just wanted to stuff myself. I didn't feel like I had any control over it.

> ...I got really scared of all those foods, and when I was dieting I wouldn't allow them in my house, and I remember I got mad at my roommate one day and I told her to hide her junk food under her bed otherwise I'd steal it. That's how in fear I was.

> ...I felt so crappy. I knew that if I didn't stop that my weight, even though I had trouble accepting that if I didn't stop that my weight would really escalate. Because after I would lose so much weight I would gain so much weight. And we're not talking little amounts of weight. Like I could lose 10 lbs. and gain 25 lbs. So I was gaining a lot in between. I was gaining way more than I ever lost. And that was becoming really apparent to me, so I was really scared, because I was starting to be really unhealthy. I felt really physically awful, so I really did want to stop.

Experiencing negative feelings about self. The women were very clear about the negative feelings they had about themselves before recovery. These negative feelings led

to negative self-talk, and in some cases isolation from others. And not only did these negative feelings extend to how they felt about themselves as people, but also how they felt about their bodies. The participants recalled these negative feelings about themselves: "I still wanted to be skinnier. I still didn't like myself that much. I still always said "Oh my stomach still isn't totally flat, I can have a better six pack."

> I think it has changed considerably because when I first turned to food I thought I was all bad. I had just felt so horrific about myself, and I had such a poor image of myself. And I think that's why I turned to food because it was something to fill that void.

> I had this idea that nobody would love me because I was so huge, nobody would want to be with me. I would be in isolation, I didn't have a lot of social networks, no dreams, I gave up on my dream.

Experiencing a low point. A number of the women expressed that they felt as though they were at a "low point," or had "hit bottom" in their lives. Some of the women inferred that experiencing this low point helped to motivate them to change what was happening in their lives. Several women described experiencing a low point: "I think I probably felt as though I had gone as low as I could in myself. Like I couldn't feel any worse about myself..." "I knew that if I didn't stop it I would have been somebody who would call Richard Simmons. I probably would have went to him. I actually hit bottom."

> ...you know how...when you're an alcoholic they talk a lot about, there will be that one day when they realized "Oh my god." You hit rock bottom. Like I know there was a time in my life where I said "I've been hating myself for 12 years, I refuse to hate myself anymore. I can't believe I've wasted so much time, I've wasted so much brain power being so cruel to myself."

Experiencing isolation. All of the women I interviewed discussed feeling isolated. This isolation could be literal, where the woman did not have many friends,

family, or opportunities for social interactions. In some cases this literal isolation was self-imposed.

On the other hand, isolation was just a feeling for others. The individuals who felt isolated may have had friends or family, but may not have felt close to them, or felt that they could not share anything personal with them. The participants expressed their feelings of isolation:

> ...I felt like there was something wrong with me, I felt like I was all alone. I felt embarrassed about it. I was ashamed about it, so that made me even more isolated...So basically I didn't tell my friends any of these things, like they didn't know any of my secrets. So my friendships, I think my friends might have thought we were close, but in reality I was keeping so much hidden and our friendships were really quite superficial.

> I just was so cut off and so alone. I had friends, but it was like, there's certain things that I didn't really want to share with them, that I didn't want to tell them, because they would use it against you.

> I weighed a lot at that point, and I withdrew from a lot of people. And realizing that I was slowly sabotaging every good thing in my life. Like not having time for friends, just wanting to be by myself. So feeling very lonely...

Experiencing physical discomfort. Binge eating led to physical pain and discomfort for many women. One woman compared the after effects of bingeing on food to being hung over from alcohol:

> And there'd be physical affects too, eventually it got to the point where I would be hung over, I really couldn't do anything more. If I was lucky I could maybe get out of bed, sometimes I couldn't even get out of bed in the morning I'd be so hung over and I'd feel so sick, so there's been some other ramifications along the way.

Experiencing obsession. Participants expressed being obsessed with food and/or their weight. These two obsessions were often experienced in conjunction with each other.

Obsession with food involved constantly thinking about food. For example, thinking about what food they wanted to eat, or what food they were going to eat for their next meal. Obsession with weight involved thinking about losing weight, which in some cases led to frequent weighing with a scale. Both of these obsessions often led to negative self-talk on the part of the women. They would berate themselves for being unable to stop thinking about food, or for weighing themselves more than they thought they should. Some examples of obsession include: "It was a very scary experience, I was always self-depricating too. It was fighting the urge to go to the fridge."

> If I didn't run I was much more concerned that day with "Oh I'm so fat I should have gone running." So it was being driven to exercise, and life was about food and exercise and the way I looked and what other people thought about the way I looked...

Feeling out of control. Feeling out of control was another common experience for the participants. This feeling of being out of control was related to eating. Most of them felt as though they could not control what they were eating, or stop themselves from eating. This feeling of being out of control is illustrated by the participants: "So I was just totally out of control, and I'd look at what I was doing and think "This is just insane." And yet I couldn't stop." "...I realized I couldn't control my eating. I didn't feel like I had any control over it." "And I felt really, I felt totally out of control and I felt like I was the worst person ever. I just felt like I was really out of control." "...knowing if I got any more out of control, and it was pretty out of control, not only was I going to look awful and feel awful, which I already did, but the problem was going to be huge."

Feeling unaccepted by others. Due to the context of "disapproval from others," many of the women did not feel accepted by those around them. This was usually due to

the negative messages they received either about their size, or about their eating habits.

The women described their experiences of feeling unaccepted:

> No it was just an awful life, being heavy and not feeling good about yourself when you're heavy. It's not necessarily being heavy, but not feeling good about it, and having society not feeling good about it. It's not a fun life.
>
> So when I say that the binge eating was a side effect, it really was a side effect of all those other issues. That was the issue of not, not feeling loved by my dad because of how I was...
>
> And that's something that I still, like I feel, like I had a real skinny sister and I still feel that pressure of being the one [who is heavier]. And I don't even think I'm fat anymore, but being that one that, now I look at her and think she's underweight, but before there was always that pressure of weight between us. Like she was always the thin one and I was always the fat one.

Practicing self-punishment. Several participants punished themselves for their binge eating. This punishment took on different forms. Some women weighed themselves repeatedly, others would eat, a couple of women exercised as a punishment, and all of the women I spoke with punished themselves with negative self-talk. In addition, one participant expressed that she sought plastic surgery as a form of punishment. Descriptions of self-punishment from the participants include: "...thinking that you've been bad and you have to eat, and you got to keep up the food intake because you've been bad." "...when I used the weight scale before it was just weighing in constantly...and it was more like a punishment "Look how much you weigh!"

> I used to go running and I used to have these visions of cutting off my fat. What a violent image. I would just chisel it off and I'd be skinny. So I just loathed my body and I loathed my lack of willpower. I just thought "Smarten up and quit eating like a pig."

Strategies

Attempting to Recover

At this stage the women were attempting to recover. These attempts occurred in two ways: **seeking help** and **focusing on weight loss**. **Seeking help** and **focusing on weight loss** are both sub-categories of **attempting to recover**.

Seeking help. **Seeking help** included going to counselling, talking to a health care professional, going to a diet clinic, and attending Overeaters Anonymous. Although these help seeking strategies were started, the majority of the women did not continue with them for any length of time at this stage of recovery. However, many of these resources were sought again in the future, particularly counselling and Overeaters Anonymous. The participants recalled seeking help:

> The first time was in my teens, at the suggestion of my friend, and I went to get some counselling. And that really triggered me to binge eat even more. So I quit counselling instead of dealing with emotions and dealing with the fact that I was eating more. I didn't know that because I was trying to deal with emotional issues that I was eating more.

> And then in '89 I went to OA for a few meetings, but at that time I was still looking at it from a weight issue, I wasn't really truly looking at if from a food issue, like what am I doing with this food? So I went to a few meetings but it didn't really click for me for whatever reason. I just wasn't ready to let go of the food at that point. So it took me another 2 years and 3 months to get back to OA...

Focusing on weight loss. The other strategy several participants used to facilitate recovery was **focusing on weight loss**. The types of actions that the women took while focusing on weight loss appear to be a direct result of their obsession with weight and food. These actions were re-examining food choices and practicing weight control.

Re-examining food choices often took the form of starting a diet. For example, this meant not allowing oneself to eat any "bad foods," eating only salads, diet foods, organic foods, or counting calories. The participants described re-examining their food choices: "I just felt like I was on a compulsive diet, where I sat there and counted

everything that I ate. Even the smallest carrot stick, I counted that as 5 calories." "I went on a salad diet at that time, I just ate salads. And I lost another 20 lbs. in 3 months time, just salad diets. So I went to an extreme..."

> ...after that I started working out a lot and I started eating only organic healthy foods, and really calorie counting. And I think that helped at first and I lost a lot of weight, but I think it limited myself, or it limited my control for myself, because I hadn't yet trusted myself.

Practicing weight control often meant exercising in addition to weight monitoring. Exercise was used with the intent to lose weight in this stage of recovery. Using a scale was the most popular way to monitor weight, although some women gauged their weight fluctuations by the fit of their clothes or with measuring tape. Descriptions of practicing weight control include the following comments: "...I remember one time I weighed myself up to 12 times a day or more just to really punish myself and to sink in my head "You're getting fat."

> I think I probably exercised, but that was part of the whole problem, because then I kind of went overboard on exercising. I would exercise for a long time. It didn't matter what happened it always ended in bingeing, like if you exercised a lot you could binge more.

Consequences

Contemplating

As a result of what was occurring in this phase, a lot of women started to think more about what was happening in their lives. The two sub-categories of **contemplating** include **noticing a lack of change** and **wondering what is going on**.

Noticing a lack of change. The women **noticed a lack of change** in themselves, realizing that they were not recovering despite their many attempts to stop bingeing. Participants recalled when they finally noticed a lack of change:

But even 3 years later, like it didn't happen right way. I didn't go to...[counselling] right away. It probably took 3 years until I could even face that. I was withdrawn 3 years later. "You're still having a lot of problems aren't you?"

Oh yeah I had seen a poster up at school, the little triggers that happened...you know I think I was really sick and tired and I realized I was in a very static point where I hadn't moved or improved.

Wondering what is going on. Participants also started to **wonder what was going on**. The women asked themselves questions, such as why they were continuing to binge eat, and what was contributing to the problem. This is demonstrated in the following examples: "It's like a gradual process...it's not like one day you wake up and go, or ask yourself "Why?" and that's then end of it. You still binge, but you're starting to ask yourself "Why am I doing this?"

> ...I couldn't go to the fridge, it was difficult to go to the fridge. I could start bingeing but I couldn't finish like I did before, because halfway through the binge I would all of a sudden realize I was bingeing. And I'd all of a sudden realize... "Why am I doing this? What am I doing?" So it stopped me from continuing until I couldn't move. And it sort of got me to ask questions on "Oh why am I eating now? What emotion does this have to do with?"

Desperation

Another consequence in Phase I was **desperation**. The women felt as though they had tried everything to recover and did not know what else to do. For some women this led to seeking new avenues for recovery. The following comments illustrate this desperation:

> Recovering from binge eating for me, it involved me going to Overeaters Anonymous because I didn't know where else to go with my food...I mean I was willing to try anything whether it was hypnosis, staples. I was willing to try whatever. As a last resort I tried OA.

> I think it was desperation because I had really tried everything I could think of. I tried dieting, tried just eating healthy, low fat, high fiber, I tried everything. I knew what to do but I just couldn't do it.

Phase II: Assessing Present Life Situation

In the second phase of recovery, the participants to assessed their present life situation. This involved examining their lives and comparing it to what they wanted their lives to be like. See Table 3 for a summary of Phase II.

Context

Dissatisfaction

The context involved at this stage of recovery was **dissatisfaction.** The participants clearly stated the dissatisfaction they felt with their lives as they were. As the women remembered: "...I didn't want to do it anymore, I was sick and tired of doing what I was doing. And that's what made me say "What am I willing to do to recover?"

> I didn't like the binge eating. I would binge until I was almost sick. Also I think one of the motivations was...I just didn't like how I felt about myself when I was binge eating. I'd feel so terrible inside, "Why are you doing this?"

> I didn't like my life, I didn't like myself. Well I liked myself, but I don't know, it was just not liking life or liking what you're doing with your life, and not feeling like you're living up to the minimum standard that you should have for yourself. I didn't want to live like that, I didn't want to look in the mirror and see what I was seeing. Just really unhappy. Trapped, I thought I was trapped.

The dissatisfaction that the participants expressed, set the stage for what follows in this phase.

Intervening Conditions

Wanting Something Better for Self

Along with the dissatisfaction that women experienced at this stage of recovery, they also verbalized wanting something better for themselves. They were tired of living their lives the way they had been, and started to think about how they wanted their lives

Table 3

Phase II: Assessing Present Life Situation

Paradigm model	Categories	Sub-categories
Context	Dissatisfaction	
Conditions	Wanting Something Better for Self	Desire to change Seeking happiness
Strategies	Seeking Information	
Consequences	Gaining Awareness	Acknowledging a problem Acknowledging the need for help Acknowledging the need to address personal issues Awareness of self-punishment

to be different. There are two sub-categories of **wanting something better for self**, **desire to change** and **seeking happiness.**

Desire to change. The **desire to change** was clearly articulated by a number of participants. They wanted to change their bingeing behaviour, their friendships, the way they were living their lives, the way they felt about themselves and their bodies, the way they felt about food, and some also wanted to change their body size. This is illustrated in the comments of the participants: "I felt really physically awful, so I really did want to stop." "I just wanted to quit eating like a glutton, I wanted to lose weight." "...realizing that I'm far too busy and life is far too short to sit there and go "Oh no I can never have another hamburger again." "I dreamt of being those women on Oprah that were 500 lbs. And that was probably what motivated me."

