Binge Eating: A Critical Incident Study on What Helps and What Hinders the Process of Recovery

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ABSTRACT

The purpose of this qualitative critical incident study was to explore what helped and what hindered the process of recovery in the lives of ten adult women who struggled with binge eating. The researcher conducted a tape-recorded semi-structured, open-ended interview (45-75 minutes) with each participant. Participants were asked to think of critical incidents that helped or hindered their journey of recovery, as well as any recommendations they had. The data were then analyzed using the critical incident technique. An independent rater was used to do a reliability test of the categorization, and 90% agreement was reached. Validity was checked by examining saturation and comprehensiveness of the categories as well as through literature cross-validation. From 423 incidents, 13 helping and 13 hindering categories were created. The eight general themes that emerged from these 26 categories were: (a) relationship with self, (b) relationship with others, (c) knowledge and understanding as related to binge eating, (d) evolution of perspectives and worldviews, (e) developing a spiritual connection, (f) relationship and connection with food, (g) reaching a point of desperation, and (h) external resources. The results can help professionals, friends and family members of those struggling with binge eating to better understand and support the process of recovery from binge eating. The findings can serve as a road map, be a form of validation, and provide inspiration and encouragement for those who are currently struggling with binge eating. The qualitative aspect provides rich information from a very personal perspective which can encourage others to also create their personal stories to assist, clarify, and encourage their process of recovery.

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ACKNOWLEDGEMENTS

I would like to thank my husband, Galen Toews, who passionately supported and encouraged me consistently throughout the entire process. I also thank my daughter, Ashlie Jade Sahara, who demanded that she be the center of attention (as a 15-month-old should) and therefore mercilessly reminded me that there were "more important" things to attend to. I also thank my parents and parent-in-laws for their encouragement and interest in this project; and a special thanks to my mom for flying out here to baby-sit so I could finish the first draft before I turned too grey.

I would like to thank my supervisor, Dr. Chuck MacKnee, for all the help he has given me *weekly* from start to finish. Thank you for all the hours you invested in this project, thank you for your advice, your gentle suggestions, your words of encouragement, and most of all, thank you for your optimism. I also thank Dr. Judy Toronchuck and Dr. Marvin MacDonald for being my committee members. Thank you for the help and suggestions you've given me.

I would like to thank all the participants who contributed to this study. Thank you for being willing to share such personal experiences with myself and with whomever may read this thesis in its present form or any form hereafter. I am grateful to each one of you, and felt honoured in being a part of what you shared. It was my endeavour to remain true to the essence of your stories, and I apologize if I inadvertently misunderstood and misrepresented anything you said in any way.

I thank God for the privilege of life; I thank God for all that I am and for all that I do.

CHAPTER I: INTRODUCTION

Research Problem

Binge Eating Disorder (BED) has not received as much attention in the field of mental health as the more classic eating disorders of bulimia nervosa and anorexia nervosa. Only within the last decade has BED been included in "Appendix B: Criteria Sets and Axes Provided for Further Study" of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994). Nor has there been much understanding of the helping and hindering factors of the process of recovery for those who have struggled with BED. Using the critical incident methodology of qualitative research, the researcher asked the participants, "What have been the significant helping and hindering factors specifically related to your process of recovery from binge eating?" The critical incident methodology was chosen for this study because binge eating has not been vigorously researched, and there is scarce information on what facilitates and what hinders the process of recovery from binge eating. This methodology uses observers that are closest to the phenomenon being studied, and the open-ended interviews are conducive to gathering rich detailed information which is essential for studying a phenomenon of which little is known. This method is exploratory in nature and has the potential to lead to important treatment information for those struggling with binge eating and for professionals working with this population.

History

In the late 1950's, it was noted by Dr. Albert Stunkard of the University of Pennsylvania that some obese people had significant problems with binge eating (Fairburn, 1995). However, it was not until the late 1980's that evidence began to reveal

that about a quarter of people who sought treatment for obesity had binge eating problems, but they did not fit the criteria for bulimia nervosa. Around the same time, "community studies of the prevalence of bulimia nervosa showed that the majority of those who binge eat do not have bulimia nervosa" (Fairburn, p. 25). These finding led to Spitzer's research group (1992) of Columbia University to propose that these individuals have their own eating disorder distinct from bulimia nervosa. It was initially named pathological overeating syndrome, and was later replaced by binge eating disorder (Fairburn).

Definition

As defined by the American Psychiatric Association (2000), binge eating is characterized by frequent episodes (at least 2 days per week for over six months) of eating unusually large amounts of food (often totalling several thousand calories in a short period of time), accompanied by the feeling of lack of control. Binge eating is also characterized by eating large amounts of food when not hungry, eating until physically uncomfortable, eating very rapidly, and eating alone because of embarrassment over how much one is eating (American Psychiatric Association). Other criteria include self-hatred, depression, disgust, shame, distress and guilt regarding binge eating, secretive eating, and lack of extreme compensatory behaviours such as vomiting, laxative use, fasting, and exercising. An important caveat to mention is that the criteria of bingeing twice a week has been criticized – implying that those who binge eat less often are less disturbed when this is not the case (Fairburn, 1995). Many researchers and clinicians believe that once a week is more appropriate, and ignore arbitrary thresholds such as this (i.e. twice a week for BED) when making a diagnosis (Fairburn). The debate is: Should it be how often one binges, for how long, over what time span, and consuming how many calories that

determines how serious the problem is, or should it be how much the bingeing affects one's life?

An important distinction between those with BED as a disorder, and those that overeat from time to time, is the feeling of no control (American Psychiatric Association, 2000). Fairburn (1995, p. 5) further enunciated this point by saying, "What is central to binge eating is the sense of loss of control. *This feature above all distinguishes binge eating from everyday overeating and mere indulgence*". The distinction from bulimia nervosa is that there is usually the absence of extreme compensatory behaviour used to control body shape and weight (American Psychiatric Association). As different from anorexia nervosa or bulimia nervosa, BED usually does not begin until early adulthood, and those with BED often do not seek help until middle age (Walsh, 1997).

Those with BED are typically moderately to severely obese (though not always), and on average, 32 years of age (Lyons, 1998). Although most people with BED are overweight, most people who are overweight do not have BED (Baker & Brownwell, 1999). A distinction between those who are obese but do not binge eat and those who are obese and do binge eat is that the latter have more eating and weight-related pathology, more psychopathology in general, and greater psychosocial impairment (Walsh, 1997). In a recent review of eating disorders, Fairburn and Harrison (2003) asserted that the nature of the relation of obesity with BED is unclear.

As with most people with eating disorders, food often controls the lives of those with BED (Walsh, 1997). Many may sleep for hours after a binge because they are physically sick from all the food eaten. Work, family, and social lives are greatly affected for those who struggle with BED. For example, social occasions (graduations, weddings, birthday parties) will often be avoided, especially those that involve eating (Fairburn,

1995). Since individuals struggling with binge eating are often quite secretive about their behaviour, it is not uncommon that family and close friends are unaware of what is happening.

Some reasons hypothesized as to why individuals binge eat have to do with neglect, lack of trust, lack of love, sexual abuse, physical abuse, unexpressed rage, grief, being the object of discrimination, and protection from getting hurt (Walsh, 1997). Fairburn (1995) adds social factors, gender, obesity, eating problems and disorders within the family, psychiatric disorders within the family, dieting, and personality characteristics. Fairburn goes on to identify personality characteristics often associated with those who binge eat as low self-esteem, perfectionism, all-or-nothing thinking, impulsivity, and borderline personality disorder. Up to half of individuals with BED have a history of depression, and many with BED say that binges are triggered by anger, sadness, boredom, anxiety or some other negative emotion (Walsh).

Throughout this present study, the terms Binge Eating Disorder (BED), binge eating, and compulsive overeating are all incorporated. Depending on the sources cited, different terminology is used. When not citing a particular source, the author of this study generally used the term binge eating rather than BED in the interest of avoiding describing individuals as having a disorder.

Rationale for this study

Historically, the focus has been on binge eating coupled with purging (bulimia nervosa) and starving oneself (anorexia nervosa). As demonstrated in the literature, binge eating alone is now considered as a serious mental health concern. The prevalence, physical health risks, psychological and social problems, and stigma involved with binge eating are some of the reasons why research in this area is important.

Prevalence

It has only been recently that BED has been accepted into the DSM IV as a diagnostic category in the criteria sets and axes provided for further study. Research shows that BED is indeed prevalent in our society (Spitzer et al., 1992) yet it continues to receive minimal attention. Spitzer and his colleagues found that binge eating is a significant problem for 46% of obese individuals in weight loss programs. Devlin, Walsh, Spitzer, and Hasin estimated that between one quarter and one half of obese patients presenting for treatment report significant problems with binge eating (as cited in Dominy, Johnson & Koch, 2000). Spitzer's research group also reported that the prevalence rate of BED is three to five percent in the general population. A slightly more moderate statistic suggests that BED occurs in two to five percent of the population, which is still more than either anorexia nervosa or bulimia nervosa which occur in less than one percent of the population, and one to three percent of the population respectively (Walsh, 1997). Additionally, more than one-third of those affected with BED are men (Walsh).

Historically, individuals who struggle with binge eating unaccompanied with purging have been frustrated in their attempts to receive treatment because their condition was not seen as serious enough to warrant it (Saunders, 1993).

Physical Health Risks and Psychological and Social Challenges

As some individuals with binge eating are significantly overweight, various health risks are also involved. Obesity increases the risk for diabetes, hypertension and gallbladder disease, and is a risk factor for cardiovascular disease (Walsh, 1997).

Ebrahima contended that the medical consequences of binge eating are less than bulimia or anorexia (as cited in Walsh, 1997), but this assertion seems untrue for those who have the above mentioned risk factors. Regardless of size, perhaps the most worrisome health risks are the psychological effects associated with binge eating, and the effects binge eating has on the individual's work, family, and social life. Depression, anxiety, despair, feelings of worthlessness, mood swings, and alcohol and drug problems have all been associated with binge eating (Fairburn, 1995). Childrearing may also be negatively effected when, for example, parents limit food in the house to avoid bingeing, or inadvertently pressure their teenager to join them on a diet.

Stigma

Unfortunately the stigma of being fat, large, plump, or well-rounded is also quite damaging in our society and adds to further psychological damage. Stigma has led to negative characterization of obese individuals, with the most negative attitudes appearing to be directed towards obese women (Dominy, Johnson, & Koch, 2000). Dominy and his colleagues asserted that this stigma can have a negative impact on satisfaction with life, as demonstrated by their research results which indicated the significantly lower level of satisfaction with life of obese individuals with BED when compared with other groups. Nash (1999, p. 59) stated that those with BED not only share many of the same psychological complications characteristic of bulimia, but also "encounter social rejection, ostracism, and discrimination because of their weight."