> ...it's like I'm wasting my time doing this. I'm not doing anything. I'm going on in my 20's and I don't have a good job, I don't have an education. So it was like let's take this brainpower and do something else.

Seeking happiness. Along with the **desire to change** came the process of **seeking happiness**. Happiness in itself became a new goal for some women. There were also women who felt that having a romantic partner would bring them happiness, and that became an aim for some. Examples of seeking happiness are shared in the following comments: "...being without a man was important to me at that time. Like wanting to be married and that kind of stuff, and thinking that because I was fat I would never have that."

> ...I was on this big quest for "How do I be happy? How can I be happy with who I am? And how can I be happy in my life?" And...that question continues to be a question that I ask myself.
>
> I wanted to be well emotionally, physically, and spiritually. I wanted to be normal. Now I kind of laugh at that because I don't know if anyone is normal,

but I wanted a happy life, I didn't want to be anxious every day and in pain. I didn't want to be in relationships with guys who were alcoholics and guys who lived on the other side of the world. I wanted to have a good solid relationships here and now.

The partner I'm with now, I had a big crush on him during that time. A serious one, I think it was part of the dependency, and knowing that I was going to leave ultimately my abusive relationship. So I had this really big crush on him. I felt that if I lost the weight he would be interested in me.

Strategies

Seeking Information

A common strategy for recovery at this stage was **seeking information**. The most popular way of seeking information was by reading books. The kinds of books the women read provided them with a variety of information. Some read about binge eating and nutrition, while others read about things not obviously linked to binge eating such as co-dependent relationships, and self-esteem. Another means of seeking information was by attending workshops on issues related to binge eating, body image, and self-esteem. The participants demonstrated some of the information they sought as well as what they learned from it:

> I read feminist things that talked about being in control or...empowerment...or again the idea of self-awareness and how that helped self-esteem. Reading helped because I could do it on my own time and in my own privacy. Just sort of learn more the way the world ticked...
>
> ...and what I was reading. It scared me the stuff I was reading, saying that you need to stop dieting and that kind of stuff, because that was the control, that was the only way I could figure out how to maintain any kind of weight, you know without escalating and escalating...
>
> ...another reason that my binge eating decreased is I had read one book on eating. I think it was Susan Powter. Because I was doing the dieting moreso, I read a dieting book...and one thing she did say that I did like was eat when you're hungry and don't eat when you're not hungry.

So I did this course, and that course was with another five women and it was just in this girl's living room. And we did visualizations and a lot of history on maybe where we had gotten this negative self-talk, or where we had learned to binge eat, or why we had this obsession with food, or why we thought that would be something that would help us or make us feel better. And it was really helpful to...understand where I had gotten these patterns from.

Consequences

Gaining Awareness

The consequence of the events of this phase was that the participants started to gain awareness. They started to become more aware of what was going on in their lives. There are four sub-categories to **gaining awareness**: **acknowledging a problem, acknowledging the need for help, acknowledging the need to address personal issues**, and **awareness of self-punishment**.

Acknowledging a problem. The women talked about how for the first time for many of them, they started to realize that they had a problem with binge eating. Some examples of this include: "...I was becoming aware that I did have a problem and that I wasn't a healthy eater." "So I knew that I didn't like the fact that I was eating lots...to the point where I was sick. So I think I realized it was a problem."

> I think there was a willingness on my part to do something different because I felt like I had tried everything else. To recognize it as a problem. As a disorder. It was the talking and the reading about things.

Acknowledging the need for help. Along with acknowledging a problem, came the admission that there was a need for help in order to recover. Participants shared their need for help with the following examples: "...acknowledging that I had a problem, that the problem was something bigger than I could solve on my own."

> ...the last binge eating that I had trouble with...I started eating everything in sight...it sure felt that way. And then what happened was that because the

> depression led to suicidal thoughts and tendencies, I finally had to get intervention.

Acknowledging the need to address personal issues. The women realized that a necessary part of their recovery was to focus on any difficulties they may have been having. The difficulties included such things as emotions that had been avoided, issues with their family of origin, low self-esteem, or any other events in their lives that were causing distress. Examples of this are: "[I thought] maybe it's true what I've been reading, that it actually is quicker to deal with the problem rather than cover it up by something else."

> ...I finally realized that I needed to let the emotions come out and that it was safe to have emotion and that there were safe ways of dealing with emotions. It wasn't until I let go of trying to control my emotions that I was able to let go of compulsively eating.

Awareness of self-punishment. Another breakthrough for a lot of women was becoming aware of how they were hurting themselves, and how this was actually not helpful to themselves. As Lisa shared:

> Just to see how, to realize how debilitating it was. Just to realize how it felt afterwards. To notice that it didn't feel good to talk to myself that way. It didn't help me to lose weight by telling myself I was really fat and ugly. It was just realizing that the negative self-talk, not just stopping it but realizing that it wasn't having any purpose. It doesn't help to slap a child or hit a child, and that's what I was doing to myself.

Phase III Healing/Restoring Oneself

The third phase of recovery involved a lot of action taken by the women in order to facilitate recovery. The most visible signs of change happened during this phase. Because of the action taken the momentum of recovery increased for the women. See Table 4 for a summary of Phase III.

Context

Learning

The context of this phase was **learning**. The sources of the learning included the women themselves, books, courses at school, self-help groups, counsellors, role models, or the many other people that the women were in contact with. Some of the most important knowledge that the women acquired came from others who had their own experiences with binge eating. Learning from the example of others was quite predominant. Women shared comments that demonstrate the learning that they acquired during this phase: "But what happened was I took a feminist course and that really encouraged me to eat a typical food intake..."

> I had read a book of Genine Roth's and it was all about people telling stories of their binge eating day, or a really terrible day for them. And it would make me laugh or cry, or I'd be emotional over it. And I really related to their stories, and when you're hearing someone else talk, I was able to kind of laugh at them and go "Isn't that ridiculous that they felt that way? That's so silly that they felt that way."

The **learning** that the women described is divided into sub-categories: **external information** and **internal realizations**.

External information. The information that the women acquired from external sources was gathered from some of the sources of learning listed above. The women mentioned two prevalent pieces of information that they learned from these sources. They mentioned learning about the cultural influences on body size and about the binge-diet cycle. For some of the women it was the first time they realized that the pressure they felt to be thin came from the culture that they were living in. One woman mentioned learning about other cultures and how the expectations placed on people's body size varies from culture to culture. Becoming aware of cultural influences had a direct effect on the way that many of the women started to think about themselves and the way they

Table 4

Phase III: Healing/Restoring Oneself

Paradigm model	Categories	Sub-categories
Context	Learning	External information Internal realizations
Conditions	Striving for Personal Happiness	Addressing personal issues Nurturing self-acceptance
	Accepting Ambiguity	Risking/trying new things Giving up control
	Attending to Emotions	Connecting binge eating with emotions Experiencing emotions Reflecting on emotions Awareness of emotions Acceptance of emotions
Strategies	Changing Relationship to Body	Reduced weight monitoring Trusting own body Treating own body well Shifting away from weight/shape obsession
	Changing Relationship to Food	
	Breaking Isolation	Opening up to others Seeking help Accepting support of others
	Creating Alternatives	Finding an outlet Getting needs met
Consequences	Self-assertion	Eliminating negative relationships Standing up for yourself

were using food. As Elizabeth shared, "I do think that feminist theory is something that was critical in me escaping the dependency on being super thin."

Learning more about the "binge-diet cycle" was another important lesson for the women. They learned that attempting to recover by dieting just leads to a cycle of dieting and bingeing. The hunger caused by dieting leads to a binge, and the guilt from the binge leads back to another diet. Learning about this cycle caused several women to re-evaluate the ways that they were trying to recover. Some examples include: "Once I think I understood how the cycle worked, I realized that that was contributing to the weight gain."

> ...understanding that I was abusing myself...it didn't matter what end of the spectrum I was on, I was still abusing myself. Whether I was dieting or bingeing. Because there was no happy medium ever with me, it was either I was bingeing or was dieting.

Internal realizations. The sub-category of **internal realizations** refers to what the women learned on their own. The realizations may have been prompted by the sources of information mentioned above, but evolved out of what the women gathered from their own observations.

The internal realizations that the women made were based on making shifts in some previously held beliefs. For example, many participants expressed that they had thought that being thin would make them happy. Now they were realizing that body size is not related to happiness. The participants commented upon the internal realization they made: "Being aware that physically being skinny doesn't necessarily make me happy, it comes from within."

> When I finally went to [counselling]...it was probably at the height of the exercise, like shrinking in size when you should be really happy. But of course I

> was never really happy with whatever size I was, it didn't ever matter what size I was.

Along with realizing that being thin does not make a person happy, some women came to the conclusion that binge eating did not make them happy either: "Okay I'm feeling lonely, I'm feeling lost, or I'm feeling sad...those are feelings and food is not going to fix feelings."

> Noticing and being aware that bingeing doesn't feel good, it doesn't taste good, it doesn't make me feel good afterwards. It doesn't solve the problem if the problem was I was in a bad mood, or something happened to start me off on the binge eating. And so being aware of what works for me and what doesn't work for me.

Another belief that women changed was the thinking that they had no control, no control in their lives or over food. The women were starting to see that they did in fact have control, and could make changes in their lives if they chose to. This is illustrated by the words of the participants:

> Being in control is a place of empowerment. And I think it's just a different way of looking at things. If you're out of control you're blaming the food for being the evil food that you can't control. But if you switched that context belief or you switch that belief or behaviour, and you just say "I'm in control," all of a sudden you have the responsibility and accountability for if you binge eat.

> I guess I felt like I didn't have control when I did have control. That I had more control over how I felt and that other people didn't have the control over how I felt. Like instead of letting someone get under my skin and pushing buttons or whatever, they don't really have that control. I have that control.

Participants found that they also started to believe that they were not alone in their experiences with binge eating. Previously they had felt as though they must have been the only ones with this problem. Examples of this include: "...just knowing there was somebody else out there who can say "Yeah I know what you're talking about," or "Yeah I've been there."

> ...I thought I had this big secret that I thought I couldn't tell anybody. So that's a pretty big heavy stress. So once I realized that I wasn't alone, that other people experienced the same negative feelings that I did, it was kind of freeing, weight came off my shoulders.

In addition, there were women who said that it was very significant when they started to believe there was hope for recovery. Many women had thought that they would never recover; however, this newfound hope was motivational. This hope is demonstrated by the participants:

> ...I was powerless over food, like I just couldn't stop eating. And the fact that it was part of the program, that all these other people in the room had admitted that they were powerless over food, and yet a lot of them had recovery gave me hope.

> I guess [realizing I wasn't alone] made it seem like it wasn't such a huge heavy problem. It became a little bit more, "Maybe I'm not so abnormal, maybe I can change this, and maybe there is hope for me."

Lastly, there were participants who said that they started to see the temporality of their situation. In the past they may have thought that things would never get better, and had "catastrophic" thinking about what was going on in their lives. Now they were changing their thinking and realizing that anything bad that was happening in their lives would not last forever. This is expressed in the following comments:

> ...I think the difference before, I couldn't think of what I could do with that, if I was feeling sad or I was having a bad week. "Oh no, it's just doing to go on and on forever." And in my depression I just felt like my bad days or weeks would go on forever. You know recognizing the temporality of the situation.

> ...realize that it's not going to last forever, that I've gotten through lots of stuff, like before it used to be like "This is the end, this is the worst." Not to the point that I was suicidal but it was really bad thoughts on "This is the worst, it can't get any worse." And now I've been through it enough times now I know I can get through it, I feel strong enough that I can get through it.

<u>Intervening conditions</u>

There are three intervening conditions in phase three: **striving for personal happiness**, **accepting ambiguity**, and **recognizing emotion**.

Striving for Personal Happiness

In Phase II, the participants identified the fact that they wanted something better for themselves, which included seeking happiness. At this stage of recovery this meant actually **striving for personal happiness**, in other words doing something to accomplish this goal of happiness. Before the women could be happy, and before they could recover, they felt that they needed to start **addressing personal issues** and **nurturing self-acceptance**. **Addressing personal issues** and **nurturing self-acceptance** are both sub-categories of **striving for personal happiness.**

Addressing personal issues. **Addressing personal issues** meant addressing any issues or problems that the participants may have been having in their lives. For example, some women felt they needed to grieve over certain events in their lives, while others felt they needed to heal family relationships. Examples of this include:

> The food was just the tip of the iceberg and if you look, no wonder you can't just stop eating and be happy. There's this massive iceberg under the surface. So basically dealing with all that other crap and getting rid of it, melting the iceberg I guess.

> ...I was in my teens when I originally started counselling. That's why I ran away from counselling because I didn't want to binge eat. And I thought running away from counselling would be the answer. And when the second time I realized things were so bad as far as other issues, I would have to remain in counselling and just deal with them. And dealing with the feelings at the beginning of counselling was binge eating, until I learned how to deal with it another way.

Nurturing self-acceptance. The other way that the participants strove for personal happiness was by **nurturing self-acceptance**. All of the women I interviewed identified that they had low self-esteem while they were still binge eating. In order to boost their

self-esteem, they tried various ways to like and accept themselves. Some women chose to work on changing the negative comments that they said to themselves. Others chose to focus on thinking about what they were good at to improve their self-esteem, and a few women decided to be more forgiving of themselves. Instances of nurturing self-acceptance are shared in the following comments:

> Well for me, because it's so easy for me to beat myself up and be really hard on myself. Learning to not have the negative self-talk, or saying to myself that I won't be so hard on myself. And realizing that I actually felt better when I wasn't so hard on myself. Let myself fall and just notice it rather than blame myself for it or be really harsh on myself for it. Just to realize the pattern or to notice the things I'm doing.

> The desire to accept myself as I was. To recognize that there was a genetic link to my body type and to accept it. There was a big push to just accept myself as I was. To recognize the things that I was good at, and to let those things carry me for a while. Like I felt that I was a good teacher so I focused on teaching.

Accepting Ambiguity

Accepting ambiguity is the term I use to describe the fact that the participants were going into "unknown territory" as a part of their recovery. Because their past attempts at recovery were unsuccessful, they were having to try something new. They were having to take risks in order to recover, and having to accept that they did not know what would happen as a result of their new recovery attempts. The two sub-categories of **accepting ambiguity** are **risking/trying new things** and **giving up control**.

Risking/trying new things. Because of the desperation that the participants experienced in response to their inability to recover, many of them started taking risks with what they were willing to do to recover. The risks that the women took were often with food. For example, they became less restrictive about what they would eat, or chose to eat healthier foods. However, some of the risks they took had to do with how they

chose to handle the urge to binge, or with seeking help to recover. "Risks" were any new behaviours undertaken in order to facilitate recovery. Examples are: "...realizing that there's nothing wrong with testing out with what I could eat." "I don't know when or where but I decided nothing is forbidden and experimented with that."

> And when I was talking about risk that's what I mean by risking, knowing that any of those things could cause me to feel really awful about myself. And knowing how I deal with feeling awful about myself, those are the risks you have to take.

Giving up control. **Giving up control** was another way that the participants accepted ambiguity. Some of them decided to give up trying to control certain aspects of their lives. This could be any aspect of life that a woman felt that she previously had to control in her life. For example, there were women who stopped trying to control others around them, or the things in their lives that they had no control over. Other women mentioned trying to stop controlling their eating, food, emotions, and weight. There were women who found that once they tried to stop controlling so much of their lives, they began to have more success at recovery. The comments demonstrating this include: "...there were control issues as well, letting go of control of other things, other people. That was freeing also. To give up control over worrying about thing I had no control over."

> And I remember that I started to lose weight and it was like a real paradox because it was when I quit weighing myself and when I quit trying to control the food and when I quit trying to lose weight that I started to lose weight...And when I finally gave up trying to control my weight, and decided to accept wherever I ended up...I settled into this weight.

Attending to Emotions

Attending to emotions is the third intervening condition in this phase of recovery. The participants said they started to recognize and pay attention to their

emotions, whereas they had previously tried to "bury" or "numb out" their emotions with food. There are five sub-categories of the category **attending to emotions**: **awareness of emotions**, **acceptance of emotions**, **connecting binge eating with emotions**, **experiencing emotions**, and **reflecting on emotions**.

Awareness of emotions. The women said they became aware that they did have emotions. While they had avoided their emotions in the past, they were now becoming more aware of their emotions and the kinds of the emotions they were having. The participants' words illustrate their new awareness of emotions: "...[I] came to terms with that I do have feelings, and I do have anger..." "...I'm realizing now that I do have a lot of anger that I've never dealt with..."

> You know what's going on down here? Meaning...down in the emotions area. You know, so what am I feeling right now? Okay I'm feeling lonely, I'm feeling lost, or I'm feeling sad. Oh okay. Those are feelings, and food is not going to fix feelings, okay?

Acceptance of emotions. Along with becoming aware of their emotions, the women also began to accept their emotions. Previously they may have denied their emotions, thinking that emotions were wrong, or that it was unacceptable to show emotions. Now they were realizing that it is acceptable to have emotions. Catherine demonstrated her growing acceptance of emotions:

> It's not bad or wrong, it's like "oh you shouldn't cry or you shouldn't feel that way." And I guess what I'm getting in my emotional recovery, it's okay to have those emotions, it's okay to feel hurt if somebody says something that's emotionally hurtful to me.

Connecting binge eating with emotions. A major breakthrough for the participants was when they finally made the connection between their binge eating behaviour and their emotions. Many had not been aware of the purpose that food had

been serving for them. Once they made the connection that food was being used to bury or numb their feelings, they could start to take steps to find other ways to address their emotions. Some examples of this include:

> I had no idea that I was eating to make myself feel better, I was eating like anesthetic kind of. Like when I couldn't handle things and when there was too much pain I just ate. And I had done that through most of my childhood. I just had no idea that it was linked to emotional stuff and it was.

> ...it became really clear and obvious...that I didn't eat just because I was hungry. I ate definitely for emotional reasons, and I ate certain foods depending on if I was in a bad mood or if I wanted a quick fix, or if I was in a good mood.

Experiencing emotions. Once the participants became aware of and accepted their emotions, they allowed themselves to experience their emotions. This meant not avoiding or numbing the feelings but feeling them, "sitting" with them, and in a number of cases crying was very important. The following comments are examples of the participants experiencing their emotions:

> And at the time I guess, because I hadn't dealt with the situation yet, it's just being able to sit with those feelings. I'm feeling sad, and just saying it's okay to feel sad. And that's what I mean by sitting with it, I don't have to go out and get something...

> ...I let myself feel the emotion rather than numbing myself and eating. So if I had to sit there for an hour and cry, by the time the crying was over I didn't feel the need to binge anymore. Because I didn't need to numb myself anymore because it was over, the emotion had come out.

> And to be able to feel, like other emotions...like I didn't think that I had anger issues but I did have anger issues. And so with any extreme emotion not allowing myself to feel the extremeness of the emotion. Like I was pretty flat, pretty numb to feelings. So that's really exhilarating to be able to actually feel anger, and to feel happiness, and to feel sadness, and...to know what you're crying about.

Reflecting on emotions. The last sub-category is **reflecting on emotions**. Reflecting on emotions involved the participants processing thoughts about the emotions that they were having. It was another step along with experiencing the emotion. The

participants described pondering about where their feelings were coming from and why they were having those particular feelings. This was done either in solitude, in some cases facilitated by writing in a journal, or by talking to a friend or a counsellor about their feelings. Examples include: "...processing the emotions and feelings and trying to locate where they're coming from."

> And I'd go to meetings to talk about all the feelings that I was having coming up...and I could talk about it and cry about it and I could call people in between meetings...it was such a relief to pout it all out.

Strategies

There are four strategies in the third phase of recovery: **changing relationship to body**, **changing relationship to food**, **breaking isolation**, and **creating alternatives**.

Changing Relationship to Body

Changing relationship to body refers to the new relationship that the women developed with their bodies in order to feel better about and more connected with their bodies. Participants discussed how they had felt very negatively about their bodies while binge eating, and also disconnected from their bodies. At this stage they were beginning to try some new strategies to feel more comfortable and connected with their bodies. There are three sub-categories of this category: **reduced weight monitoring**, **trusting one's own body**, and **treating one's own body well**.

Reduced weight monitoring. The participants reduced their weight monitoring. This change was implemented in order to take away some of the focus they had on weight loss, and to curb the negative self-talk that they inflicted upon themselves. They reduced their weight monitoring by decreasing the amount they weighed or measured themselves, and some even stopped altogether. Another way was to avoid looking in a

full length mirror. The following comments illustrate some of these changes: "...I had to make a choice of not having a scale because it was a punishment, it was a way of saying you're not good enough."

> ...changing the whole way of doing things...not having mirrors in my bedroom so that you wouldn't have the opportunity to have that abusive talk to yourself. You know like "Oh you're still fat," that kind of stuff.

Trusting one's own body. Some women tried trusting their own body to help them recover from binge eating. It was important for them to become more aware of their bodies by paying attention to and trusting the internal cues or signals coming from their bodies. For instance, this meant trusting when their bodies were sending hunger cues or having cravings for certain kinds of foods. Integral to this process was learning what it meant to feel hungry, which many women had not previously been aware of. Examples of trusting one's own body include:

> I think reading a little bit and understanding that you need to trust your body and that your body is going to give it what it naturally wants, and your body doesn't naturally overeat. That's part of the numbing process, or that's not a normal process to overeat.

> And so it was more just listening to my body. I had to just listen to "Oh I'm hungry now." And it felt so gratifying to be able to hear that, because at first you're like "Oh it's 12 noon." And a lot of people, not just binge eaters, but "It's 12 noon, it's time to eat." "Well are you hungry now? Oh no I had a big breakfast. Okay maybe wait. You know do you have to eat at 12 noon? No. Could you eat at 2 o'clock? Oh yeah sure."

Treating one's own body well. As a part of changing their relationship to their bodies, the participants were kinder to their bodies. This meant not punishing themselves with over-exercising, dieting, or fasting. For some it meant eliminating drugs and alcohol. Lisa commented on how she chose to treat her body well:

> And I had to...[decide] to take better care of my body, not by dieting, not by fasting, not by exercising, or doing the drugs and drinking alcohol and all that kind of stuff. To realize that all that wasn't necessarily good for my body either.

Changing Relationship to Food

Changing relationship to food was another strategy that the women used to recover from binge eating. This was a result of their willingness to try new things and to take risks. In regards to this category, this meant that the women experimented with their relationship to food. They changed or eliminated the rules that they had previously held in relation to their food consumption, and became more aware of how they were eating and using food.

The participants had a variety of different approaches that helped them to change their relationship to food. Many used more than one approach. These approaches included: incorporating forbidden foods, stopping all diets, eating when hungry, eating until full, not eating when emotional, eating healthier food, enjoying food, planning meals/structuring meal times, abstaining from binge foods, and being aware of eating; which included being aware of what they were eating, how much they were eating, and how fast they were eating. These approaches are illustrated through the words of the participants: "...just not eating on the run, but trying to more have a meal planned, like a sit down [meal], rather than just sort of stuffing my face as I went out the door or something." "Not going for Doritos for snacks, instead going for...I'd get one hot rod instead of a bag of Doritos and downing them in one gulp. So I was modifying..."

> ...just 3 meals a day, and I didn't restrict on any specific foods. Like if I wanted to eat chocolate at one of my meals then that's what I ate, I didn't cut anything out. And that seemed really important to me, because as soon as I would try to cut something out I would obsess about it.

...and really letting go of the whole idea of dieting, because that's the whole cycle right? Dieting, starve yourself, binge, starve yourself, binge. I think that maybe that was a big thing, to know that I didn't have to diet ever again. I don't feel that I ever have to go on a diet. And that for some reason was quite freeing, because then I didn't have to starve myself.

[No] sugar because...it would be really nice if I could have a spoonful of chocolate pudding, or if I could have a chocolate bar. But that's not what happens for me, I don't stop at one, I just keep right on going.

> And I realized that [I ate] especially when I was upset. And instead I would go "I feel upset right now. What's this all about?"...then I started to say that I won't eat when I'm emotional. Later on as I dealt with those emotional times it kind of balanced itself out too.

The majority of the approaches listed above are self-explanatory and therefore they will not all be commented upon. However, the approaches of "incorporating forbidden foods" and "abstaining from binge foods," require further explanation. These two approaches appear to be mutually exclusive, whereas none of the other approaches seem to be. The majority of the women started off by abstaining from binge foods in order to recover, but later switched to incorporating these forbidden foods. Nevertheless there was one participant who continued to abstain from binge foods.

This participant abstained from binge foods to prevent further binges. She likens binge eating to an addiction just like alcohol and drug addiction. She chooses to abstain because she feels eating any food that was a binge food may lead to a relapse. Therefore she has eliminated all sugars from her diet. It is important to note that despite the fact that this particular participant chose to address food in a different manner than the other participants, both approaches can be successful, what matters is what works for the individual.

Breaking Isolation

The third strategy at this phase of recovery is **breaking isolation**. As mentioned in the first phase, the participants were isolated. Now in the third phase these women found ways to overcome their isolation. There are three sub-categories: **opening up to others**, **seeking help**, and **accepting support of others**.

Opening up to others. The participants talked about a change in their relationships. They became more open and willing to share with others about what was going on in their lives, specifically information about their binge eating. Some women mentioned that they felt as though their relationships became closer and more satisfying:

> ...I started to finally be more honest with my friends. Like sharing more and more and developing for the first time in my life intimate friendships, where I could really be myself and be honest about what I was feeling.

> Well it's really really good to be able to pick up the phone in the middle of the night and say "You know I'm just doing absolutely crazy here and I've gone to the refrigerator 6 times and I don't know what it is but something's bugging me but I don't know what." I can reach out and I can talk to somebody about it...whereas before when I didn't have any program I thought I was all out there on my own and I was responsible for myself and I had to fix all my problems, and everything was because of what I did or didn't do.

Seeking help. The participants also sought help again. Although there were some participants who had continued on with the help that they had sought in Phase I, the majority were returning to those original sources of help for the second time. The most popular sources of help at this phase were counselling and Overeaters Anonymous. Examples of this strategy include the following: "What...happened with me, I went back to...counselling...when I started recovering. Counselling was so great, I was seeing a lot of successes in counselling."

> So I went to this therapist because I had heard her name mentioned in the 12 step circles of AA, and I thought "Well maybe she can help me with this food thing." Because I didn't want to go back to OA and admit that I couldn't solve my eating problem on my own. Because I had been there in '89...and I had only been there

> for a few meetings and then left. And I thought if I go back in 1991 someone is going to be standing at the door taking attendance saying "She's back, we knew she'd be back."...So that particular therapist encouraged me to go back to OA when I said I didn't know what to do about my eating.

Accepting support of others. The final sub-category of **breaking isolation** is **accepting support of others**. The women accepted support from friends, family, partners, and the groups in which some of the women were involved with such as Overeaters Anonymous. Because the women were finally opening up to the people in their lives, it seemed natural that they would also be allowing these people to help support them through their recoveries. The supports in their lives helped them to create goals for themselves, as well as motivate and encourage them. Not being alone in recovery was very important for the women:

> ...I had to learn deliberately as an adult to accept support and to find support and to take care of myself and to let people close to me, to let people help me. It's just been crucial, now I can't imagine life without these supports.

Creating Alternatives

At this stage the women were taking more responsibility for their healing. Instead of automatically turning to binge eating when they felt the urge, they were **creating alternatives** for themselves. **Finding an outlet** and **getting needs met** are both sub-categories of the category **creating alternatives**.