Because obesity is stigmatized in our culture, weight-loss programs may be seen as the solution for those who are obese and binge eat. Unfortunately, this outlook misses many of the other important issues that can be contributing to struggles with binge eating.

In fact, dieting can even increase the downward spiral of binge eating as will be explored in the literature review.

Eating problems can often be seen as trivial, simply a lack of willpower, or due to vanity. These assumptions deny the real pain, distress and emotional struggles that are involved. Because of the shamefulness that is often felt, many struggling with binge eating are alienated from their own experience. “Many individuals will not broach the topic of their eating patterns with [care-] providers, often because of shame and embarrassment” (Baker & Brownell, 1999, p. 345). Other reasons why those who binge eat may avoid getting help are: the risk that friends will find out about the problem and all the deceit involved to keep it secret; the hope that the problem will go away; not believing the problem is serious enough to warrant treatment; not thinking they deserve to get help; care-providers trivializing the problem; and care-providers providing inappropriate help (i.e. a diet regime) (Fairburn, 1995).

In sum, it is apparent that binge eating is a valid concern and struggle in our society today. Although there have recently been more attempts to validate and understand binge eating, very little has been researched and explored regarding factors that help or hinder the process of recovery. This critical incident study intimately explored this topic through personal interviews with individuals who have struggled with and are in the process of recovery, or have recovered, from binge eating. Individuals who have struggled with binge eating were asked to recall significant incidents that were helpful or unhelpful throughout their process of recovery. This information is helpful for professionals, individuals who struggle with binge eating along with their family and friends, as well as the general public in that it offers more understanding of binge eating as well as concrete possibilities of recovery. In addition, an unexpected outcome in

Hagan, Whitworth, and Moss's (1999) study pointed out potential benefits of participating in research for this population. They had asked participants to do a number of self-report questionnaires regarding binge eating behaviours and semistarvation-related behaviours. The participants informed the researchers that the process gave them a more objective view of their eating behaviour, and others were surprised to discover that they were not alone in doing what they perceived as such strange and shameful activities. This is an example of how research can also be of benefit to the participants since those who binge eat often feel isolated, as well as deny the severity of their activity.

Key Concepts

Key concepts which have been defined and discussed in the literature review and/or throughout this study are as follows: Binge Eating, Binge Eating Disorder (BED), Compulsive Overeating, Critical Incident, Helping and Hindering Factors, Process of Recovery.

CHAPTER II: LITERATURE REVIEW

This chapter introduces the major theoretical models for BED. Current trends in treatment and multi-cultural concerns will also be discussed.

Theoretical Models

Mood, and Emotional Regulation

Binge eating is associated with increased psychological difficulties, especially mood-related symptoms. Individuals who binge eat "generally report more psychological symptoms and distress, lower self-esteem, and more feelings of demoralization compared with obese individuals who do not binge eat" (Baker & Brownell, 1999, p. 346). In addition, Baker and Brownell found that when compared with controls, women with BED have been found to have higher lifetime prevalence rates of major depression.

Negative emotions have traditionally been associated with binge eating. In Hagen's research group (1999), binge eating was reported to illicit numbness, depression, and disgust. They also found that negative emotions occur before the binge episode and during the preparation stage. In a phenomenological study of adult professional women who experienced binge eating, reasons for overeating were attributed to stress and anxiety (especially related to change), loneliness, boredom, isolation, celebrations, and the desire to reward oneself (Lyons, 1998). In the same study, the emotional consequences reported for binge eating were guilt, shame, denial, rationalization, and blaming. When comparing groups of obese women with BED with groups of obese and nonobese women without BED, it was found that obese women with BED reported less satisfaction with life and higher levels of depression (Dominy et al., 2000). These results were ascertained through the use of the Satisfaction with Life Scale, and the Beck Depression Inventory.

A positive relationship among females was found between EAT-26 (eating attitudes) factors scores and anxiety and depression, with anxiety being the stronger predictor of binge eating (Lynch, Everingham, Dubitzky, Hartman, & Kasser, 2000). Anxiety was also a predictor of lack of control. However, among males, depression, not anxiety, was found to be associated with binge eating. Contrary to expected results, factor analysis in this study revealed that negative affect was significantly increased rather than decreased as a result of binge eating. The findings were different for bingeing and purging where the purging behaviours were associated with elevated mood. These findings are relevant because there has traditionally been an interest in the connection between emotions and binge eating, suggesting that bingeing may be rewarding. Kaplan and Kaplan (as cited in Lynch et al.) also theorized that overeating might function as a means of controlling anxiety.

Greeno, Wing, and Shiffman (2000) compared obese women with BED with women without BED concerning mood, appetite, and setting each time they ate. Poor mood, low alertness, feelings of poor eating control, and craving sweets were all found to precede binge episodes for the BED group. These findings support evidence of the relationship of binge eating and decrements in emotional and appetitive functioning.

Hudson, Ritchie, Brennan, and Sutton-Smith (1999, p. 38) assert that "what all women with eating problems have in common is that they are using food and the body in very concrete ways to cope with emotional distress and a sense of emotional emptiness".

Dietary Restraint

Dieting plays an important role in some attempts to explain the etiology of BED (Timmerman, 1998). Chronic dieting is often seen as being promoted by a culture that

emphasizes thinness. Polivy and Herman assert that the consequences of dieting (hunger, feelings of deprivation, and preoccupation with food) often precipitate binge eating (as cited in Timmerman). Timmerman thus conducted a study to examine whether dieting preceded binge episodes, predicting a spiral model of chronic dieting and binge eating. It was found that the caloric intake for binge eaters was characterized by extreme fluctuations, and that caloric intake for the day preceding the highest-calorie binge day was significantly lower (using simple linear regression, 45% of the variance in the caloric intake of the highest-calorie binge day was explained by the caloric intake for the preceding day). This was a prospective study rather than retrospective in which individuals recorded their daily food habits over a period of 28 days. Interestingly enough, the lowest calorie-intake days were still not low enough to cause actual physiological deprivation. This leads to the hypothesis that it is not physiological deprivation that leads to binge eating, but rather the perception that one has been deprived. It is recognized that mood or cognitions were not taken into account with this study.

There are historical (during wartime food shortages, imprisonment in enemy camps, being marooned during expeditions) and empirical accounts (the Minnesota semistarvation experiment) of binge eating following a period of limited food intake/semistarvation (Hagan et al., 1999). A Semistarvation-Associated Behaviours Scale (SSABS) was developed by Hagen and his colleagues to assess the prevalence of post-semistarvation (limited food intake) behaviours in college students. The items for the questionnaire were taken from historical semistarvation literature and clinical descriptions reporting semistarvation-like behaviours. The purpose of this study was to determine the extent to which various eating habits and rituals emerge following

semistarvation. The results of this study, using analysis of variance, showed that increased frequency of dieting was strongly related to reported experiences with semistarvation-associated behaviours ($r = .54$, $p < .001$). Such behaviours included hoarding, stealing, lying, secrecy, defensiveness, licking, diluting food, making strange concoctions, eating inappropriate foods, and eating appropriate foods in an inappropriate manner. Dieting was also found to be associated with the severity of binge eating which supports the dietary restraint model.

A study done by Saunders (1993) also demonstrates the association of dieting with binge eating. Approximately three-quarters of his group of binge eaters reported that the onset of bingeing behaviours followed fasts or restrictive diets.

Societal Influences

It is also hypothesized that societal factors play a significant role in the etiology of eating disorders. Striegel-Moore (1993) discussed how the way women define themselves and the expectations society imposes on them combine to make women vulnerable to the development of binge eating problems. As physical attractiveness seems to contribute significantly to social success, Striegel-Moore comments how it is not surprising that women make appearance and weight high priorities. Women who feel insecure about their identity, especially about how they are valued by others, focus on physical appearance because this provides a concrete way to construct an identity. Furthermore, the contemporary beauty ideal is biologically unattainable for most girls, and physical maturation takes them further from this ideal. Failure to achieve this ideal adds to low self-esteem and continues the cycle (Striegel-Moore).

Nash (1999) discussed how media messages play a role in the development of negative body images and body dissatisfaction. These images are then often translated into actual discrimination and ostracism of people who are overweight. She asserted how culturally defined standards for thinness and appearance are accepted and internalized. This creates dissatisfaction with the body and a disturbed body image which produces shame and a devaluation of self-worth.

Binge Eating as an Addiction

BED as an addiction is another theory used to explain this type of "excessive appetite" (Orford, 2001). Addiction can be evidenced in a variety of excessive appetites such as drinking, smoking, gambling, eating, sex, and drugs. Addiction is considered to be a strong craving towards an object or activity and, despite harm that it brings, neither the use of reason nor the encouragement of others is enough to bring about control (Orford). Individuals cannot moderate the activity despite the fact that it is causing harm and disrupting their lifestyle. A narrative study that explored the process of change in individuals who had recovered from addictive behaviours (alcoholics, drug addicts, smokers, sex addicts, and gamblers) included individuals who struggled with binge eating (Hanninen & Koski-Jannes, 1999).

Orford (2001) recognizes that the scientific and professional worlds of "drug addiction" and "eating disorders" are presently quite separate. Fairburn (1995) asserts that focusing exclusively on the similarities of the addiction theory distracts from the differences that are central to understanding and treating eating disorders. The two essential differences Fairburn notes are the inherent drive to avoid the behaviour, and the fear of engaging in the behaviour. Therefore, he asserts that binge eating treatment should

focus on moderating self-restraint rather than strengthening it. However, many theoretical concepts, such as deterrence and restraint, positive incentive learning mechanisms, and cognitive schemata, are shared among concepts of addiction and binge eating.

Deterrence and restraint

The concept behind deterrence and restraint is that the addiction can be restrained or deterred by outside forces, such as family, religiosity, and social pressure (Allport & Hyman, as cited in Orford, 2001). There is evidence that unconventionality and non-conformity are among the most significant predisposing personality characteristics for appetitive (addictive) behaviours among school and university students (Jessor, Donovan, & Costa as cited in Orford).

Positive incentive learning mechanisms

There are a variety of positive incentive learning mechanisms, such as operant and classical conditioning, that have been used to explain addiction. In the case of binge eating, the emotional regulatory function of eating can be consistent with operant conditioning: as an episode of binge eating goes on, various negative emotions are diminished (Hsu, as cited in Orford, 2001). Tension-reduction theory and escape theory have also been applied to excessive eating (Heatherton & Baumeister, as cited in Orford). Conditioned responses are also thought to take on positive incentive value, which point to the probability of positive reinforcement (Orford).

Cognitive schemata

Cognitive schemata involve the combination of learning and memory elements. There are complex memory schemata based on past experience of the activity (Orford,

2001). For example, an argument with a spouse (stimulus) leads to binge eating (response), and has meaning (emotions relieved and feelings of being in control).