Finding an outlet. The outlets that the women created for themselves were other options that they could turn to instead of binge eating. For example, several women wrote in journals, others found exercising a good way to relieve stress. Taking a hot bath or talking to a confidant were also used along with attending counselling and/or Overeaters Anonymous. Danielle described her experience of finding an outlet:

> So it just kind of happened naturally that as I just focused on the emotional work and because I had all the support I had alternatives, and so slowly over time it just seemed to happen. And the more I dealt with the stuff, the more I had room to kind of have things like healthy relationships and a meaningful relationship with myself.

Getting needs met. The participants were becoming aware of their needs. Instead of trying to meet these needs with food, they were finding other ways of addressing their needs. For example, if a woman felt lonely or upset she would seek out someone to spend time with or call up a friend to talk to. One participant demonstrated how she got her needs met while visiting another country:

> ...I went to India for 3 months in '96 with a group of students I didn't know and I was there and I figured I would be fine without my regular supports. And after I was there for 6 weeks I really felt that I needed help emotionally, I felt I needed to talk to someone who was safe. And I actually looked up AA in the phone book, and I went to an open AA meeting which means you don't have to be an alcoholic to go...you know I didn't have to wait 6 weeks, now the further I go along with this, I can find ways to have my needs met, I don't have to suffer.

Consequences

Self-assertion

The one consequence of this phase was that the women became more assertive. The **self-assertion** manifested in two ways: **eliminating negative relationships**, and **standing up for oneself**. These are both sub-categories of **self-assertion**.

Eliminating negative relationships. There were several participants who ended relationships that they felt were not healthy or were detrimental. A couple of women left abusive relationships, another woman severed ties with some family members, and there were other women who ended friendships. The ending or eliminating of the negative relationships in these women's lives is an example of them taking care of themselves, and making better choices. Marie discussed a friendship that she had to end:

> I had to let go of that friendship, even though we had spent almost every weekend together. I had to let that relationship go, I mean I *really* had to let it go. And it took all of my effort because they continued to want to be friends, but it was an unhealthy relationship, and it kept me in a place of being insecure, especially around men. And so I had to say no to that relationship.

Standing up for oneself. Another way that the women showed their self-assertion was by standing up for themselves. For example, one woman said that she began to defend the things that she believed in, which was something that was new for her. Another woman talked about how instead of taking a passive role in her relationship she gradually became more assertive. Marie recalled her experience of practicing assertiveness:

> ...I felt that...I was really fighting for myself. So I wouldn't let other people get in the way of how I was growing. I would get mad when old things would come up again, like I remember saying something to somebody in my family, like "You will not put me back there." Really it had nothing to do with her, but it had to do with my saying no, and identifying that that one thing, that one comment or whatever was something that held me in that bondage of feeling crappy. So saying no to a lot of things.

Phase IV Creating Balance

The fourth phase **Creating balance** is the final phase of recovery. It is the time when the women began to enjoy life more and feel more stable in their recoveries. **Creating balance** was a matter of the women living the lives that they wanted to be living, while maintaining the changes that they had made. For a summary of Phase IV see Table 5.

Context

Making Room for Life

The context of the fourth phase is **making room for life**. The women felt that they had lives. They were no longer as focused on the problem of binge eating and

therefore had time for other things in their lives. There are five sub-categories of **making room for life**: **working towards personal goals/thinking about the future, becoming less self-absorbed, becoming involved with life, connecting with others**, and **helping others**.

Working towards personal goals/thinking about the future. At this stage the participants were thinking more about what they wanted in their lives, not only in regards to school or a career, but also personally. Because of this they began pursuing new things in their lives, goals for themselves that they may have had for quite a while. For example, some participants went back to school. Another participant helped organize a protest, started a non-profit organization, and put on a variety show. One participant illustrated this new way of thinking about the future:

> ...just really trying to focus on who I wanted to be and the things I wanted to contribute to the world. Now that's what I feel like, I feel like now I contribute myself to the world. Like I'm not always hung up on thinking about me. Like I'm a contributing member...

Becoming involved with life. Along with working towards personal goals/thinking about the future, the women became involved with life. The women talked about how their lives changed and became much busier. They felt that because of this they were more productive and satisfied with their lives. Their more productive lives left very little room for binge eating. The participants shared how their lives became busier: "...one of the more practical reasons [is that] I'm pretty busy, I can't sit down and so life has replaced [binge eating]..."

> Some weekends I don't even get in all three meals in anymore, because you're so busy doing fun things and you're excited, and...you don't have to be focused on what you're going to have for breakfast and lunch. And you don't have to be planning ahead all the time. Because that would be something that I would do too, is always be thinking about food. I would always be thinking about it, and

Table 5

Phase IV: Creating Balance

Paradigm model	Categories	Sub-categories
Context	Making Room for Life	Working towards personal goals/thinking about the future Becoming less self-absorbed Becoming involved with life Connecting with others Helping others
Conditions	Fostering Self-renewal	Spirituality Spending time alone Doing enjoyable activities Getting to know yourself better Acceptance of self Being kind to self
Strategies	Practicing Prevention/ Maintaining changes	Proactive strategies Reactive strategies
Consequences	Experiencing Self-acceptance	Improving self-esteem Becoming more comfortable with body size Taking in positive messages Believing in abilities Accepting struggles through recovery
	Overcoming Obsession	

> then when these other things start to take over your life, like going for walks, or doing pottery, hanging out with friends or whatever, then you have time to just enjoy those things and...you're not hungry so you're not thinking about it.

Becoming less self-absorbed. The women described themselves before recovery as being very focused on themselves and their problems. Now they were **becoming less self-absorbed.** They were busier with their lives and the goals that they were working towards and had less time to think about themselves as much. As well, there appeared to be such a shift in some women's thinking, realizing that not everything revolved around them:

> It's not thinking less of myself, but thinking of myself less. It's like all of a sudden I'm not the only person on the planet, there are other people here, and if something happens whether it be good or bad, it's not all because of me...Whereas before I would have thought it's all my fault, or I'm responsible for the whole world.

Connecting with others. The participants also discussed **connecting with others** or allowing themselves to go out and meet new people. New friendships were formed by many of the women, some with people who had already been in their lives and some with strangers. Some of these new connections were made at school, church, work, self-help groups, or in other activities. As Catherine explained,

> I can have relationships with people today that at one time I just [couldn't]...one of the relationships in my life that I have now is with my step-daughter. I'm having an incredible relationship with her today, and I never would have dreamed of that 11 or 12 years ago.

Helping others. Volunteer work or helping others in need was something that a few of the participants became involved with in their recoveries. Sometimes the women gave help to others experiencing difficulties with binge eating, self-esteem, or body image, by sharing their own experiences. In some cases the help was unrelated to the women's experiences, for example in the case of the participant who became a math

tutor. **Helping others** appeared to be the participants' way of making a contribution to others and being assured that they were doing something worthwhile. Several women shared that it was their commitment to helping others that motivated them to volunteer for this study. Danielle shared how her commitment to helping others evolved from her involvement in OA:

> Another concept in OA that is really important...is the idea that you can only keep your recovery if you give it away, if you share it with other people. So in other words if I'm thinking about eating what could I be doing instead to help somebody else, like maybe I could phone somebody on the OA phone list, see how they're doing. So it's all about helping other people and doing service.

Intervening Conditions

Fostering Self-renewal

The participants described endeavors that encouraged personal growth or self-renewal. These endeavors were a way for the women to care for themselves, to start giving themselves what they needed. This self-care was hindered in the past because the women had not been aware of what they needed, or were in the process of self-punishment and therefore were not ready to nurture themselves. These endeavors have been grouped into six sub-categories: **spirituality**, **spending time alone**, **doing enjoyable activities**, **getting to know oneself better**, **acceptance of self**, and **being kind to self**.

Spirituality. **Spirituality** was an important aspect of self-renewal for a number of the women. **Spirituality** took the form of praying, attending church, or believing in a higher power. Having a sense of spirituality provided hope for recovery and a source to turn to when they needed to express their feelings. One woman discussed how spirituality influenced her recovery:

> ...I got to believe in this loving higher power, [it] gave me the gift that there was purpose behind it all. And it allowed me to kind of make meaning for what had happened. And I think that if I'd only tried to work on it myself with self-help books, I wouldn't have had that sense that there was something bigger than myself that was going to carry me through this, and then at the end I would realize that I had a purpose and it wasn't all just a painful waste of time. And I think the fact that I got to believe in a higher power gave me faith and hope that I needed to stick with the process.

Spending time alone. Many of the participants fostered self-renewal by **spending time alone** to reflect and enjoy their own company. Before recovery, some participants said they were afraid of being alone, but now in recovery they actually wanted time by themselves and saw the benefits of it. For example:

> ...as a child I was so abandoned so many times that I was afraid to be alone. I think if you'd met me 15 years ago you would've thought I was the ultimate extrovert. People didn't know what was happening in my heart, but I was so social, I always had to be out. I couldn't bare the thought of being alone, which was one of the reasons I think I stayed in horrible relationships. God forbid the alternative of being alone. And finally in recovery I started to realize that I was going to find a lot of insight and healing in time spent alone.

Doing enjoyable activities. The women talked about how they began taking part in activities that they enjoyed. This was another way of fostering self-renewal. Any activity that the women felt added something to their lives or that they took pleasure in could be placed in this category. Some examples of the activities mentioned included walking, making pottery, gardening, reading, cooking, and spending time with friends. Marie described some of the activities that she enjoyed:

> ...having passion for things...I'm really into church and so being very passionate about God. Gardening and all of those things...I was really into pottery at that time, so I wanted to spend more time doing pottery.

Getting to know oneself better. **Getting to know oneself better** was very important for the majority of the participants. The participants felt as though they did not know themselves very well before recovery. Now they were taking active steps to learn

more about themselves and many women continue to do this presently in their lives. The women discovered more about themselves such as their likes and dislikes, what they enjoy doing, and what makes them feel better. Some women also believe that they have learned more about what contributed to their binge eating. Lisa described the process of learning more about herself:

> I think it's a growing process of one little thing at a time, where I might have done the one course and found a little bit about myself, and was like "wow, I didn't know that" and then I just wanted to learn more. And so now I've been doing more and more courses or reading more or going to courses in school. Even in courses in school I learn more self-discovery, I learn more about myself and what kind of job I would like to do, or what makes me tick. Or what things give me a rush, what things make me feel I've been rewarded.

Accepting oneself. Another aspect of fostering self-renewal was **accepting oneself**. Instead of focusing on what the participants wanted to change about themselves, many decided to accept the part of themselves they had difficulty with. They applied this decision to the area of their weight in order that they would feel better about themselves and improve their very low self-esteem. Danielle discussed her decision to accept her weight:

> And when I finally gave up trying to control my weight, and decided to accept wherever I ended up, and that was [at] 136 lbs., it was like if I could be grateful for 136 lbs. instead of constantly trying to weigh120, then I didn't have to go up to 160.

Being kind to self. The last sub-category of **fostering self-renewal** is **being kind to self**. The participants discussed how they took action to treat themselves better and be more loving to themselves. For instance, instead of giving herself a negative message, a woman may have decided not to be so hard on herself or to practice positive affirmations. For some women this also meant not exercising if it became too painful, not eating an

amount of food that would cause pain, or not practicing any other means of self-punishment. **Being kind to self** is illustrated in the following comment:

> And some of those meditations where I go and look for that little girl inside of me and talk to her, sometimes that's a really powerful way to shift one of those messages. And [one way to] get rid of these negative messages, is to go and find that part of myself and do something really nurturing, to do something in opposition to the messages.

Strategies

Practicing Prevention/Maintaining Changes

In order to maintain the changes that the women had already made, they practiced strategies that would help in the prevention of relapses. These strategies are grouped into two sub-categories: **proactive strategies** and **reactive strategies**. The **proactive strategies** were used regularly in advance of any urges to binge in order to be prepared for any vulnerable times. The **reactive strategies** were used in direct reaction to urges to binge. There were a couple of strategies that could be used both proactively and reactively.

Proactive strategies. The **proactive strategies** included self-monitoring, changing self-talk, and identifying vulnerabilities. Self-monitoring was a strategy that was used by most of the participants. The women monitored their food intake, the physical signs of hunger and satiation, the messages they were giving to themselves, their emotions, their urges to binge, their amount of weight monitoring, and how they were doing in general. A comment by Lisa illustrates self-monitoring:

> ...still sometimes I say, "Am I, is everything fine? Do I still sometimes eat too much?...but I think that I'm asking the questions but I'm not really doing it. Like I still have to check in with myself. But I don't think it's because I've turned off, it's just like I'm just checking in with myself and double checking that everything's okay.

Changing self-talk was another important proactive strategy for the participants. The women identified that the way they talked to themselves contributed to the way they felt about themselves and to their vulnerability to binge eating. Changing self-talk from negative to positive helped to prevent future binges and increased self-esteem. For example, Danielle discussed her use of positive self-talk:

> ...if I'm struggling with a specific issue, I come up with an affirmation. I was just running and I'll say it while I run. So that's one little technique that I've found really powerful. Like today I was actually saying "I have a healthy comfortable body, I love my body." And I'll just come up with whatever I'm struggling with I'll just turn it around to a positive and say it many times.

Identifying vulnerabilities also helped the women to avoid the urge to binge. The women found that if they knew what made them vulnerable to a binge, they could be prepared. For example, Catherine mentioned that she is likely to binge when she is hungry, angry, lonely, or tired. Therefore she has a plan to address each of these vulnerabilities when they happen, such as having a snack when she is hungry and a nap when she is tired. Danielle said that she avoids certain health magazines and television shows that lead her to want to lose weight.

Reactive strategies. The **reactive strategies** discussed by the participants included doing something else and choosing not to binge. The participants said that they felt the urge to binge, instead they would do something else. For example, the options of phoning a friend, reading, writing in a journal, or exercising were all mentioned. Some participants also said that they made a choice not to binge. When they felt that they were wanting to binge, they might stop themselves and ask whether that was the way that they wanted to handle their stress. Often the answer was no and then they would do something else.

Finally, there are two strategies that can be considered both proactive and reactive. These include remembering the past and addressing underlying issues. Remembering the past was used by some women to remind themselves of what their lives were like before recovery. This could be done on a day to day basis or directly following the urge to binge. For instance Lisa said, "I guess it helps to have my memories of the bad times to...not go back there again. Not to forget the history of I wasn't happy there, and that it's not fun to feel out of control."

Several women also chose to address underlying issues. This meant addressing any issues that might have been contributing to the urge to binge directly after the urge comes or addressing these issues before the urge in order to prevent future urges to binge. For example, Danielle shared that "...now if I catch myself thinking about food a lot my next thought isn't let's go eat, it's okay what's troubling me? Why am I thinking about food so much? What am I trying to push down and what do a I really need?"

Consequences

Experiencing Self-acceptance

As a result of the experiences of the women on the journey of recovery, they experienced self-acceptance. They felt better about themselves instead of thinking negative things and punishing themselves. There are five sub-categories of this category: **improving self-esteem**, **becoming more comfortable with body size, taking in positive messages**, **believing in abilities**, and **accepting struggles through recovery**.

Improving self-esteem. The participants expressed feeling better about themselves as people and even liking themselves. Although self-esteem may still be a struggle at times for the women, the improvement was significant. The following

comments illustrate the changes in the women's self-esteem: "Before it was I'm this horrible person that can't be changed, I'm this horrible person. And now it's more like there are parts of me that I would still like to work on, but there are parts of me that definitely I like." "I think at the time I started getting opportunity and believing I could do things and feel good about life. Feeling good about myself and feeling good about life. I think those factors contributed to the successes I had."

Becoming more comfortable with body size. The women also talked about **becoming more comfortable with body size**. Like self-esteem, feelings about their bodies improved despite the fact that there were still some struggles with body image. However, even though there were still struggles, the overall perceptions that the women had about their bodies changed. Participants expressed the shift in the way they feel about their bodies: "So I do think that being able to look at myself in the mirror naked and say that's okay, that's part of recovery for me, to actually believe that."

> So I don't know really why I started to like my body even though it wasn't as thin as I'd hoped it would be. It just came, it slowly came that I started to like it more and more and to be content with it. I'm grateful for that, I spent so many years hating my body.

Taking in positive messages. Another part of self-acceptance for the participants was **taking in positive messages**. Before recovery participants said that they would not accept compliments or positive comments about themselves from others. However, part of recovery was learning to accept these positive messages: "Now I've been told by a lot of people "You're not fat." Finally taking those messages in, before I could never receive those messages because I think the strongest messages I got were from my family."

> Sometimes it's just discipline to say "Oh thanks" [instead of] "This has been in my wardrobe for 8 years and this was when I was a size 20 and now I'm a size..." Sometimes that's in your head, but out of discipline you say "Thank you," just so

> you don't do it. I think that I probably do a lot of that. Just being okay with things sometimes on the surface level and then it goes deeper just because you've done it...

Believing in abilities. The participants also mentioned that they began to believe in their abilities. While they were in the pattern of negative thinking they were either not aware or did not believe that they could accomplish what they set out to do and be successful. Now the participants were realizing that they were capable people. Elizabeth described the process she went through which led her to believe in her abilities:

> It was when I started getting productive and I started realizing I could do these things, and I can work from morning to night every day and feel good about myself and feel increasingly better about myself. Feel worthwhile, feel like I have a role in this society, feel like I have a direction, a future...the more results I got, the more goals, the better I felt about myself for a change. I felt motivation.

Accepting struggles through recovery. The final sub-category of self-acceptance is **accepting struggles through recovery**. The women accepted that they may have some difficulties while recovering from binge eating, and that they would accept it rather than punish themselves for any relapses that they may have. Jasmine discussed her acceptance of struggles through recovery:

> Giving yourself permission to have those slip ups. I think through this last relapse what really helped me is the word permission...it's almost like acceptance, "I'm binge eating a lot, okay I'm binge eating." And you come to the point where you almost accept it, and all of a sudden it becomes a lot easier to deal with...because you can't recover from something it you're always punishing yourself.

Overcoming Obsession

The second consequence in Phase IV is **overcoming obsession** with weight and food. The women mentioned that they no longer thought about their weight all the time, such as what they weighed and how much weight they wanted to lose. The women also said that they were no longer thinking about food all day or planning their next meal.

Because their lives were filled with other things, food and weight were no longer as important as in the past. The participants words illustrate overcoming obsession: "That's another thing that's changed for me, food is not the first thing I think about when I wake up in the morning, and it's not the last thing I think of when I go to bed at night".

> So somehow it was this shift of focus to just feeling grateful that I was just losing weight without killing myself to do it. I still struggle with the increase [of weight] with pregnancy but not that much, it's not the focus of my day.

The Recovery Process

The information that the participants shared also reflected on the broader aspects of the recovery process. They talked about what the recovery process was like, about relapses, and what being recovered means to them. Each of these matters are addressed in turn.

Recovery process. Overall the recovery process from binge eating was a very gradual and difficult process. For many of the women recovery took up to a year or more, frequently several years. They found recovery to be very slow in coming, requiring a lot of trial and error and hard work. Jasmine shared the following comment about the difficulty of recovering from binge eating:

> And big things like binge eating don't happen overnight, they happen very gradually. It was like a baby learning how to walk, and when the baby first learns how to walk it doesn't look like walking sometimes, and it might look more like crawling, and sometimes at the beginning they fall a lot. But no one says to that baby "Oh you should be walking right now." They pick them up and dust them off and I'll try again. And that's the biggest thing to do is to continue to persevere and have hope.

The recovery process was also described by the women as very painful and one of the hardest accomplishments of their lives. Danielle expressed that "...much of the time it was excruciatingly painful, because it meant feeling feelings that had been frozen there

for years that I hadn't allowed to come up." Although it has been described as painful and difficult, some positive terms such as "liberating" and "freeing" have also been used to describe the process. The recovery process appears to be bittersweet not only with rewards but also pain along the way.

Relapses. When discussing recovery from any issue, it is important to find out about experiences with relapses and how they are handled. The majority of the women I interviewed did not have anything that they considered a relapse since recovering. They said that although there are times when they may eat more than they are comfortable with, it is different than a binge. Danielle discussed her thoughts on relapse:

> [Relapses are] never like they were. Never that eating and eating and eating until I'm in pain and thinking "God, why am I still eating?"...I hope it doesn't come back but I definitely overeat at times. I can't think of when the last time would be but now it's more a conscious choice, it's like I'm going out for dinner and I want to have an appetizer and I want to have a main course and I want to have dessert and I eat and I really enjoy it. And I know I'm a bit full and I think "What the heck, that was really good." Yeah so I think...I definitely overeat at times but it's probably more along the lines of what the average person does rather than bingeing.

One participant, Jasmine, did have what she considered to be a relapse between our first and second interviews. What she said about this experience was that she was much faster at identifying that she was bingeing again, and faster at recovering from the relapse. In fact she said that she was able to stop bingeing within a week. It may be that once a person attains recovery, subsequent relapses may be much quicker to address. However, future research on this topic is necessary.

Recovery. All of the women I interviewed considered themselves to be recovered from binge eating. Recovery meant several things to the women. Recovery meant no longer binge eating or obsessing about eating, being comfortable with food and enjoying

food, feeling better about themselves and their bodies, and feeling in control. One woman described her beliefs about recovery:

> I think with respect to food, recovery means eating because I'm hungry. Recovery means enjoying food without feeling guilty about it, just enjoying food for what it is. It's an essential pleasure, it's a wonderful gift. But recognizing when I'm full and not wanting to eat more when I'm full. That's a blessing, on a good day I eat lunch and I'm full and I don't want to eat more...It means accepting my body weight where it's at. And not wanting to make it different than it is. You know really good recovery is loving my body the way it is. And I guess emotionally and spiritually recovery means to me feeling at ease with myself.

Although the participants gave very similar ideas as to what recovery meant, they had differing ideas about the essence of recovery. The participants who were involved with Overeaters Anonymous preferred to think of themselves as "in recovery" as opposed to "recovered." They felt that they would likely have to continue to self-monitor their use of food throughout their lives to maintain being "in recovery." Other participants felt that despite the fact that they once engaged in binge eating did not mean that they would struggle with binge eating for the rest of their lives. However, none of the participants felt confident enough to say that they thought they would never binge eat again in their lives.

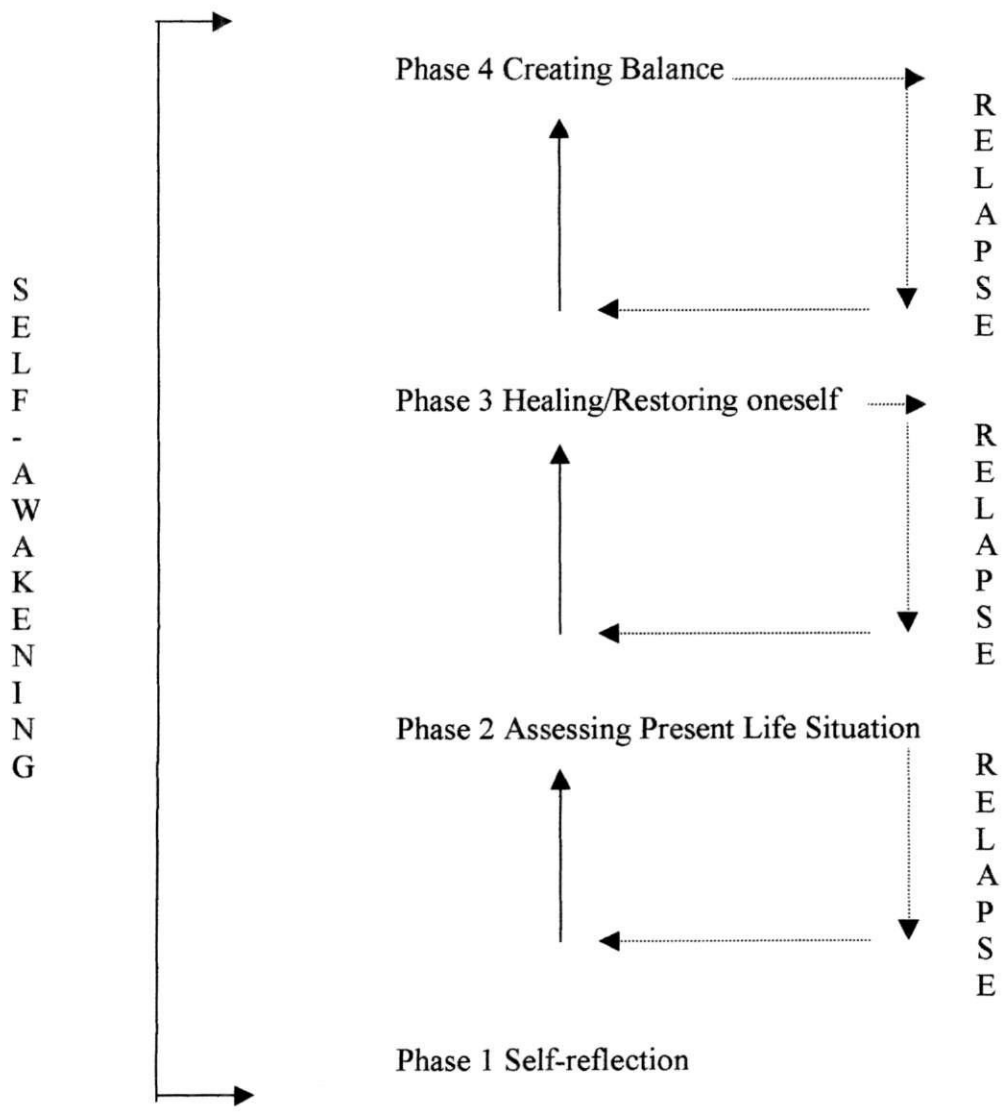
Core Category

As discussed in Chapter Three, the core category is the central phenomenon or basic social process being studied (Strauss & Corbin, 1990). It is determined by asking questions about the connections between the categories. The core category that emerged from this study was **Self-awakening**. See Figure 1 for a diagram of the recovery process, including the core category and the phases of recovery.

Self-awakening is the process that the women went through, of resolving the disconnection that they felt in relation to themselves and the world around them.

Figure 1

The Grounded Theory of Recovery



Movement from one phase to the next was dependent on the presence of **Self-awakening**. For instance, before the participants moved from Phase II to Phase III they "awakened" to the fact that they had a problem with binge eating. Many women had not realized this before, thinking that they were just eating too much and not knowing why. Once they made this revelation they were free to go on to learn what might help them recover from binge eating.

Throughout the process of recovery the women learned more about themselves, "awakening" to who they are. This appeared to be integral to the success of recovery. While the participants were in the midst of binge eating there was a lack of self-awareness. They were avoiding what was bothering them and "numbing" themselves. As some participants said, they felt disconnected from their bodies and emotions.

However, through the process of recovery the women "awakened" to what was actually taking place in their lives. They discovered more about their emotions, what they wanted out of life, what was contributing to their problem with binge eating, the detrimental effect of low self-esteem and having a negative body image, and what worked to help them from relapsing. The women also discovered that it was safe to open themselves up to others and allow support in their lives. The process of recovery was about each woman "awakening" to, and finding out what worked for herself, through testing things out and learning from the process. Through the process of **Self-awakening** the women became re-connected with themselves and the outside world.