Love and Relationships

In a narrative study that aimed to identify the main storyline and relate it to story types, belief systems, and myths that are part of our culture, Hanninen and Koski-Jannes (1999) found that the "love story" was predominantly told by women who recovered from binge eating. In this story, binge eating was compensation for lack of love and the key to recovery was receiving love and care. The individual was released from guilt by realizing that the binge eating was a justified means to achieve that of which he or she was deprived. Recovery is accompanied with the feeling that intimate relationships are a basis of significant meaning in life. This explanation of the roots of binge eating is similar to psychoanalytical thinking, in which an unsatisfied psychological need is redirected onto a compensating object or activity (binge eating). The need for binge eating recedes when the need of being cared for is satisfied. Hanninen and Koski-Jannes go further in their analysis of narratives of individuals who have recovered from addictive behaviours in suggesting that all addictive behaviours may stem from various fundamental problems in human relationships. Every one of the 51 stories they studied described a change in the individual's relationships with other people. Baker and Brownwell (1999) also note how the majority of their clients with BED struggled with significant difficulties in their interpersonal relationships.

Parental Acceptance-Rejection Theory

Along similar lines of having satisfying relationships, a quantitative study was done comparing obese women with BED, obese women without BED, and nonobese

women without BED (Dominy et al., 2000). It was found that obese women with BED perceived their parents as more rejecting, specifically in reference to paternal rejection and neglect. Contrary to expected results, obese women with BED did not find their mothers any more rejecting than the other two groups, and obese women found their fathers more rejecting than their mothers. These results were surprising considering that past empirical research that established the parent-child relationship in the development of an eating disorder has focused mainly on the mother, food, and early infant bonding. For example, Hudson, Ritchie, Brennan, and Sutton-Smith (1999) believe that the roots of eating problems lie in the disturbed relationship with the mother at a very early pre-verbal level. An explanation for this is that the "addict" is still seeking the breast-mother of early infancy in the external world because there is little or no identification with an internal caretaking mother. The addictive substance, in this case food, is at first seen as good, and then experienced as bad and destructive. Hudson and his colleagues go on to explain that women with eating problems "believe that their needs and feelings must be bad, dangerous and too much for anyone, and their symptoms represent a desperate attempt to keep them hidden and under control because they are afraid of expressing them within the context of real human relationships" (p. 39). Therefore, eating problems are actually problems with self – a self which is unknown, feared, or hated.

Another aspect underlying the significance of the parent-child relationship is the lack of parental affection and acceptance. Aronson states how individuals with BED often do not experience being truly loved for themselves (as cited in Dominy et al., 2000). Food may be the substance of choice to numb the internal pain of perceived parental rejection.

Childhood Experiences

Certain childhood experiences have also been associated with binge eating. Lyons' study (1998) revealed how childhood perceptions of being overweight and parent modeling (such as a parent having food that no one else could have) as being common among adult binge eaters.

Current Trends in Treatment

Research on treatment approaches for binge eating is still relatively limited. Kristeller and Hallett (1999, p. 359) contend that one possible reason for the unsuccessfulness of finding effective treatment is the "lack of attention to increasing awareness and acceptance of bodily cues that maintain bingeing behaviour, in particular, the sensations of hunger and satiety". Among the most common treatments are Cognitive Behavioural Therapy (CBT), self-help books (largely based on CBT), group and individual interpersonal therapy, behavioural weight control, and pharmacological interventions. Overall, there is a decrease in the frequency of binge eating in response to these above mentioned therapies, but there have been no studies on the long term course or outcome (Fairburn & Harrison, 2003). Concerning eating disorders as a whole, Fairburn and Harrison assert that "there is a pressing need for more treatment research, both in terms of developing more effective treatments and focusing on the full range of eating disorders" (p. 414).

Pharmacological Intervention

According to Baker and Brownell (1999), it is useful to investigate antidepressant medications for treating BED for two reasons: (a) the positive association with affective disorders and (b) positive outcomes in studies of selective serotonin reuptake inhibitors (SSRIs) and bulimia nervosa. Antidepressants decrease binge frequency for those with

bulimia nervosa, and whether they are depressed or not, the effectiveness of the medication is the same (Maxmen and Ward, 1995). Interestingly, the highest dose (60 mg) of fluoxetine (Prozac), usually the dose for obsessive-compulsive disorder, works better than the usual antidepressant dose (20 mg). Although low serotonin levels can have varying effects depending on the individual, a common underlying factor seems to be that serotonin levels are associated with suppressing impulses or maintaining a normal mood (Kalat, 2004).

There have been positive outcomes in studies of certain serotonin reuptake inhibitors (SSRIs); however, their effectiveness is less than CBT used alone (Baker & Brownell). A combination of CBT and pharmacological support has slightly better outcomes. A 6-week, double-blind, flexible dose study (Eating Disorders Review, 2003) on the effectiveness of fluoxetine for individuals with a DSM-IV diagnosis of BED showed moderate improvement. At 6 weeks, the mean difference between groups (fluoxetine or placebo group) in frequency of binges was 1.1. Of the 30 participants from the fluoxetine group, 7 withdrew because of negative side-effects. A present concern is the long-term effectiveness of pharmacological interventions. It has been found that individuals have a high rate of relapse while still on the medication, as well as relapse when they stop taking the medication (Baker & Brownell).

More recently, topiramate, an antiepileptic drug, has been used in the treatment of BED. A randomized placebo-controlled trial revealed that participants in the topiramate group experienced significant reductions in binge frequency (topiramate: 94%, placebo: 46%), binge day frequency, body weight, and body mass index compared with participants in the placebo group (McElroy, Arnold, and Shapira, 2003). However, there were adverse affects severe enough to cause 6 of 28 participants from the topiramate

group to withdraw. These included headaches, tingling, nausea, change in taste sense, and paresthesias.

Behavioural Dietary Treatment

As many with BED are also obese, a popular approach is dieting. Unfortunately dieting is hypothesized to be one of the contributing factors to binge eating (Timmerman, 1998). Therefore, some current treatment strategies include stabilizing eating patterns to prevent extreme fluctuations that often result from dieting.

Cognitive Behavioural Therapy

As mentioned, cognitive approaches have been used to treat those with BED, but this has not led to weight loss, subsequently there is still a health risk for those who are significantly overweight. Cognitive therapy helps individuals work on the connections with feelings and binge eating. It has shown to be the most effective treatment available in over 40 randomized trials (Waller, 2001).

CBT for binge eating focuses on normalizing eating behaviour and on dysfunctional thoughts about food, shape, and weight. Saunders (1993) conducted a study in which binge eaters took part in a 16-week program that focused on cognitions and behaviours. The focus on behaviours helped participants distinguish between urge and hunger, and to develop behavioural techniques to deal with the urges. The cognitive component helped participants focus on "identifying and modifying dysfunctional thoughts, beliefs, and values and learning how to experience emotions" (Saunders, p. 128). Results showed a significant improvement in the level of depression, with better control over eating being associated with lessening levels of depression. Interference with life activities also improved significantly, including interference with daily activities,

thoughts, feelings about self, and personal relationships. Less bingeing was reported, along with reduced frequency of intake of large amounts of food, less frequency of rapid eating during a binge, fewer feelings of being out of control during a binge, reduced depression, and less interference with life functioning. Saunders also mentioned that since binge eating is a chronic disorder, greater attention needs to be paid to the issue of maintenance.

Self-Help Methods

Self-help material has also been shown to be effective in the treatment of binge eating; studies show that one-third to one-half of individuals who recover from binge eating use this method (Waller, 2001). Most self-help programs are also based on cognitive behavioural therapy. As many people are reluctant to reveal their binge eating to anyone, self-help programs have much to offer (Fairburn, 1995). Strategies suggested, from binge eaters themselves, to assist with the prevention of BED have been: education beginning in childhood and ongoing through adulthood, support from self help groups, and love and support from family members (Lyons, 1998).

Group Work

Group work has also been effective for those with BED (Corey & Corey, 2002). It is especially helpful because feelings of shame and self-hate are often very isolating, and meeting in a group helps individuals realize that they are not alone. Some common group goals for those with BED are to shift the attention from food, to that of feelings and relationships. Group Interpersonal Therapy works with current interpersonal patterns such as conflict and role transitions.

Meditation

Meditation has also been suggested as an effective component in treating BED. Kristeller and Hallett (1999) conducted a study to evaluate the efficacy of a 6-week meditation-based group for 18 women with BED. General mindfulness meditation, eating meditation, mini-meditations, and a specific theme related to overcoming binge eating were all included in the treatment. The basic element of mindful meditation used in this study was to maintain a relaxed focus on a single object of attention, and to gently return to this object of attention as the mind wanders. The outcomes of this study were that the number of binges and the intensity of binges decreased, attitudes towards eating improved (measured by the Binge Eating Scale), and depression and anxiety decreased (measured on Beck Depression and Anxiety Inventories). Participants also reported significant improvements in a sense of mindfulness, perceived control of eating, and awareness of hunger and satiety cues. A sense of mindfulness is described as the ability to bring focused, yet detached, awareness to all objects of attention, while maintaining a non-judgmental, self-accepting attitude. Kristeller and Hallett (p. 358) commented that "meditation appears to have the potential to facilitate self-regulation, and may enhance insight and the integration of physiological, emotional, cognitive, and behavioural aspects of human functioning". It makes sense that meditation could help individuals with binge eating as these individuals appear to struggle with the regulation of multiple psychological processes that contribute to binge eating, including elevated anxiety and dysphoria, distorted and reactive thinking patterns, and disturbed awareness of normal physiological cues related to food intake (Fairburn & Wilson as cited in Kristeller & Hallett, 1999). An added note of interest of this study is that participants found that the

non-eating meditation exercises were also helpful; in particular, "forgiveness meditation" helped to resolve feelings of anger (a common binge trigger) towards parents or husbands.

Cross-Cultural, Gender, and Socio-Economic Status Concerns

A common myth present in the field of disordered eating is that this is an issue that predominantly affects middle or upper class Caucasians. However, it has been shown that binge eating is a cross-cultural phenomenon. A study that reported the association of dieting and binge eating severity included a population that was 70% Hispanic (Hagan et al., 1999). When examining race differences in clinically significant recurrent binge eating, it was found that binge eating is a significant problem in black and white American women (Striegel-Moore, 2000). Binge eating was shown to be as common in black and white women, in addition, body weight and psychiatric symptoms also increased in both groups as a result of binge eating.

Very little is understood regarding men who struggle with binge eating. Most studies that included male participants did not have an adequate sample size to determine significant or reliable results. However, Lynch's research group (2000) reported a significant difference between men and women in the emotions involved in binge eating; anxiety, more than depression predicted binge eating in women, whereas depression was more of a predictor of binge eating in men and anxiety seemed to serve as a protective factor.