Summary

This chapter presented the grounded theory of recovery from binge eating disorder. The four phases of recovery were presented, followed by some comments on

the process of recovery in general. Lastly, the core category was discussed and related to the theory of recovery.

CHAPTER FIVE: DISCUSSION

Researchers have only recently begun to take an interest in the area of recovery from BED. To date this study is the first to examine the recovery process from BED from the participants' perspectives. Six women were interviewed in order to construct a theoretical model of recovery using grounded theory methodology. This theoretical model provides a framework for understanding the recovery experiences of the women in this study.

The specific aims of the study included: generating a theoretical framework for understanding the process of recovery, identifying and describing the factors that stimulated and aided in the process of recovery, and identifying and describing the strategies that helped along the process of recovery. The research questions used to guide this study included: What is the experience of recovery for women with BED? Who and what helped along the process of recovery? And what replaced binge eating in the women's lives?

This chapter discusses the theory of recovery that emerged from this study in comparison with existing literature. Firstly, the theoretical model of recovery from BED is compared to the literature on models of change. Secondly, the core category is related to supporting literature. Thirdly, the factors and strategies found to be helpful to recovery are compared to the eating disorder literature on recovery. The strengths and limitations of the study are also discussed, followed by the delimitations, counselling implications, and suggestions for future research.

Links to the Literature

Support for Theoretical Model of Recovery

The two theories of change outlined in chapter two, Virginia Satir's model and the transtheoretical model, lend support to the theoretical model of recovery developed in this study.

Satir's model of change. Virginia Satir's six stage model of change (Gross, 1994) contains concepts about recovery similar to the ones discovered in this study. Satir's first stage is "status quo." An individual is considered to be in this stage when there is little thought by the individual that they should make a change. This stage most closely resembles the first phase, **Self-reflection**, of this study. In Phase I the women had not yet made a commitment to change or even acknowledged a problem.

Satir's second stage, "the foreign element," describes the entry of something external to the individual's system, such as a new experience, a loss, social pressure or support from significant others (Gross, 1994). This stage is also comparable to what occurs in Phase I of the present theory. The categories of **Life changes/transitions** and **Disapproval from others** particularly capture the concept of "the foreign element." The women experienced moving, a loss, the ending of relationships, the beginning of school or a new job, or a birthday. They were also faced with negative comments about their weight and amount they were eating. These experiences were the contexts in which the motivation to make the transition to the second phase of recovery occurred.

Chaos, the third stage in Satir's model captures the eruption of the tension to both resist and move toward a change (Gross, 1994). This third stage is comparable to the second phase of recovery from BED, **Assessing Present Life Situation**. During this phase the women came to the conclusion that they had a problem and wanted to change.

However, they remained engaged in the behaviour of binge eating. They did not want to continue to binge eat, but at this point were unable or not ready to stop the pattern.

The fourth stage of Satir's model is implementation, when the individual begins to make healthier lifestyle choices, become more assertive, and take risks (Gross, 1994). This is in line with the third phase of recovery form BED **Healing/Restoring Oneself**. In this phase the women were making different choices for themselves by changing their rules with food and the way that they treated their bodies. They were also taking more risks and trying new things to encourage recovery, as well as asserting themselves in their relationships with others. The assertion that the women described involved ending detrimental relationships and standing up for themselves.

The fifth stage of Satir's model is relapse (Gross, 1994), which is thought to occur at any point between the third and sixth stages of the model. This stage is not accounted for in the phases of the present study but is considered a part of the recovery process from BED. The participants all discussed experiencing relapses while working towards recovery.

The final stage of Satir's model is the "development of a new status quo," when the strange or new has become familiar (Gross, 1994). This is the end product of having integrated the new into the old system of action, thoughts, and feelings. This final stage approximates the fourth phase, **Creating Balance**, of the present theory. It is in this phase that the participants are solidifying the changes that they have made.

Although Virgina Satir's model of change and the model of the present study do not occur in the same number of phases, they both contain comparable ideas about what occurs in recovery.

Transtheoretical model of change. Like Virginia Satir's model of change, the transtheoretical model of change also has many similarities with this study's model of recovery.

As discussed earlier the transtheoretical model has five stages (Prochaska & Norcross, 1999). The first stage is precontemplation. In this stage the individual has no intention to change her or his behaviour in the foreseeable future. As with Satir's first stage "status quo," precontemplation is comparable to the first phase of recovery of this study, **Self-reflection**. They are similar in the sense that the participants in this study had not yet realized that they had a problem with binge eating in Phase I. Nevertheless, there is a difference between the two models' first stages. The difference is that the participants in this study were **Attempting to recover** in Phase I by **seeking help** and by **focusing on weight loss**. These recovery strategies, particularly focusing on weight loss through diets is commonly found among people with BED (Spitzer et al., 1993). However, these strategies were aimed at addressing the effects of binge eating, including the distress in the women's lives, rather than tackling the problem of binge eating itself. Perhaps attempts to recover at this phase may not be found with people struggling with problems other than binge eating. People with BED could be attempting to recover early on in their struggle with binge eating because weight gain and being overweight are not socially acceptable in North American culture, but are often a symptom of binge eating. Future research is needed to clarify this point.

The second stage is contemplation, when the individual becomes aware that there is a problem and considers making an attempt to change (Prochaska & Norcross, 1999). This stage fits with the second phase of recovery from BED, **Assessing Present Life**

Situation. In this phase the participants realized that they wanted something better for themselves and gained awareness that they did have a problem and likely needed some help.

Preparation, the third stage, begins when the individual has the intention to take action immediately and starts to show small behavioural changes (Prochaska & Norcross, 1999). Again this fits with the second phase of recovery from BED. The women in this study sought out information about binge eating, nutrition, and any other area that they felt was related to their binge eating problem. The information the women read had an impact on their behaviour, and some women managed to decrease the amount they were binge eating.

The fourth stage of the transtheoretical model, the action stage, is equivalent to the third phase of the present study, **Healing/Restoring oneself**. Prochaska and Norcross (1999) describe this stage occurring when the individual modifies her or his behaviour, experiences, and/or environment in an attempt to overcome their problems. In Phase III the women in this study started to change their relationships, eliminating negative ones and seeking out support from others. They also worked at changing their behaviour in regard to food and their own bodies, for example, eating forbidden food and reducing weight monitoring. Their experiences were also modified in the way that they experienced their emotions. Before recovery, emotions were numbed with food, but in this phase the women worked at feeling their emotions and experiencing them as acceptable and normal.

The fifth and final stage of the transtheoretical model is maintenance (Prochaska & Norcross, 1999). As with the fourth phase of recovery from BED, **Creating balance**,

both of these stages exemplify individuals working at preventing relapses and consolidating the progress made up to that point. The participants in this study created strategies such as self-monitoring or avoiding triggers, to help prevent themselves from relapsing. They also engaged in nurturing activities to maintain and strengthen their improving self-esteem.

The transtheoretical model of change also does not occur in the same number of phases as the present theory. However, both of these models do contain the same processes in the same order, and similar ideas about how people change.

Support for the Core Category

The core category **Self-awakening**, describes a fundamental aspect of recovery from BED. **Self-awakening** unfolded throughout recovery, and entailed the participants learning more about themselves, opening themselves up to others and new experiences, and becoming more present, aware, and involved in their lives. The experience of "awakening" or "opening up" is also found in other literature on recovery. The concept of **Self-awakening** is compared to different types of literature to provide support for its use as the core category in this study. The types of literature include: personal accounts of recovery from compulsive overeating found in self-help literature, and literature on recovery from trauma and mental illness.

Self-help literature. Self-help author Geneen Roth has written many books about compulsive overeating. In Roth's (1993) book Feeding the Hungary Heart, personal accounts are given by women who have experience with compulsive overeating.

Women's stories found in this book capture the concept of **Self-awakening** (Roth, 1993). For example, Laura Fraser writes, "But I've stopped letting myself be controlled

by the external—whether food or outward perceptions of appearance—and I've learned to listen to my inner self and to like that self. I've freed myself forever." (p. 171). Florinda Colavin also shares her experience, "The process of recovering from food and alcohol abuse has been a transition, a bridge that has taken me across to another side where my eyes are open, my senses alert." (p. 194).

Both of these women exemplify **Self-awakening**. Laura describes becoming more aware of her inner self, and Florinda also expresses a new awareness of herself and her surroundings. This growing awareness or "opening up" is a central aspect of **Self-awakening**.

Recovery from trauma. In Herman's (1997) book Trauma and Recovery, she describes three stages of recovery from trauma. The third stage of recovery "reconnection," is similar to the concept of **Self-awakening**. "Reconnection" entails the individual creating a new self, reconnecting with others, and finding new beliefs that give meaning to her life. Herman believes the task of this stage is the survivor reclaiming her world.

The stage "reconnection" captures a new awareness that survivors of trauma develop in recovery (Herman, 1997). Herman suggests that the statement "I know I have myself" could stand as the emblem of this final stage of recovery. The survivor learns from the past in order to create the person she wants to be. She reconnects with lost aspirations and rebuilds her life. Herman includes a quote by Sylvia Fraser (1987) which exemplifies the concept of **Self-awakening**, "Yet even here I see a gift, for in place of my narrow, pragmatic world of cause and effect...I have burst into an infinite world full of wonder" (p. 253).

The descriptions of "reconnection" capture the process of **Self-awakening** undergone by the participants in this study. The participants went through a process of reclaiming their worlds and creating new lives for themselves. Learning more about themselves contributed to this process, which also appears to be essential in Herman's (1993) conceptualization of recovery.

Recovery from mental illness. Insights into the recovery from mental illness are provided by Marsh (2000). Marsh examines important factors in the recovery from mental illness based on personal accounts.

Reconstructing a new self is one factor important to recovery. This involves individuals rediscovering parts of themselves that they assumed were lost, and discovering and developing new parts of themselves. Developing new meaning and purpose in life is another aspect of recovery, as well as becoming an agent of one's own recovery. Marsh (2000) includes the following quote which captures one individual taking charge of recovery, "By learning more about myself, my limits, and weaknesses and strengths, and by making changes in my way of life, I have been able to maintain my health and prevent a recurrence of mental illness" (Houghton, 1997, p. 86).

Marsh's (2000) article supports the concept of **Self-awakening**. The people discussed in this article "awakened" to themselves. Similar to the participants in this study, they rediscovered themselves and became more aware of the tasks they must accomplish in order to facilitate recovery.

Support for Major Findings

The factors and strategies that were found to be helpful by the participants of this study are supported by existing literature in the area of recovery from eating disorders. The literature is discussed in association with the findings of the present study.

Factors Stimulating Recovery

Experiencing a significant life transition has been found to stimulate the recovery process for women in studies on eating problems (Rorty et al., 1993; Thompson, 1994). The women in this study described **Life changes/transitions** as having an impact on their recoveries by instigating thoughts about their situation in life.

Other factors that have been noted to stimulate recovery include: hitting rock bottom (Koski-Jannes & Turner, 1999; Rorty et al., 1993); negative medical, social, or professional consequences (Rorty et al., 1993); admitting that something was wrong (Noordenbos, 1989; Peters & Fallon, 1994); acceptance that a problem exists (Goldkopf-Woodtke, 2001); being fed up with illness (Hsu et al., 1992); desire to improve self-esteem (Stanton et al., 1986); desire for a better life (Rorty et al.), and the desire to get well (Goldkopf-Woodtke, 2001).

All of these factors were found in the stories of the women in this study. They mentioned experiencing a low point or hitting bottom in their lives (**Distress – experiencing a low point**). The participants also experienced health problems or concerns such as physical pain and discomfort (**Distress – experiencing physical discomfort**), and negative social consequences such as isolation and disapproval from others (**Distress – isolation; Disapproval from others**). In addition, the participants acknowledged that they had a problem (**Gaining Awareness**), and were tired of living their lives the way that they had been (**Dissatisfaction**). The women had the desire to

change many aspects of their lives such as their bingeing behaviour, the way they were living their lives, and the way they felt about themselves and their bodies (**Wanting something better for self**).

Factors and Strategies Helpful to Recovery

Self-discovery. Literature on the recovery from eating problems suggests a number of factors and strategies that women have found helpful. One important factor found in this study, as well as in a study by Beresin et al. (1989), was the participants getting to know themselves better. The women in Beresin et al.'s study talked to themselves about their feeling states, desires, and body image to enhance their self-understanding. The women in this study made an effort to learn more about their likes and dislikes, what they enjoy doing, and what makes them feel better (**Fostering self-renewal**). In addition, **attending to emotions** was a strategy used for self-discovery for the women in this study, learning more about emotions that they had not been aware of before recovery.

Reduction in dietary restraint. The recovered participants in Fairburn et al.'s (2000) study on the course of BED showed a reduction in dietary restraint. Although it is unknown whether the women in Fairburn et al.'s study used reduction in dietary restraint as a strategy for recovery, it was used for this purpose in the present study. The category **Changing relationship to food**, included the practice of stopping the diets that the women had been engaging in for years. When the women stopped the diets that they were on, they then had the freedom to experiment with the way that they used food. This experimentation with food was integral to the recovery process.

Giving up control. Gross (1994) believes that some changes have been found to require "letting go" of the attempt to control the process of recovery and allow change to happen as and how it will. The participants in this study felt that the strategy of **giving up control** over certain aspects of their lives was integral to the recovery process (**Accepting ambiguity – giving up control**). This meant giving up control over eating, food, emotions, and weight. Once the participants let go of trying to control these things, recovery came much more easily.

Support. Support from others is another factor that is thought to be helpful in the recovery from eating problems. Shifting from isolation to connection with other people is important for women recovering from eating problems (Peters & Fallon, 1994), particularly building solid relationships with friends (Rorty et al., 1999). Not only is having support from others helpful, but also sharing problems and emotions with supports. For instance, Stanton et al. (1986) discovered that women recovered from bulimia nervosa used sharing with at least one person about the eating problem as a strategy for recovery.