Overall, compared with other eating disorders (anorexia nervosa and bulimia nervosa), BED "appears to be more heterogeneous in terms of both gender and ethnicity" (Baker & Brownell, 1999, p. 345). Spitzer and his colleagues (1992) showed that there were similar rates across gender in nonpatient community and college samples. In a more

recent study, Barry, Grilo and Masheb (2002) found that men and women did not differ significantly on the developmental variables of age at first overweight, age at first diet, age at onset of regular binge eating, or number of weight cycles. Men did, however, have significantly higher body mass index (BMI), and were more likely to be classified as obese. Men and women did not differ significantly on eating disorder features such as binge eating, eating concerns, and weight or shape concerns, but women reported significantly greater body image dissatisfaction and drive for thinness (Barry et al.). Current rates of depression and self-esteem were similar, but men reported a greater frequency of past drug abuse problems.

Socio-economic status is another cultural variability to be aware of concerning its association to binge eating. Lang (1998) reported that food insecurity can lead to binge eating. Food insecurity is used in the context of poor rural women, who do not always have enough food in their homes. These women are at risk for BED because they tend to engage in binge eating when adequate food becomes available.

Summary

As demonstrated in the literature, binge eating has recently become recognized as a legitimate mental health concern. To date, the reasons and explanations for binge eating are quite diverse, and even conflicting. We know that binge eating exists, that it affects a significant proportion of the population, and that it affects men, women, individuals of varying socio-economic status, and individuals from a variety of cultural and ethnic backgrounds. We also know that various treatments have been reported as effective short-term, but that there have been no studies on the long-term effectiveness.

With BED's introduction into the *Diagnostic and Statistical Manual of Mental Disorders* in 1994, there is more interest and need for research on effective treatment.

Although there has been some research regarding the treatment of binge eating, it remains a relatively under-researched area. In order to implement effective treatment programs, it makes sense to hear and learn what worked and what didn't work from the closest available source. This critical incident study specifically asked for the significant facilitating and hindering factors of the process of recovery from binge eating, from those who struggled with binge eating. This methodology not only explored what was helpful, but also what was not helpful; the latter being especially significant as unhelpful factors are often neglected in research. The results of this study gives vital information to professional and lay people who wish to understand and assist with the process of recovery for this population, as well as provides a relevant categorical map for individuals struggling with binge eating.

CHAPTER III: METHOD

This chapter discusses the history and evolution of the critical incident methodology. The procedures of this design as they pertain to this current study will also be discussed, including participant recruitment, data collection, data analysis, and several reliability and validity checks.

Design

This study has been done using the critical incident technique (Flanagan, 1954). Using a qualitative approach of inquiry, the researcher was looking for rich information that would inform readers of the significant helpful and unhelpful incidents involved in the process of recovery from binge eating. The critical incident methodology was appropriate for this study because it directly elicited the helpful and unhelpful factors that were significant to the process of recovery from binge eating. This information is relevant because it can help counsellors, health care workers, and other professionals improve their services for this population. The presentation of the results, often using verbatim quotes from the participants, is information relevant and accessible to those struggling with binge eating, along with their friends, families, and partners.

The qualitative approach to inquiry has various benefits. For example, because of the rich data it elicits, it is ideal to use for phenomena of which relatively little is known (Van Manen, 1990). Furthermore, open-ended personal interviews help individuals clarify the meaning of their own struggles, as well as provide connection, hope, and encouragement for others struggling with similar problems. There has been a phenomenological study on various addictions, including binge eating, which revealed that individuals trying to quit their addiction can be encouraged to create personal stories (narratives of their lives that can help make sense of their addiction and recovery) that fit

their own experience and culture (Hanninen & Koski-Jannes, 1999). The profound differences found in the story types indicated that an addiction can stem from various kinds of problems and that there are many routes to recovery. Thune (as cited in Hanninen & Koski-Jannes) analyzed AA stories and concluded that in telling life histories, individuals have used other individuals' stories as models for a way to construct and analyze their own past. This helped them to make sense of their past and attain control over their drinking. In a critical incident study undertaken to understand the process of transitioning from a homeless lifestyle, MacKnee and Mervyn (2002) mentioned how the results serve as a map designed by experienced travelers to help guide street people's transition to mainstream society. Likewise, the categorical map created from this research can be useful for many – professionals, friends, family, and those who personally struggle with binge eating as a resource for recovery.

The critical incident methodology is an outgrowth of studies in the Aviation Psychology Program of the United States Army Air Forces (Flanagan, 1954). The critical incident technique was formally developed and given its present name by Flanagan in 1947 with the start of two extensive studies analyzing critical job requirements. Since then, this technique has been modified and applied to many other areas of psychological research. As originally developed, Flanagan asserted that, "the Critical Incident Technique consists of a set of procedures for collecting direct observations of human behaviour in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles" (p. 327). An incident is defined as any observable human activity that is complete enough within itself to allow inferences and predictions to be made. An incident is critical if the purpose or intent is clear to the observer, and the consequences are definite enough to leave little doubt of its effects.

Rather than collecting opinions, hunches, and estimates, the critical incident technique "obtains a record of specific behaviours from those in the best position to make the necessary observations and evaluations" (Flanagan, p. 355).

When Flanagan (1954) outlined the critical incident methodology, he asserted that the technique does not consist of a single rigid set of rules, but rather is a flexible set of principles to be modified and adapted to meet specific situations. Two basic principles of the technique are that factual reports of behaviour are preferable to ratings and opinions based on general impressions and that only behaviours which make a significant contribution to the activity should be included (Woolsey, 1986). The five main steps Woolsey outlined for the technique are: (a) determining the general aim of the activity, (b) developing plans, specifications and criteria for the information to be obtained, (c) collecting the data, (d) analyzing the thematic content of the data, and (e) interpreting and reporting the findings. Emphasis is placed on factual and accurate description. Factualness is obtained by the participant's first-hand experience of concrete situations and accuracy is obtained through the use of qualified observers, and the quality of the incidents reported; if the details are full and precise, the information can be taken as accurate (Flanagan, 1954).

The critical incident technique has been modified in a variety of ways since Flanagan's original formulation of it (Wong, 2000). This is not unexpected as the critical incident methodology is meant to be highly flexible, being used to study a variety of phenomena and modified to accommodate various aims (Woolsey, 1986). In a review of research using the critical incident technique, Wong found that the method was expanded to include subjective experiences, beliefs, attitudes, and feelings. In this context, critical incident was defined as having a significant positive or negative impact on an individual

which could involve three components; the antecedent conditions, the event, and the consequences. Each of these components could include thoughts, feelings, behaviours, and relationships. Critical incidents now went beyond the very specific activity to include antecedents and effects of the activity. This helps to broaden the analysis and generate more information about the contributing factors and the effects of what one is studying. The researcher included this variation in this current study in order to have a fuller and more accurate picture of the context surrounding the event. A semi-structured, open-ended interview was used to explore the critical events. For the purpose of this study, critical incident (critical is used interchangeably with significant, and incident is used interchangeably with event and factor) was defined as the following: An event which is clearly related to the process of recovery from binge eating and has a significant positive or negative impact on the participant. This can include the antecedent(s), the event, and the consequence(s). The critical incident was not confined to activity alone, but included thoughts, feelings, beliefs and relationships.

Ethical Considerations

All participants were asked to sign a consent form at the beginning of the study. This form included a variety of descriptions such as the purpose of the study, the nature of the participants' involvement in the study, limits of confidentiality, how the data would be safeguarded, debriefing, and the potential risks and benefits of participation. Refer to Appendix B to read the consent form.

Participants

The participants for this study consisted of ten adult women. The participants were found through word of mouth and through professionals, support groups, and

associations working in the field of binge eating. A recruiting announcement was sent through email to interested parties, as well as posted around the community (see Appendix C). Once a volunteer expressed interest, she received a telephone call explaining the nature of the study (see Appendix D).

All volunteers were required to answer a brief preliminary questionnaire (see Appendix E) that asked about the history and current status of their struggle with binge eating. From this questionnaire, the researcher determined whether the volunteers fit the criteria for the study. Volunteers must have struggled with binge eating for at least six months. Binge eating was then subjectively defined using the following criteria as a general guideline:

1. Eating large amounts of food when not hungry.
2. Eating until physically uncomfortable.
3. Rapid consumption of large amounts of food.
4. Feelings of being out of control.
5. Eating alone because of being embarrassed by how much one is eating.
6. Negative feelings following a binge (such as shame, guilt, disgust, or depression).
7. Bingeing on average twice a week for at least six months.
8. The bingeing is not associated with the regular use of inappropriate compensatory behaviours

   (purging, fasting, excessive exercise).

This follows the current criteria for BED in the *DSM-IV-TR* (2000). Volunteers were required to be in the process of recovery for at least one year (determined by self-report). This requirement of one year was set simply in the hopes that participants would have more information to report. As well, many may question whether they truly struggle with

binge eating or not, but generally if individuals have been in the process of recovery for some time, the issue is clearer. The term "process of recovery" is used broadly, but for the purpose of this study, participants were considered in the process of recovery if: (a) they acknowledged that they struggled with binge eating, and (b) they were actively working on and reducing the symptom of binge eating through any variety of means. Volunteers were not restricted as a result of marital status, gender, ethnicity, sexual orientation, or socio-economic status. Criteria for exclusion included being below the age of 19, being suicidal within the last year, and having any physical, mental, or emotional reason not to participate. Any physical, mental, or emotional reason not to participate in this study was self-defined by the participants, and left to their discretion.

Using the critical incident method, the minimum number of participants needed depends on when a saturation point (synonymous with comprehensiveness) is reached. Saturation is reached when no more, or a significantly small number of new categories of critical incidents emerge (Andersson & Nilsson, 1964). In Andersson and Nilsson's study, the last 215 incidents were separately classified. It was found that all of these incidents could be placed in categories that had already been established. This was evidence that the data collected for the phenomenon being studied was sufficiently comprehensive. Saturation and comprehensiveness is further addressed in the section on reliability.

Data Collection

Aside from a preliminary questionnaire, the data were collected through an interview. Each participant was contacted via telephone prior to the interview in which the purpose of the study, the nature of their participation, anonymity, and confidentiality were explained (see Appendix D). The participants then answered a brief preliminary

questionnaire (see Appendix E) to ensure that they met the criteria for inclusion. The latter part of the questionnaire also included some general non-identifying demographic information about the participants. Following Flanagan's (1954) direction that the objective be made clear, participants were made aware of the following:

> The purpose of this study is to find out what helps and what hinders the process of recovery for those who have struggled with binge eating. This information is intended to benefit counsellors and other professionals assisting those with BED, the general public, individuals struggling with BED, and their friends and family members.