The participants in this study also found support from others helpful to their recoveries. The category **Breaking isolation** captures the shift the women made from isolation to opening up to others about their problems. The women also began allowing others to provide support for them through their recoveries. **Breaking isolation** was an important strategy for recovery in this study.

Having positive support is helpful for recovery but having detrimental relationships is not. Some findings indicate that women recovering from eating problems may find it necessary to eliminate, defer, or revise negative relationships (Beresin et al.,

1989; Epston et al., 1995; Hsu et al., 1992). The participants in the present study thought it essential to end relationships that they felt were harmful to their own well-being or a hindrance to their recoveries (**Self-assertion – eliminating negative relationships**). This self-assertion demonstrates the shift that the participants made in taking control of their recoveries and making better choices for themselves.

Productivity. Productivity in school or work has also been discovered to be a factor contributing to recovery. Productivity may instill feelings of power, effectiveness, achievement, and satisfaction (Beresin et al., 1989). The women in the present study went back to school or undertook other activities that they had been putting off. Their lives became busier and binge eating became less of an issue in their lives (**Making room for life**). Becoming involved with these new activities provided the women with a new focus in their lives outside of food and body issues. The activities that were filling their lives also contributed to the way that they felt about themselves, increasing their self-esteem.

Peters and Fallon (1994) discuss the continuum "passivity to personal power," the change women recovering from bulimia nervosa go through from feeling lost and not knowing what they want out of life to taking control of their lives. This continuum captures what the women in this study experienced. The participants went from having a lack of direction in their lives to planning for their futures and pursuing their goals. This self-reevaluation caused some women to go back to school or re-evaluate their careers (**Making room for life**).

Participating in activities. Another factor which appears to contribute to recovery are the activities used by women to facilitate recovery. The participants in Garrett's 1993

study (1997) listed activities such as gardening, swimming, yoga, belly dancing, cycling, walking, and running for the pleasure of fitness rather than weight loss. Activities such as these were also important to the women in this study and included running, walking, making pottery, gardening, reading, cooking, and spending time with friends (**Fostering self-renewal – doing enjoyable activities**). Activities related to exercise also shifted from a focus on weight loss to fitness or stress reduction as they did with participants in Garrett's study.

The activities listed above are also an example of the category **Creating alternatives** from this study. These activities, as well as some others, were used as an alternative strategy to binge eating by the participants to prevent binge eating.

Nurturing self-acceptance. Goldkopf-Woodtke (2001) mentioned that appreciating and accepting herself was important to her recovery from anorexia nervosa. In addition, Arnow et al. (1992) discovered that women found positive self-regard to be an important factor in preventing binge episodes. A strategy that the women in this study also found helpful was **nurturing self-acceptance**, a sub-category of **Striving for personal happiness**. The women in this study changed the negative things they said to themselves, focused on the things they are good at, and became more forgiving of themselves as strategies for recovery.

Strengths and Limitations

A number of strengths and limitations emerged in this study of recovery from BED. First the strengths and then the limitations are discussed.

Strengths. This study is the first to examine recovery from BED from the perspective of the participants. The theory of recovery was developed using the

information relayed to me by the participants. This type of study is important because it allows us to learn from the participants who have actually experienced the phenomenon under study. Other alternatives can be restricting in the sense that they limit the amount and type of information that can emerge. Peters and Fallon (1994) critique treatment outcome studies, the most popular type of study on recovery, for excluding the views of recovered women.

> The emphasis of treatment outcome studies has been on the quantification of predetermined factors assumed to be pertinent to the alleviation of bulimia and anorexia. The variables measured, while allowing for specific comparisons, have left no place for recovered women to instruct us about the process of change, nor has it allowed for the discovery of curative factors beyond the experimenters' assumptions. (p. 339)

Studies on the course of recovery offer another alternative. Although these type of studies can provide us with useful information about length of recovery, relapses, and any other factors the researchers decide to measure, again the participants themselves are not given a voice to teach us about their perspectives of recovery.

This study clearly fulfills the criteria of a useful theory outlined by Glaser and Strauss (1967). It "fits" the situation being researched, has "grab," and "works" when put to use. The theory "fits" because the generated categories are indicated by, and applicable to the data. The determination of "fit" was confirmed through member-checks, as well as my own checking and re-checking to make sure that the categories captured the essence of the data. The theory has "grab" because it is relevant to the social or practical world and the persons in that world. The theory of recovery that emerged from this study has relevance for both clinicians and people with BED. The theory has many implications for counselling which are discussed in the following section. In addition, the participants in this study felt that the theory of recovery captured their

experiences of recovery. Because of this, people with BED may also find the theory useful in order to learn what recovery was like for others and to get ideas and strategies for their own recoveries. The theory also "works" because it has relevance or usefulness to explain, interpret, and predict the phenomenon under study. The theory explains and interprets the process of recovery, and predicts the phases that someone trying to recover from BED will go through.

Limitations. Although many measures were employed to ensure the trustworthiness of this study, caution must be taken when considering the results of this study.

The transferability of this study may have been compromised by the degree of homogeneity in the sample of women who participated in this study. Despite the fact that I tried to invite a variety of participants, all of the women who participated are White and middle class. In addition, all but one of the women in the study are under the age of forty, the majority of the women are college or university educated, and only one woman identified herself as a non-heterosexual. I would caution transferring the data to another context based on the homogeneity of the participants. The results of this study should be taken as unique in relation to its context, participants, and researcher.

An additional limitation of this study is the issue of memory. The participants were asked to recall and discuss their experiences of recovery. Some of the participants were having to remember events that occurred as long ago as 10-12 years. On occasion the participants could not remember all of the details of their recoveries. One may also speculate, given the way that memory functions (being "constructive" rather than "reproductive"), that events may not have been remembered exactly as they occurred

(Ceci & Bruck, 1995). However, despite the fact that some information may not have been remembered or remembered accurately, the participants shared their experiences as they recalled them and provided useful information regardless.

Delimitations

Boundaries were put in place to limit the scope of participants selected for this study. Only women over the age of 18 who at one time met the criteria for BED were chosen to participate. Therefore no males or adolescents were selected to participate in this study.

Implications for Counselling

The information shared by the participants in this study point to various ways that counselling can be improved when working with women who have BED. As well, issues that counsellors need to be aware of and address in therapy when working with this population emerged. The counselling implications discussed are supported by literature in the area of eating problems.

Counsellor Awareness

Based on the results of this study, as well as existing literature, there are a few issues for counsellors to take into account when working with clients who have BED.

Treatment seeking. Research suggests that only a small percentage of women who binge eat seek treatment specifically for their eating problem (Thompson, 1994; Whitaker et al., 1990). This is supported by the findings of this study. Many of the participants who attended counselling did not go to address their eating problem, but rather to discuss other issues in their lives. Counsellors need to be aware that they may have clients with BED who do not discuss their eating problem in therapy. If a

counsellor suspects a client of struggling with BED, inquiring into that client's coping strategies may be one way to identify whether or not they in fact have BED.

Stages of recovery. Counsellors working with clients who have BED need to be aware of the client's stage of recovery and how many attempts the client has made to recover. By keeping in mind the client's stage of change, the counsellor can tailor therapy to the client's level of readiness for change (Levy, 1997). The models of change that counsellors can use for this purpose include the transtheoretical model, Satir's model of change, or the present study's theory of recovery.

Counsellors can also draw ideas from the client's past attempts at recovery, keeping in mind what the client found helpful and unhelpful about past attempts. DiClemente et al. (1991) suggest that each time a person relapses and attempts to recover again, they can learn from past mistakes and try new strategies for recovery.

Level of knowledge. Counsellors should also be mindful about their level of knowledge about BED. A lack of knowledge about BED can be detrimental to the therapeutic process. Although some of the participants in this study discussed positive experiences with counselling, the negative experiences of two of the participants highlight some of the problems that women with BED may experience with a therapist uneducated about BED:

> ...you would go in to counselling, in my case two times, and get the message that you need more willpower, you need more discipline. And those are not the things that I need more of...So...come to think of it that really annoys me, to go through it twice, and the third time finally find someone who really did know her stuff. And could speak in a mature and professional way...

> ...in fact I didn't openly deal with [binge eating] in counselling because I had been in a hospital once and I went to see a woman who specialized in eating disorders, because I was binge eating on the unit. And I went and talked to her about it and she didn't think it was an eating disorder. So I felt put off...and later

> I met with a different counsellor...and she said "no, if you're feeling that's an eating disorder it is." And that helped me..."okay I can deal with this now."

The experiences of these two women demonstrate the lack of knowledge and understanding about BED that still exists in the counselling community. The ideas that people with BED could get over their problem if they only exerted more self-control, or that binge eating is not a serious problem, can be harmful to clients seeking help. The two participants whose ideas are shared here persevered in seeking help after their negative counselling encounters; however, this may not be the norm. It could be that many individuals who have similar negative experiences do not continue to seek out the help that they likely need.

It would be beneficial for therapists who are not familiar with BED to inform themselves about this particular eating problem by reading literature or by attending conferences on eating problems. In addition, therapists may need to examine their beliefs about people who binge eat and about individuals who are overweight. Any biases and prejudices that are identified should be explored. If therapists are not able to change their biases or prejudices by educating themselves about BED, or feel unable to avoid having their biases or prejudices influence their ability to counsel this population, referring clients with BED to another professional is appropriate.

Issues to Address

The results of this study show that the recovery from binge eating involves more than changing eating patterns. When counselling someone struggling with BED there are several issues that may need to be addressed or considered in addition to focusing on changing the behaviour of binge eating.

Context. Peters and Fallon (1994) believe recovery is a multi-dimensional process involving a progression of changes in relationship to self, body, family, and culture. This is based on their study involving women who recovered from bulimia nervosa. Coming from the feminist perspective of binge eating, I believe it is necessary to take into account the individual's context or environment when counselling, and this includes the four factors mentioned by Peters and Fallon. In addition, examining how the conditions of a woman's life have shaped her experience with weight and eating is also necessary (Brown, 1993).

The importance of taking context into account is supported by the findings of this study. The participants discussed the influence that the messages they received from others about their weight and/or eating had on their binge eating. In addition, abuse and family problems were common and were the contexts in which binge eating began for many of the participants. Participants who had attended counselling discussed how helpful it was for them to address their family context and/or the cultural context in which the messages they received about weight and food are embedded. They found that discussing these conditions of their lives contributed to their recoveries. The participants in Peters and Fallon's (1994) study also expressed that an essential component of treatment for them was talking about physical, sexual, and emotional abuse to others who listened and honored their pain.

Additional issues discussed by the participants in this study that may be necessary to explore in therapy include body image, self-esteem, depression, and emotions.

Body image. The participants in this study all shared a struggle with body image. They talked about wanting to be thin and having negative thoughts about their bodies

before recovery. This type of body disparagement (Goodrick et al., 1999; Romano & Quinn, 1995) and drive for thinness is frequent among women with BED (Goodrick et al.). A study by Rorty et al. (1993) found that women who had recovered from bulimia nervosa felt that negative body image and the fear of becoming fat were the hardest aspects to change in recovery. Participants in this study also thought that improving their feelings towards their bodies was difficult, and remains a continuing challenge. They felt that part of recovery was learning to accept their bodies the way that they are, as well as overcoming weight and shape obsession.

One study found that women recovered from anorexia nervosa rated the aspect of having positive experiences of one's self and body as the most important goals for therapy, while the aspects of eating and weight were considered the least important goals for therapy (Noordenbos, 1989). Although this information has not previously been gathered from women recovered from BED, the participants in this study did emphasize the importance of working on the issue of body image, and minimized the importance of addressing eating behaviours in therapy. Due to the fact that body image is a struggle for women with BED, therapy is a good arena to address this issue.

Self-esteem. Because women with BED often have low self-esteem (de Zwaan et al., 1994; Goodrick et al., 1999), self-esteem is another factor which needs to be addressed in therapy. The participants in this study discussed having poor self-esteem while they were engaging in binge eating. However, through the process of recovery their self-esteem improved. This association between recovery and self-esteem has been found in other research as well. Troop, Schmidt, Turnbull, and Treasure (2000) discovered that increases in self-esteem were associated with recovery from bulimia

nervosa. The participants in their study showed significant improvement in self-esteem between the beginning of treatment and the 18 month follow-up. Those that changed little in their self-esteem maintained their bulimic symptoms.

Stanton et al. (1986) discovered that the desire to improve self-esteem was the most influential factor in initiating change in women with bulimia nervosa. Rossotto et al. (1996) suggest that in order for women to recover from bulimia nervosa, women must acknowledge the harmful impact of low self-worth, and begin to accept themselves despite their struggle with the eating problem.

Given the associations between BED, self-esteem, and recovery it may be helpful for therapists to assess the self-esteem of their clients with BED, and work towards building better self-esteem for those who appear to need help in this area.

Depression. Depression is an issue for many people with BED (de Zwaan et al., 1992; Kuehnel & Wadden, 1994; Marcus et al., 1990; Mussell et al., 1995; Specker et al., 1994; Spitzer et al., 1993; Yanovski et al., 1993). Although none of the participants in this study explicitly stated that they had been depressed, many mentioned signs of depression. For example, suicidal ideation, lack of energy, feelings of worthlessness, and oversleeping.

Counsellors need to be aware that their clients with BED may also suffer from depression. The level of depression should be assessed, and counselling interventions used to address depression as needed.

Emotions. The participants in this study emphasized the importance of exploring emotions in their recoveries. This included the **awareness of emotions**, **acceptance of emotions**, **experiencing emotions**, and **reflecting on emotions**. The participants often

used binge eating as a means of escaping emotions. Part of recovery was accepting the emotions that may be tied to binge eating and exploring them.