Woolsey (1986) added that the wording for the aim of the activity is particularly important because participants will be using this purpose statement to select incidents to report; therefore, simple everyday language with obvious meaning is most effective. An interview date was then set up at the earliest convenience, and the participants were asked to reflect in the meantime on what they found to be significantly helpful and unhelpful in their process of recovery.

The researcher interviewed all 10 participants. Before the interview started, the participants were asked to sign the consent form and were given an opportunity to ask any questions. The researcher then orientated the participants by explaining the purpose of the study, what constituted a critical incident, and how the interview would be conducted (refer to Appendix A). The purpose of the study was to learn about the significant helpful and significant unhelpful factors that were directly related to the process of recovery from binge eating. Flanagan (1956) specified the criteria of a critical incident as: an actual and complete behaviour that was reported, the behaviour was directly observed by the participant, relevant factors were given regarding the situation where the behaviour occurred, the participant made a definite judgment regarding the behaviour (i.e. helpful or

not helpful), and the participant made clear why the behaviour was critical. As stated earlier, subjective experiences, beliefs, attitudes, feelings, and the antecedents and consequences were included as relevant. The participants were repeatedly asked, "What is a (another) critical factor that facilitated (or hindered) your process of recovery from binge eating?" The interview continued until the interviewees could not think of any more significant incidents. Additional "prompt" questions were asked, similar to Woolsey's (1986) suggestions, as well as Herzberg, Mausner and Snyderman's (as cited in Wong, 2000) line of questioning. For example, "How was the incident helpful" or "What were the consequences, how did it turn out?" This helped provide a fuller context and allowed participants to freely talk about their experiences and feelings. Questions regarding beliefs, feelings, and attitudes were also asked (see appendix A for sample questions). To complete the interview, the following final question was asked: "Based on your personal experiences, in a paragraph of two, what would be your top recommendations for individuals in the process of recovery from binge eating?" This question allowed participants to process and integrate their experience through giving recommendations, and also served as closure to the interview (Wong, 2000). See Appendix A for a copy of the interview introduction and sample questions.

All the interviews were taped and transcribed. The format of the interview was semi-structured and open-ended which ensured that certain pertinent information was obtained, while still providing sufficient latitude to explore the responses. The researcher was careful not to shape the questions or responses to inadvertently reinforce certain types of responses. Perception checking was used to be sure that the researcher correctly understood what the interviewees were saying. It was important that both helpful and unhelpful incidents that were relevant to the purpose of the study were generated.

Data Analysis

Analyzing the data consists of an analysis of thematic content through inductive reasoning (Woolsey, 1986). "The objective of data analysis is to provide a detailed, comprehensive and valid description of the activity studied" (Woolsey, p. 248). Flanagan (1954) adds that this stage is a summarization and description of the data in an efficient manner so that it can be effectively used for practical purposes, while sacrificing as little as possible their comprehensiveness, specificity, and validity.

Flanagan (1954) and Woolsey (1986) identified three steps in the process of data analysis. First, there needs to be a frame of reference from which the researcher can decide on the categories that will be most useful and comprehensive. In this study, the principle frame of reference was within the research question itself: The significant helping and hindering factors in the process of recovery from binge eating. The principle consideration made when selecting the frame of reference was the uses to be made of the data. In this case, the principle uses of the data are for individuals who are struggling with binge eating, and for friends, family, or care-providers who want to assist individuals who are struggling with binge eating.

The second step was the formulation of categories. Starting with a small number of critical incidents from the first interview written on 3 X 5 cards, the researcher tentatively defined certain categories and the first incidents were classified into them. New categories were then created, and old categories modified, as more incidents from additional interviews were added. With the help of the supervisor, reclassification and redefinition was a continual process until all incidents were categorized. As an example, Woolsey (1986) found that she needed to add more information to the incident cards as she went along because they initially lacked richness and distinctiveness. In this current

research, sometimes it was necessary to revisit the transcripts and add additional information surrounding the context of the incidents.

Finally, the level of specificity was chosen. The headings and subheadings under which the data were reported establish the level of specificity and generality, and it is desirable to maximize the richness and distinctiveness of the categories (Woolsey, 1986). As Woolsey suggested, the researcher categorized the incidents as they naturally became represented, rather than forcing the same number of incidents into each category as per Flanagan's guidelines. "It is important to continue working with the category system until a point such as this is reached – a kind of 'aha' response" (Woolsey, p.250). With this in mind, data analysis with the thesis supervisor proceeded as follows:

1. The entire interview was listened to, to get an overall feel for the material.
2. Critical incidents that helped, critical incidents that hindered, and recommendations were written on 3 X 5 cards.
3. Descriptive labels were created for the critical incidents.
4. Categories and sub-levels were made from the descriptive labels.
5. When greater specificity was needed, critical incidents were further clarified for maximum richness and distinctiveness.
6. Categories and sub-categories were modified and created continuously as necessary. The researchers were careful to include only categories and sub-categories that were relevant to the phenomenon being studied.

Reliability

In qualitative research, it is the accuracy of the findings that determines reliability. Andersson and Nilsson (1964) outlined three important considerations to determine the reliability of the critical incident method: reliability of collecting procedure, control of categorization, and saturation or comprehensiveness of the data.

The reliability of the collecting procedure refers to the extent to which the number of incidents and their distribution into categories and sub-categories were affected by methods of collection (i.e., interview or questionnaire), and by different interviewers. Andersson and Nilsson (1964) found that the structure of the material was not influenced by the two methods of collecting, and that there were no great differences between the interviewers concerning the number of incidents reported. This study involved only one interviewer, and one main method of collecting data (an interview), therefore there was no concern over the discrepancy of the collecting procedure.

The saturation and comprehensiveness of the data was the first check for reliability in this study. Andersson and Nilsson (1964) verified the saturation and comprehensiveness of data by checking the last 215 incidents collected in their study, and finding that these incidents could already be placed in the categories that were previously established. Furthermore, they determined that when two-thirds of the incidents had been classified, 95% of all of the subcategories had appeared. For this study, the incidents of the last interview were collected and set aside. The last interview was comprised of 43 incidents, which was 10% of the total 423 helping and hindering incidents. The categorization process was then completed for the first nine interviews. A total of 26 categories were created, 13 helping and 13 hindering. Once the categories from the first nine interviews were fixed, the 43 incidents from the last interview were easily classified

into them. Because 100% of the incidents from the last interview were easily classified into the already existing categories, it was determined that the data collection was sufficiently comprehensive.

Control of categorization was the second reliability procedure used in this study. It is possible to present two alternative interpretations of data if this offers a unique understanding of a phenomenon (Heppner, Kivilighan, & Wampold, 1999). However, it is desirable that the critical incidents are classified into appropriate categories in a consistent and objective way; another person should be able to produce similar results. Andersson and Nilsson (1964) asserted that the category system chosen should be an obvious one, with as little arbitrariness and chance as possible. To check for the consistency of the categorization process, an independent rater (a graduate student of Counselling Psychology) was asked to sort 58 incidents, 14% of the total number of incidents, into the 13 helping and 13 hindering categories. The independent rater was given the category names, along with a brief explanation of each. Every category was represented by the incidents sorted by the independent rater to ensure a comprehensive check of the category system. The incidents within each category were randomly chosen. The percentage of agreement reached was 90%: 52 of the 58 incidents were placed in agreement with the researcher. As Andersson and Nilsson suggested that it is acceptable if an independent rater is able to replicate classification of 75% to 85% of the incidents into the categories, it is concluded that the categorization of this study is credible.

A discussion was held to ascertain whether the 6 incidents differently placed by the independent rater should be adjusted. After the researcher revealed more of the context around the incidents, the independent rater decided 4 of the incidents were better suited in their original placement. One incident was not fully read because of information

written on the back, once it was read again, the independent rater also placed this incident in the category it was originally in. One final incident was found to be better suited in the category that the independent rater chose, and was subsequently changed.

Validity

Validity is determined by whether or not the results of the analysis are believable or trustworthy, and whether the results accurately describe what the participants want to say. This was achieved through establishing a well thought out research question, and clearly defining and explaining the purpose of the study to the participants to ensure that the critical incidents remained relevant. This was attained by careful definition and explanation to the participants involved. Furthermore, the incidents were believable and trustworthy because the participants involved were qualified to report the critical incidents because of their own direct experience.

The validity of the results were also made apparent through literature cross validation, which is discussed in Chapter V. MacKnee and Mervyn (2002) asserted that the soundness of categories can be gauged by assessing the results with previous research. If the categories are comprehensive, they will be found to cover the major aspects of the activity studied. This check is made explicit in the Discussion chapter.

The recommendations that the participants gave at the end of the interview were also a form of validity. The recommendations were consistent and agreed with the helping and hindering incidents previously reported by the participants.

Heppner and his colleagues (1999) mentioned that although the term validity is not always applied to qualitative research, quality is an important concept. Quality is assessed by the impact of the research on the participants, the researchers, and the consumers. Hopefully the participants will benefit and change a little as a result of this

study; perhaps they will experience greater understanding, closure, or inspiration to help others. The results should be understandable to the consumers (counsellors, health care workers, other professionals, individuals struggling with binge eating, and their friends and family), considering the everyday experiences of the audience. As well, this research could have social utility for the consumers. Perhaps hearing stories of recovery will enable other people who have struggled with the same or similar issues to fit another piece into their journey to recovery. Perhaps others will simply be made aware, or more aware, that binge eating is an issue – and awareness can often be the first step in a more productive direction, or in transformation.

CHAPTER IV: RESULTS

Interviews were conducted with ten participants. Of those interviewed, three participants responded through contact with professionals in the field, three participants responded through word of mouth with colleagues, and four participants responded through contact with Overeaters Anonymous. There were also two other "potential" participants through Overeaters Anonymous, but one decided to withdraw after the first telephone call, and the second was not available until data analysis was well underway; therefore, neither of them were included in this study. All of the ten participants were female, ranging in age from 21 to 40, the average age being 31. Nine of the participants described themselves as Caucasian and one described herself as African American and British. The participants struggled with binge eating anywhere from 3 to 20 years with an average of 12 years. The participants considered themselves in the process of recovery anywhere from 1 to 12 years with an average of 5 years. One participant considered herself fully recovered, for two years. The nine other participants did not consider themselves fully recovered and viewed recovery as a life-long process.

From the ten interviews, a total of 423 incidents were elicited. Of the 423 incidents, 255 were found to be helpful in the process of recovery from binge eating, and 168 were found to hinder the process of recovery from binge eating. The 423 incidents were sorted into 26 categories: 13 that were helpful, and 13 that were unhelpful. The categories were given names that attempted to capture most accurately and comprehensively what was involved. The remainder of this chapter will describe each of these 26 categories. The recommendations the participants gave at the conclusion of their interview is also touched upon.

Categories that Describe what Helps the Process of Recovery from Binge Eating

The 13 categories under this heading were found to be helpful in the process of recovery from binge eating. The categories are presented by frequency of incidents; the category with the most incidents is presented first and so on. This is not to imply that categories with a higher frequency of incidents are more important, but rather to notice that these categories occurred repeatedly and therefore *may* be more commonly found in other individuals as well.

1. Developing a Healthy Relationship with Self (54 incidents, 10 participants)

Building a healthy relationship with self is an especially large category; therefore, it has been divided into four subcategories to facilitate understanding. As the four subcategories are part of the same category, the reader will find that there is some overlap of ideas. The four subcategories are: (a) Developing greater confidence, self-efficacy, and self-esteem, (b) Acknowledging one's worth and expressing that in loving action towards self, (c) Learning about, recognizing, and expressing one's emotions, and (d) Personal exploration, self-introspection, and working on self. As one participant emphatically stated: "That's so important, having a relationship with yourself."

a. Developing greater confidence, self-efficacy, and self-esteem (7 incidents, 3 participants)

Developing greater confidence, self-efficacy, and self-esteem was often facilitated through personal victories and successes. One participant illustrated this in the following two examples: "When I feel I can deal with something without having to binge…I work through it and things work out fine and I'm happy…it just develops a pattern of dealing with things without food." "Becoming successful at certain things was helpful…I knew I

could accomplish a lot on my own…all that built me up and made me feel more confident."

Greater confidence, self-efficacy and self-esteem was also facilitated through improving self, or helping others as the following two examples portray: "That [helping people] goes to build my self-esteem that was so destroyed for so many years by isolation and by my self-judgement." "Even as simple of a thing as going to a counsellor improved my self-esteem because I was taking steps to improve myself." Developing greater confidence and self-esteem was also related to following one's passion in life. One participant talked about how she was much happier and more confident when she was doing in life what she wanted to be doing. She said:

> To get out in the world and have my own successes and be my own person…I really think that's when it [binge eating] really ended. When I applied for this job, suddenly I felt like I was working towards something I wanted to do and so the bingeing stopped. I'm a lot more confident now…happy with what I'm doing and with the direction my life is taking.

Building confidence, self-efficacy, and self-esteem is closely related to the perception of one's worth. As confidence and self-esteem increased, one starts to recognize more fully one's worth as a human being, which is discussed next.

b. Acknowledging one's worth and expressing that in loving action towards self (21 incidents, 8 participants)

Acknowledging one's worth, commonly facilitated through therapy, included loving, respecting, and forgiving self. The following five examples express this. "[It's helpful] learning how to love myself more…it [counselling] helps me see that I have friendships, I have people who love me, I have a life and interests and talents and

abilities." "Self-love and self-acknowledgement [was helpful]; learning how to take time for myself was key."

> It [therapy] made me realize that I am worth it, I am worth spending time on and it's o.k. to do self-care, to nurture myself…and it still helps me now in my process of recovery. Just realizing that if things become too difficult or if I'm having a hard day that it's o.k. if I stop and take a break, go do something nice for myself, or even talk to a friend for an hour and take up their time…whereas before I would never want to burden anyone, I would never want to take luxuries for myself.
>
> My relationship with myself is open enough…[that] there is space to struggle, I give myself permission whereas beforehand there was no opportunity for that, it was more perfectionist tendencies…the criticalness and the negativity has subsided. And so it [relationship with self] is much more positive, accommodating, permissive, forgiving, and encouraging.
>
> When I'm learning to treat myself more respectfully, then I'll make it more familiar to be treated with respect…kind of putting out what you want in the world hoping that what you decide for yourself manifests in other relationships.

The more one realized one's self worth, the easier it became to allow one's self to care for, notice, nurture, and simply *be* with self; this could be described as loving action towards self. Loving action towards self often meant taking time out to rest, relax, be quiet and calm. This could take place in a variety of venues such as at home, in nature, or in a yoga session. Some participants described this time out as "lying down and letting the stress go out of your body" or, "going outside on the deck and just breathing and sitting there" or, "getting out in nature…sitting outside on your own, taking time for yourself, time to meditate, taking time to just reflect". A couple of participants mentioned the practice of yoga as helpful. "Yoga is an opportunity for me to take time out for myself 30 minutes a day…a time for me to relax and a time to be calm, be still, go inside, reflect, relax, de-stress." One participant explained this time as "finding the quietness…when I

can stop all of that [busyness] and just be quiet, on the inside…being able to stop and allow my brain to stop thinking, almost like a meditation, an ability to be quiet".

Loving action towards, and caring for self often specifically implied one's body: enjoying one's body, relaxing one's body, and especially *listening* to one's body. For example: "When you take that time [to check in with your body], you can actually unwind and so you don't feel so anxious…checking into your body rather than just pushing through everything." Listening to one's body includes noticing physical signs as in this next example. "To be quiet and notice if I'm tired, notice if I have aches and pains in my body." And listening to one's body also means listening to satiety cues: "It's helpful when I can take the time to notice that my body is satisfied with the amount of food I've consumed." Exercise and yoga were some ways to really feel and enjoy one's body, as the following two participants portrayed:

> Being in my body, by exercising, is one way of quickly getting back into my body rather than ignoring my body completely and not feeling, or being in my head and letting my thoughts race. It's a physical way of bringing myself way back.

> It [yoga] helped me like my body. When you practice yoga you are very much in tune with your body, with how you're feeling, you have to pay attention to your sensations…you're nurturing your body, and slowly over time I really feel like that's helped me like my body, to feel good in and enjoy my body.

Lastly, loving action towards self also involves taking action to change situations that aren't healthy for self. For example, "Asserting myself in relationships and then eventually leaving relationships that weren't respectful."

Seeing one's worth and loving one's self is also related to connecting with one's emotions. More specifically, this involves honouring *all* emotions, especially the "low" ones, as the next subcategory describes.

c. Learning about, recognizing, and expressing one's emotions (11 incidents, 4 participants)

This category is learning about and recognizing one's emotions, as well as being able to follow that acknowledgement with healthy expression. In all cases it was about recognizing, accepting, expressing, and dealing with low emotions. Low is used instead of "negative" because the researcher does not want to imply that emotions such as sadness and anger are implicitly negative. The next three examples portray how participants felt a need to connect with their emotions: "It really is a lot about staying connected to what I'm feeling." "Monitoring my feelings, looking what my feelings tell me about what I really believe [is helpful]."

> I've done a lot of learning on how to tell certain emotions. I didn't have a lot of conscious access to anger. I had really suppressed a lot of anger so I had to do a lot of work on anger and getting angry at people. And [there was] a lot of pain, a lot of grief; there was a lot of emotional work.

Once again, therapy was a common avenue through which individuals were able to learn about and express their low emotions, as the next two examples show: "I also do a lot of therapy…[it] has certainly made my life a lot happier, helped me through a lot of backlogged emotional stuff."

> It [therapy] helped me cry, and it was o.k.….I never cried so much in my entire life, I just felt like I was this never ending flowing of tears…like my emotions were freed. Emotions as in crying and also anger…I was much more willing to express it [anger] more than I ever had in my life. I could be so mad or in my journal I would write the angriest most hateful things…it was an emotion that was never let out so intensely before.

Being connected to one's emotions involved being honest with self and asserting self. Two examples of this were: "I try to name things more often, like I'm angry, instead

of just pretending that everything's fine, or that everything's o.k. Basically I try to tell the truth and name my feelings more often."

> So now if I'm ticked off about something, instead of passively being ticked off, I can do something about it. If something is really bothering me internally, I'm going to try and do something about it. Whether that means going and talking to a person about my problem or calling up someone or even talking to a friend and getting that anger out…so I cope better with negative things now in that I will try to take an active stance, actually do something about it rather than sit around.

Anger and sadness were two of the more common emotions that participants found it helpful to connect with. Once participants knew how to tell they were angry or sad, they learned how to express it, which led to becoming more honest as a person.

The above three subcategories involve personal exploration, self-exploration, and working on self, which is discussed next.

d. Personal exploration, self-introspection, and working on self (14 incidents, 6 participants)

The fourth and final subcategory of developing a relationship with self is personal exploration, self-introspection, and working on self. Individual therapy, group therapy, support groups, and journal writing were some of the avenues through which this was facilitated. Participants stated this in the following ways: "It's a very personal exploration…there needs to be a space for us to be personal, share personal stories, share what's really going on…there has to be personal exploration continually." "My writing is very helpful, autobiographical writing, journal writing. Basically my journal writing was my lifeline when I was really struggling, a way to write down what was going on in my life when it was really hard."

Learning about personal boundaries, as well as being able to assert one's boundaries was an important part of self-exploration. For example: "My father was a

classic food pusher and I did have to be very upfront with him. It came to a point where I told him I wouldn't be seeing him if he continued…just really setting boundaries with people." Working on self also meant working through childhood issues as in the following example: "I didn't realize that a lot of issues in my life stem from childhood, and I guess I didn't realize that I hadn't nurtured that, nobody had nurtured that little child."

Working on self led to being more honest and living with more integrity. The following four examples capture this: "You do a moral inventory, you make amends for your past and then you do an ongoing assessment…how I am being in this world." "[It's helpful] living with integrity, living according to my own values." "Being kind of clean in the world in terms of how I live. And then I don't hate myself, then I'm o.k. with who I am, I don't' need to binge to suppress how I feel about myself." "It's about being honest about some of the ways in which I'm just not like your average person when it comes to food."

Self-exploration was a way through which one could become more authentic. Getting in touch with one's inner child, and exploring creativity through drawing, images, and writing, were additional tools some participants found helpful. Doing somewhat non-traditional therapy, specifically therapy that involved more than one's cognitions, was seen as helpful in becoming a more whole and happier individual. For example: "I'm currently doing Holotropic Breathwork which I think is really helping me generally in my life release a lot of things, a lot of places where I'm stuck…an overall me fulfilling my potential and me becoming increasingly happy." Holotropic Breathwork is a technique that includes deeper, connected breathing, music, art, and trained facilitators to explore an

individual's emotional, physical, and spiritual aspects (Association for Holotropic Breathwork, 2001).

Seeing the value of working on one's self, being willing to do the work, and making it a priority was all necessary as the next three examples portray: "[I had] to be willing to do the work [on self]" "It did take a lot of working on it myself, and being able to put in that energy." "Making it a priority not to binge, putting my recovery first, and if that means hurting people in my family, that's what that means for right now."

Personal exploration, self introspection, and working on self are about learning more about one's self at present, as well as learning about one's self through past experiences. This took considerable effort and willingness. Through this self-knowledge, participants were then able to live with more integrity, which helped the process of recovery from binge eating.