Research supports this connection between recovery and exploring emotions. Based on her study with women recovered from various eating problems, Thompson (1994) suggests that recovery depends on a woman learning that she has the right to feel, and learning how feelings affect the woman's actions, including her eating patterns. The participants in her study identified how painful emotions fueled their eating problems, and they tried to understand their emotions rather than eat. These steps were also taken by the women in this study.

Yager, Rorty, and Rossotto (1995) discovered that women recovered from bulimia nervosa show an increased tendency to seek out emotional support and an inclination to focus on and vent their emotions compared to non-recovered women. This suggests the importance of emotional expression to recovery. Counsellors need to keep in mind that when clients with BED seek counselling they may not be aware of the connection between their emotions and the way that they use food. Counsellors will have to educate their clients about the role of emotions in their eating problem. Work in therapy can then be done to identify and explore emotions with the client.

Suggestions for Future Research

Because of the limited research on the recovery from BED more research is called for. The majority of research discussed in this thesis focused on the recovery from eating problems other than BED. More research on the recovery from BED is needed so that future researchers studying BED are able to compare their findings with research on the same eating problem, ultimately assisting counsellors to help their clients.

Apart from numerous treatment outcome studies, and two studies on the course of BED, there have been no studies examining recovery from the participant's perspective. Studies focusing on peoples' experiences of recovery are needed. In addition, recovery studies with a variety of people representative of the broader population are needed. Studies including men, people of colour, lesbians and gays, people of a variety of ages, as well as research outside of North America is necessary.

In conjunction with research about participants' perspectives on recovery, we require research about the process of recovery. A replication of this study would be beneficial to compare the themes that emerge, as well as the factors and strategies found helpful to recovery. As well, a longitudinal study of the recovery process with a focus on participants' perspectives is sorely needed. It may also be helpful for future research to examine the applicability of the transtheoretical model to people with BED.

Research comparing peoples' recovery experiences with and without treatment is also necessary. This study has found that it is possible for people to change with treatment, as well as without. The fact that some women in this study changed without treatment is in contradiction to Wilfley and Cohen's (1997) belief that very few individuals who suffer from BED significantly improve or change without treatment. Research examining self-change in people with BED is needed.

Studies about the predictors of outcome in BED are also lacking. We know little about why some people manage to recover while others do not. While the literature on recovery from other eating problems can give us clues, it is important for studies of outcome with people recovered from BED to be undertaken.

Summary

This chapter compared the process of recovery from BED, and the factors and strategies considered helpful to recovery, with existing literature. Support was provided for the major findings of this study. The strengths, limitations, and delimitations of the study were also outlined, as well as the counselling implications raised by the data. Finally, suggestions for future research were made based on the gaps in existing literature.

Conclusions

This study provides insight into women's experiences of recovery from binge eating disorder (BED). The core category that emerged from the data gathered from the participants is **Self-awakening**. This is the core around which the theory is integrated. The process of **Self-awakening** involved the participants learning more about themselves; becoming more open to others and new experiences; and being more present and engaged in their own lives.

Four phases of recovery were also identified. These phases include: Phase I **Self-reflection**, Phase II **Assessing Present Life Situation**, Phase III **Healing/Restoring Oneself**, and Phase IV **Creating Balance**. The process of **Self-awakening** linked the four phases and facilitated movement from one phase to the next. However, these phases occurred in a non-linear fashion as earlier phases were commonly re-experienced by the participants.

The findings in this study suggest that recovery is a long and difficult process, involving a lot of hard work as well as relapses. Despite the numerous challenges of recovery, there are also many positive aspects. Some of the important aspects of the recovery process for the women in this study include the following: becoming more open

to supportive people, being nurturing of self, developing positive feelings about self, taking more risks, and trying new strategies in order to promote recovery. In addition, life for the recovered women became much more than just about food and weight. The participant's lives became filled with pursuing personal goals and interests, as well as with helping other people. It is exciting to know that the women in this study identified the problem of binge eating for themselves and embarked on an important journey to overcome the problem. Furthermore, the participants strove to optimize and maintain the quality of their lives.

The results of this study are optimistic. The results suggest that it is possible for women to recover from BED and have a healthy relationship with food. We may also infer from the experiences of the women in this study, that recovery from BED does not necessarily remain a lifelong battle. Although recovery from BED is often a long and difficult process, the struggle with this eating problem can be overcome.

EPILOGUE

The process of undertaking a qualitative study demands much of the researcher. The researcher "lives" with the research for a prolonged period of time. Many hours, days, or even years are spent thinking about the research by the investigator, regardless of whether the investigator has intended to think about it at any particular moment or not. Thoughts about the research may happen at any time, while grocery shopping, eating, or even when falling asleep. Because the research takes up so much of the investigator's life, the investigator may go through her own process much like the participants in a grounded theory study. This section discusses the process that I went through as a researcher on the journey to discover how women recover from BED.

Since creating a theory about the process of recovery from an eating problem, I feel as though I went through my own internal process. This process started with uncertainty and doubts about my own abilities as a researcher. With each new challenge that I tackled from the writing of the research proposal, to interviewing participants, to creating the theory, to the writing of the thesis, I struggled. I grappled with questions such as "Am I doing this right? Does this make any sense? Will I ever understand how to do this?" However, through this process I learned, just as the participants learned along their own processes of recovery. I learned that it is normal to struggle with the research and to question my abilities. I learned that the process of qualitative research is not easy. I also learned to trust myself and what was evolving from the data.

Hope played a large role in my research process. Hope that I would some day finish the thesis. I also had hope that I would get the recovery process from BED "right." However, another lesson I learned in this process is that there is no "right." There are a

number of different ways that grounded theory can be executed depending on the focus that the researcher takes. I realized at one point that I could probably work on the theory forever and it still would never be "right," only different. I had to accept that fact that there is no "right" way of interpreting data when using a qualitative research method. The theory that I created would be unique to me and no one else could create the theory in quite the same way that I did. Just as some of the participants discussed "giving up control" while recovering, I also had to let the research process unfold and give up trying to create perfection, and instead create a version.

Several times throughout this project I struggled with questions about whether I had made the right choice. The right choice about being in the thesis program, and the right choice about choosing a qualitative methodology. I watched as my fellow classmates in the course based program, and those writing theses using quantitative methodology, graduated and went on to other endeavours. However, I persevered and continued on with my research.

Much like I expect that the women I interviewed do look back at all of their hard work in recovery, I can also think back to all the difficulties I faced along the two years since I began this project. Now that these difficulties are behind me, I feel proud that I managed to stand up to my doubts and not give up no matter how lost I felt along this process. I learned more about myself, more about my abilities to be a researcher, and more about my abilities as a counsellor to support people with BED. I also learned that I am able to persevere even when the challenges feel insurmountable.

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APPENDIX A

Poster

Women over the age of 18 who
have recovered from
BINGE EATING/
COMPULSIVE OVEREATING
for at least 6 months
are needed for a research project
examining women's experiences of recovery.

Participation will include taking part in
two to three interviews with the researcher.

This research project is being conducted by a graduate
student in the Division of Applied Psychology
at the University of Calgary.

If interested or for further inquiries please contact
Adrienne at
229-9427
or email
akrentz@yahoo.com

APPENDIX B

Screening Questionnaire

1. Name:

2. Age:

3. At what age did you begin to binge eat?

4. How long have you considered yourself to be recovered from binge eating?

5. Do you experience any recurrences of binge eating?

6. When you used to binge eat, in a discrete period of time, for example within a 2 hour period, did you eat an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances?

7. Did you feel a sense of lack of control over eating during the episode, for example, a feeling that you could not stop eating or control what or how much you ate?

8. When you were having a binge-eating episode did you experience any of the following? (3 or more):
- Eating much more rapidly than normal
- Eating until feeling uncomfortably full
- Eating large amounts of food when not feeling physically hungry
- Eating alone because of being embarrassed by how much you were eating
- Feeling disgusted with yourself, depressed, or very guilty after overeating

9. Did you feel distressed when you were binge eating?

10. On average how many days a week were you binge eating? How many months did this last? (at least 2 days for 6 months)

11. When you were binge eating did you also engage in any of the following?:
- Self-induced vomiting, misuse of laxatives, diuretics or other medications, fasting or excessive exercise

12. Have you ever been diagnosed as having binge eating disorder, bulimia nervosa, or anorexia nervosa?

APPENDIX C

Letter of Information

Dear _____,

My name is Adrienne Krentz. I am a graduate student in the Division of Applied Psychology at the University of Calgary, conducting a research project under the supervision of Dr. Judy Chew, as part of the requirements for my M.Sc. degree. I am writing to provide information regarding my research project **Recovery from Binge Eating Disorder: A Grounded Theory Investigation** so that you can make an informed decision regarding your participation.

This letter of information is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Please take the time to read this form carefully and to understand any accompanying information.

The purpose of the study is to investigate the process of recovery from binge eating disorder with women who have struggled with this eating problem. I am interested in the strategies that you found helpful along your process of recovery.

As part of the study you will be asked to allow me to audio record two to three interviews, which will be conducted between you and myself. The audio recordings will be transcribed, and the transcripts will only be reviewed by you, myself, and my supervisor, Dr. Judy Chew.

Each of the interviews will last approximately two hours. The first interview will be a discussion of how you were able to recover from binge eating. Between the time of the first and second interviews you will be asked to review a transcript of our first interview, to make any corrections, or clarify any information from our first interview. The second interview will be a discussion of what you would like to correct or add to the information from our first interview. You will also be asked for any feedback on the theory of recovery that I will be developing. If necessary, a third interview will be arranged to further discuss the theory of recovery. You should be aware that even if you give your permission to participate you are free to withdraw at any time for any reason and without penalty.

Participation in this study may involve both risks and benefits. The risks may include you experiencing some distress due to disclosing personal issues. If you become distressed and would like someone to talk to, you may call the 24 hour Distress Crisis Line at 266-1605. In addition, I will also provide you with a counselling referral at your request. The benefits of participating may include developing new insight into your experience of recovery, experiencing catharsis, and gaining a sense of satisfaction knowing that you are making your story available to women who are currently struggling

with binge eating. Your story of recovery will also be contributing to the field of counselling, by providing information that has the potential to help counsellors working with clients who have eating problems.

Data will be gathered in such a way as to ensure confidentiality. You will be asked to choose a pseudonym before the first interview. One list of pseudonyms cross-referenced with participant names, all copies of the transcripts, the telephone questionnaire, as well as the audio recordings, will be stored in a locked file cabinet accessible only to myself. The transcripts and telephone questionnaire will be kept for five years, after which they will be destroyed. After seven years, the audio recordings and the list of pseudonyms cross-referenced with participant names will also be destroyed. No identifying information will be shared with anyone, and no identifiable information will be used for teaching, publication, or any other scientific purpose. Only group results will be reported in any published studies.

Your signature on the consent form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research please contact me at 229-9427, or my supervisor Dr. Judy Chew at 220-4071.

If you have any questions concerning the ethics review of this project, or the way you have been treated, you may also contact Mrs. Patricia Evans, Research Services, at 220-3782. If you have concerns about the project itself, please contact the researcher.

Sincerely,

_____

Adrienne Krentz, B.A.
M.Sc. student

APPENDIX D

Consent for Research Participation

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Please take the time to read this form carefully and to understand any accompanying information.

I, the undersigned, hereby give my consent to participate in the research project **Recovery from Binge Eating Disorder: A Grounded Theory Investigation**.

I understand that my participation means that I will take part in no less than two, and no more than three audio recorded interviews with the researcher, each of which will last approximately two hours. I understand that I will be asked to discuss how I was able to recover from binge eating, make corrections or additions to information in the transcript of my first interview, as well as give feedback on the theory of recovery being developed by the researcher. I understand that the audio recordings will be transcribed, and the transcripts will only be reviewed by myself, the researcher, and the researcher's supervisor, Dr. Judy Chew.

I understand that my participation in this study may be terminated at any time by my request or at the request of the investigator. Participation in this project and/or withdrawal from this project will not adversely affect me in any way.

I understand that there may be both risks and benefits to my participation in this study. I understand that I may experience some distress due to disclosing personal issues. If I become distressed and I would like to talk to someone, I am free to call the 24 hour Distress Crisis Line at 266-1605. I may also request a counselling referral from the investigator. I understand that I may also develop new insight into my experience of recovery, experience catharsis, and gain a sense of satisfaction knowing that I am making my story available to women who are currently struggling with binge eating. I will also be contributing to the field of counselling, by providing information that has the potential to help counsellors working with clients who have eating problems.

I understand that I my identity will remain confidential and that the information obtained will be kept in the strictest confidence.

I understand that only group data will be reported in any published reports.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. Your continued participation should be

as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research please contact me at 229-9427, or my supervisor Dr. Judy Chew at 220-4071.

If you have any questions concerning the ethics review of this project, or the way you have been treated, you may also contact Mrs. Patricia Evans, Research Services, at 220-3782. If you have concerns about the project itself, please contact the researcher.

_____	_____
Participant	Date
_____	_____
Investigator/Witness	Date

A copy of this consent form has been given to you to keep for your records and reference.

APPENDIX E

Interview Guide

- How were you able to recover from binge eating?
- What did you find helpful in your process of recovery?
- What strategies did you use to facilitate your recovery from binge eating?
- What was the recovery process like for you?
- What was going on in your life at the time you stopped bingeing?
- Have you had any bingeing relapses?
- What do you think contributed to relapses?
- How have you managed to stay away from bingeing relapses?
- If you had tried to recover in the past and were not successful, what was different about your recovery this time?
- What kept you motivated to change your bingeing behaviour?
- Do you consider yourself fully recovered?
- What does the term "recovery" mean to you?
- Is there anything you would like to add that could improve my understanding your recovery?