2. Having a Supportive Environment and Support Networks (35 incidents, 8 participants)

This category is about being in, choosing, and creating supportive environments and support networks that helped the participants get through the tough times, grow, and maintain positive change. In one case this meant a geographical move, as the following participant elaborated: "It was helpful to be on the West Coast in some ways because it is more of an alternative scene, there's a lot of people doing healing and therapy, it's kind of more culturally acceptable to do that." In all other instances, building a supportive environment and support networks involved "finding a way to have contact with other people" and "staying connected to people" who can share in an authentic way of being. One participant put it simply as "getting married to the right person."

For many, a supportive environment included being in a support group or group therapy where people experienced and *understood* the same struggles one was going through. The following four examples portray this: "Just to be an hour and a half somewhere [in a support group] where people shared that they had the same kind of self-talk in their head was a relief…because in some ways I thought I was crazy."

> We went to that first meeting [Overeaters Anonymous (OA)] and I cried. I heard people talk about the isolation and this self-hatred and this obsession to eat even when you know you don't want to…so what helped was to be in the company of people who understood what it was like.

> Exploring support group and group therapy was really great for me, that group dynamic…[when you're] exploring your own feelings and roles with other people and working through those emotions, you're not alone. There's almost that constant support where you struggle together with this group of people.

> Building a support network with people who understand has been the most helpful thing…I can phone in the middle of the night if I need to…they'll be there to talk me through it. Or I meet with a group once a week in my home and we just talk about what's going on for us.

Some of the many benefits of group support were that participants did not feel so alone, they received constant support, they received encouragement, they felt "normal" (i.e., not crazy), and they made close friendships.

Some of the helping factors of having a support group were the role models, the structure, the resources, and the accountability. These all helped to maintain positive change or a certain outlook on life. Three participants represented this in the following examples:

> If I'm with a friend who knows how I act, because she's been there, she'll read me a lot better…people in the program (OA) would notice something was up and they're much more in tune to what's going on, and it makes it a lot harder to binge, and to want to binge.

> It [OA] is sort of like my constant medicine to try and get my thoughts moving in a positive direction…the support structure helps to remind me that it's really a lot

> to do with my attitude and my choices…it's a huge source of support and I continue to go because it makes my life a lot happier and I think I would easily return to compulsive eating behaviour.
>
> [It's helpful] having a sponsor and other people who had the same problem who could relate to the thinking patterns; the perfectionism, the self-loathing. And having a lot of people who were in different stages who could reflect back certain parts [of their experience with binge eating] so I could listen to the suggestions or try and pattern myself on their behaviour because they have what I want. It's kind of like group therapy really, you know what's working and not working for other people.

It is important to note that although participants most often found it helpful to have support networks with people who intimately understood the nature of binge eating, this wasn't always necessary. It was helpful if others were simply open or supportive even if they did not understand or even know what was going on. This is illustrated by the following two participants: "While I say my family doesn't really understand, they've been very supportive…they'll listen to me, and they don't get it, by all means they don't understand, but they try to…and they're open." "Having supportive friends…it's not like I shared everything with these people but it was a group to hang out with and be with so you didn't have to be anything but yourself."

Individual therapy and partner support was also integral to some participants' support networks. Connecting with others provided support and a way to get through tough times. One participant affirmed this as she talked about the importance of support when going through a difficult time with her mother: "Only through a lot of support, like with my current partner, but also through therapeutic support with my counsellor, am I able to make it through that." Another participant said: "If I didn't have the therapist that I do now, then quite possibly my eating would get more distressed."

Part of building a supportive environment for one's self was choosing friends that had similar values. For example:

> Without exception, the people who I'm close to today are those who live a spiritually based life by spiritual principles…we have to tell the truth, we have to own up to it when we make mistakes and try to correct those mistakes.

Sometimes building a supportive environment meant being with people who had similar healthy lifestyle interests. One participant found it helpful to be around others who ate healthy, and were active. Some of her examples are as follows: "When it was at its worst [bingeing], the biggest help was the people who were around me…when I'm around people who are eating more healthy….Being around people who live healthy lifestyles is helpful." "I really like sports…if I'm with people who enjoy those things, it really helps me with the whole problem [bingeing]…when I'm surrounded with people who enjoy the same types of activities I do." Two other participants found it helpful to be around people where food was *not* a focus or concern. The following two examples explicate this: "It was really helpful to have people not say anything at all [around eating], it could rub me the wrong way if people said I wasn't eating enough or if people said I ate too much." "People not commenting about my weight, not commenting about the food I was eating [was helpful], just staying away from the entire area."

> He [partner] doesn't care less, he can eat chef Boyardee and be very happy with his meal choice…he doesn't care about what calories might be in it…he never let it be an issue [food], it doesn't even cross his mind to talk to me about that kind of stuff, his interest in food is so low, it's a non issue.

Creating a supportive environment and support networks were found to be important for 8 participants. Whether it was joining a support group, going for individual

or group therapy, being in a supportive intimate relationship, or having supportive peers, all were part of a vital support network that encouraged one's growth in recovery.

3. Changing Major Perspectives on Life and Embracing New Worldviews (28 incidents, 6 participants)

This category is about becoming aware of different explanations (different from one's previous understanding or experiences in life) for why things may be as they are, and major shifts in perspectives on life as a whole. Understanding or becoming aware of alternative perspectives led to an overall different view on life, or worldview. An important observation is that for many of the participants, though not all, the perspective change or worldview change was facilitated by spirituality – which is talked about in greater depth in category 4. It also may seem that a couple of the incidents in this category overlap with other categories that discuss self-worth, and a feeling of universality. These particular incidents were placed in this category because the broader context was clearly related to an overall perspective change.

For a few participants, this perspective change was moving away from a view of being victimized towards a vision of purpose, or understanding one's reason for existence in a different way. Some examples include: "I approach the world from a hopeful place rather than from a victimized defeatist kind of approach." "Instead of feeling victimized or trapped, [I adopted] a different perspective on what life was all about, what I was here to do and where I was going." "I saw my reason for existence as being more related to being of service than to external excess." "Just to have faith that my life does have meaning, I am good enough, and there is a plan."

> Instead of thinking that the world owes me and it's all terribly unfair, just to put that aside for a moment and try to help someone else…it breaks through to me that I'm not the only one that suffers…there's a real dignity and strength and

> compassion and respect for each other as individuals and afterwards, rather than feeling like I'm a burden in the world, I feel I have some worth in the world, maybe I've helped somebody.

For many, the perspective change was shifting one's emphasis from external validation and external values, to more emphasis on internal validation and internal values. Participants stated: "My perspective today is letting go of external validation…all of those things are outside of me and in the end they'll run out…people will make mistakes, food will run out, a job title [will change]." "What matters is that I've been the best human being that I can be, that I've been kind to myself and others, that I try to be helpful, that when I make mistakes I apologize for those." "I used to value what they [others] thought so much, and it really doesn't matter…and I just came to understand that, and to not really care what everyone thought." "The stability in my life, the strength in my life was what I carried within." "Being o.k. without all the external validation [has helped]."

Accepting and being at peace with the human condition was another shift in terms of how to understand life and what it meant to be a human. This included being able to accept imperfection, to see the good despite the imperfection, and to accept uncertainty. Some examples of how this shift was expressed are as follows: "Just being able to hold onto the ambiguity of it [life], the uncertainty of it, and see what happens." "Being o.k. with [and] seeing mistakes as a normal and necessary part of being alive." "To feel some forgiveness for myself, and to feel some forgiveness for the ways in which they [others] have harmed me, because we're human and we do that." "I used to have really high expectations of myself, I'm learning that my best is good enough." "Realizing I'm not

perfect…being o.k. with my humanity." "[I started] to see the good parts in life, to see the good in other humans and in my self."

> Now I see all the human beings, and I see I'm just another one of the human beings on the planet…I don't think there's anyone who has such a thing as a perfect body, and at the same time we all have perfect bodies….There's a lot of women on this planet and we're all good enough.

For another contributor, understanding women's history and the social context were essential to the process of healing. She discussed how through gradually understanding and learning about women's place in history as well as her own privilege as a woman in this society, completely changed the way she perceived the world. This understanding significantly changed her worldview, which in turn significantly facilitated her process of recovery from binge eating. Her evolving worldview is illustrated by the following quotes: "There's the whole other back-story and background information that we really need to have before we can start to make meanings, trying to make connections, trying to make sense of our lives."

> One thing that got me out of the whole cycle was reading a book called *A Woman's Worth* by Marianne Williamson and I think that was my first introduction into feminist thought, and also a sense of something larger than myself, that there was a bigger social context that I was a part of, and that for me was the key to moving me out of these particular behaviours.
>
> I took a woman's study course and started to understand woman's history, woman's place in the world through time…and this is like the unfolding of feminism for me, and this is what I found basically essential to me being able to heal myself in eating…I became aware of these oppressive situations and where I was situated in them….[I was] learning about feminism, about ways of being in the world and how I didn't have to play a role, play a feminine kind of role; I could still be a woman and still express my needs and my concerns and my anger.
>
> [The unfolding of feminism] gave me a clearer picture of the world, gave me kind of the back-story for why I might feel the way I do, but also why things are set up the way they are. For example, starting to understand capitalism…the whole diet industry is predicated on capitalism…and so I became aware of who benefits from me feeling really bad about myself.

> Seeing the film *Slim Hopes* by Jean Kilbourne, an analysis of advertising and how it affects women's perception of their own bodies, and people's perception of women's bodies in general, was particularly helpful….It [seeing the above film] was like coming up for some air, breaking through really dark clouds and seeing some light, and things just began to make sense…I had that awareness so I was able to give myself a bit of a break and stand back from it…stand out of the middle of the chaos and go, o.k., this isn't just me, there's a much larger picture that I need to see.

Gaining a broader understanding of the social context and developing an expanded view of the world involved continual questioning of the status quo. "I continue to question, it's a necessary part of my existence, to continue to question the status quo."

Whether it was understanding binge eating through a feminist perspective, accepting imperfection, shifting to a more internal than external focus, or feeling purpose in life rather than feeling victimized, participants were facilitated in the process of recovery by these new and expanded perspectives and worldviews.

4. Developing a Spiritual Connection (27 incidents, 5 participants)

Quite a few participants attested to how developing a spiritual connection was integral to the process of recovery. Some examples that illustrate this are as follows: "It [recovery] is the process of developing a relationship with a higher power." "I found that developing a relationship with God has changed my life." "What I eat, and how I think about myself and my body, and how much I think about myself, about food, and about my body, has lessened the more I develop a spiritual way of life." "I have no doubt in my mind that it's about a connection to a God of my understanding."

> The solution has been to find a Source [God] of strength that's real…because everything else can change. The strength I had [when estranged from family, lost partner, and had no home] wasn't my own, it was connecting to a strength beyond my own.

Developing a spiritual connection enabled various outcomes for many of the participants. For some it was a matter of putting faith and trust in God or a higher power. Part of that trust and faith included a sense that God or a higher power had a plan, that each individual's life had meaning, and that things would somehow work out. This perspective facilitated letting go, not worrying as much, and not trying to control life so much. Examples from participants include:

> It [spirituality] has just given me a faith that I've never had before…I'll be completely taken care of if I continue to pray and try to do the best I can every day. It's hard to put in words, it's just become a knowing that I have.
>
> It [a spiritual connection] has given me a lot more peace about my life. I might be upset about the way my job's going or the way a relationship's going, but I know that at the end of it, everything is going to turn out fine because I have faith in God. I feel calmer, I don't get as worried about what is going to happen tomorrow because I know I'm not in charge of that, God is. It makes it much easier to live in the present.
>
> When I put God in charge, if I pay attention to the messages I get about how I should run my life, then those things [challenges, conflicts, chaos] dissipate and I have a much more serene day. Relationships go better, interactions at work go better and I don't get upset about things that might have upset me in the past. I can go through the uncomfortable feeling of thinking I'm hungry and knowing that it's going to pass. God is taking care of me.
>
> With spirituality I see myself not in control, although there are things I do that I have control over….[Before] I felt really subject to the whims of the universe, it's something that I still struggle with. But I have purpose.
>
> It [spirituality] has helped me let go of a lot of stuff in my life, control-wise…I worry a lot about other people's stuff. There's just a sense of safety, with a spiritual [connection], a sense of safety, that things are going to somehow work themselves out….It's a sense of security and that things are going to be o.k., and that I'm being taken care or, and even if a situation is very hard, that it's going to pass.

Some participants mentioned various avenues through which a spiritual connection could be facilitated. Prayer and meditation were common pathways, as well as being in nature and taking time to connect. These avenues helped to draw strength from

and increase faith in a spiritual source, as well as return to a more balanced perspective in life. Participants expressed this in the following ways: "Sometimes my connection to that [spirituality] is through my own body in that I've learned to pray and meditate regularly, to be quiet."

> Praying, meditating, or writing, and somehow trying to communicate, whether it's quietly or in a written form, to that God of my understanding, has developed a connection and a strength and a faith that, you know what, I didn't get that job for a reason…just to have faith that my life does have meaning.
>
> I pray on a daily basis, I ask to be kept from compulsive eating every day and I ask God to show me what I need to do in the day. And you know, I've had periods where everything is going wrong in my life and I still pray and I'm still not overeating, not bingeing. And I don't think that would be possible if I didn't have God in my life.
>
> I spent every day [during a vacation] by myself, 8 hours. I just went down to the water. It's really nature, nature helps me to shut up inside…it's just me and the ocean and the trees…it's just quiet and I feel connected to God. And I feel more balanced, my spirit feels more balanced. Moderation is what's in my mentality.
>
> It brings up my spirituality, when I'm taking time to connect. That's when my mentality of balance is the most prominent. So when I have that time and I take that time to connect, that mentality shifts to more of that desire to be balanced.

One participant mentioned Holotropic Breathwork as having a spiritual aspect. "[Holotropic] Breathwork has quite a spiritual component to it too; it also works on that level."

Developing a spiritual connection through "working" the 12 steps of OA (which includes many aspects already described above such as prayer, meditation, and trusting in a higher power) was facilitative for many of the participants. Often this included redefining one's understanding of God or of a higher power, as well as developing and honouring intuition. Contributors stated: "A big part of it has been being able to access intuition which provides some kind of guidance for my life." "God can be anything that I

want God to be." "It's not a religious God, just a spiritual God." "It's the source of hope and love that I've tapped into that I've become willing to open up to."

> OA is a way to develop my own spiritual connection. It's the 12-steps themselves, as I work them. The purpose of those steps as I understand it today is to clear the path between me and some universal force of strength and hope and love, upon which I can depend, that is dependable.
>
> With OA, it's all about spirituality…I've often heard people describe having a hole, that they were needing to fill something up. And I felt that a lot...I think that [spirituality] helped me…religion did not help me, but a spiritual path did.
>
> My belief in God today is more about the cycles of nature, the intuitive feeling that I call a friend that I care about, pausing a moment in traffic when there's no real reason to but I just have a sense….I have to rely on my inner guidance or my intuition and accessing that through prayer and meditation to try and get clearer with my intuition, with my gut, get a sense of what I need to do.
>
> I don't feel alone because of this spirituality that developed. For me it's God…but a much less judgmental being [than childhood]…you create what you want your higher power to be and I needed something to take care of me regardless of where I was at.

Not surprisingly, spirituality meant various things to different people. Whether it was connecting to spirituality through nature, meditation, prayer, or breath work, this was a definite source of strength, hope, faith, and love for many of the participants. Through spiritual connection, individuals seemed to develop a more positive outlook on life and a feeling of purpose, which in turn facilitated recovery from binge eating.

5. Disclosing to Others (23 incidents, 8 participants)

Disclosing to others was about being in positive relationships where disclosure could take place and where one was able to talk honestly about what was going on in one's life. These relationships could be with one's partner, with a professional, within a support group, or with one's friends or family. There were specific qualities that the other person or people would have in order for disclosure to take place. These included being

non-judgemental, respectful, supportive, and a good listener. Often the participants needed to feel safe, and that they could trust the person they disclosed to. One participant talked of going to her sister: "I went to her home, and I talked to her about what I was feeling, I felt safe with her, I needed to talk with someone I felt safe with and I knew wasn't going to judge me." Another participant commented: "The relationship that I'm in now is extremely supportive and respectful and mutual, and so I find this a great support." Another participant talked about her relationship with a therapist: "I need a person to go to that I trust, that I can go and talk with about personal things in my life and struggles and so on."

It was very helpful to connect with people who understood the nature of binge eating, whether it was a credible professional who had the appropriate training and experience, or peers who had gone through the same or similar struggles. One participant said of a professional: "Getting medical help [through a psychiatrist] was helpful, talking about stuff and knowing that someone was just hearing what I had to say and understood the pain I was in." The next two quotes are of participants who were helped by disclosing to others who had gone through the same experience: "I got a sponsor in OA who is someone whose story I can relate to a bit, who I had a much more personal, intimate relationship with…that was really helpful." "It's been really helpful talking about things, talking about my recovery, talking to people within the fellowship [OA] and reaching out when I was having a hard time."

Disclosing to others and being able to honestly talk about one's struggles had various effects. The following three participants expressed how talking was cathartic and allowed emotions to move: "To talk about it [a binge] kind of relieves the stress of it, and probably a lot of guilt associated with it." "You can share it [a binge] with someone and

get it off your chest…the mere fact of talking about it makes you feel better, it gets some of your emotions out." "Now when I do have a negative thought, I try to share my feelings about that thought with my partner and through sharing it, it's almost like letting go, it moves through me." For some, talking about binges also helped to lessen the shame they felt.

Another outcome of sharing one's struggles with other people was that one could then get feedback, learn more, and move towards progress faster. Once again, this could come from a variety of sources such as from professionals or from friends, as the following three examples show:

> I did some intense therapy a few years ago, I felt pretty great then too, and that was being able to talk on a regular basis about what I was feeling, and to get that feedback from a therapist about different ways of how to look at a situation or have somebody else recognize what the situation was.

> I had to get out of myself and talk with other people…I think the key is interacting with other people and learning from other people. I don't think I would have ever figured out my problems with food if I just continued to read books and tried to figure it out on my own.

> The counsellor had expertise to sort of point me in directions that I might feel too uncomfortable for me to go on my own. The safe environment with somebody there, directing a conversation or taking me through an exercise…I wouldn't get to the same place as quickly or in the same way if I was just trying to figure it out on my own.

Disclosing and sharing personal stories with others also helped participants not feel so alone. The following example illustrates this:

> We talked about how we felt, how we were feeling…what's going on in our work, or with our family, or with our friends, and some of our insecurities, whatever our feelings are. Just to be heard, and not have that isolation and loneliness, and to be reminded of that, to remind each other [that we are not alone].

The isolation was also decreased through disclosure because then binge eating was no longer a secret and something that had to be hidden. For example:

> It was helpful to talk about it, even with people who didn't necessarily understand but that it wasn't kept as a secret anymore…it was almost like coming out of the closet in a sense, it wasn't as secretive, I could even explain how I was feeling, maybe even saying that I felt like an episode was coming on, or I had an episode of binge eating…so it enabled me just to kind of express what was going on with myself…it was not being ashamed or if I was ashamed, fessing up to feeling ashamed.

Furthermore, as some participants became more comfortable with their recovery, they were able to talk more openly about it with their friends that had not experienced binge eating. This was another step in becoming more authentic. For example:

> Eventually, as I became more comfortable, as I'm coming through recovery, I've been a lot more open with my friends and just people around me, becoming more honest about it [binge eating]…it [talking with people] helps me put down a guard, it's a level of honesty that I've never had before.

And finally, one participant talked of feeling gratitude through disclosing and sharing with others:

> I often get a lot of gratitude when I talk about things…talking about what it's like or how far I've come is a big thing of gratitude. Because it's really easy for me to forget how bad it was…and when I go to meetings [OA], I hear people talk about things that I did a lot and I need to be reminded because it's real easy for me to forget. I've had relapses after a month because I've forgotten how it's like, I've forgotten how bad it was.

In summary, this category of Disclosing to Others is mostly about participants taking courage to talk with others about their personal struggles. Through this, participants decreased their isolation, received support, gained perspective and experienced catharsis.

6. Increased Knowledge, Awareness, and Ways of Understanding Binge Eating (20 incidents, 5 participants)

This category discusses how participants found it helpful when they became more aware of and learned more about binge eating. It was also helpful when others acknowledged and began to understand binge eating. This category also includes how participants found it helpful to have a specific structure of how to understand binge eating, and of how to progress towards recovery.

For some it helped that binge eating or compulsive overeating had a name. This helped to validate the experience not only in the eyes of one's self, but in the eyes of others as well. The following two examples portray this: "It [binge eating] had a name at a certain point, other people had it and that kind of stuff was starting to come out…that was helpful."

> [It was] helpful, definitely, being able to label it…it was kind of giving my thoughts and feelings and actions a name so that it wasn't necessarily all in my head, something that was then tangible that other people could then relate to because they understood what it was if there was a name or label to it.

Learning about the possible underlying reasons for bingeing and that dieting was not the only solution was also helpful in the process of recovery from binge eating. The following two examples illustrate this: "Just the education…trying to understand what makes it happen, what made me do what I did."

> I learned over the years that it's not all about weight and food, it's all the emotional stuff behind it, most of us eat to fill a hole somehow….There was a reason why I hadn't been able to stop the eating problem in the past…and I didn't know that people could lose weight other than in standard weight loss programs or diets. I didn't know there was another option.

Learning about and coming to understand binge eating more fully was often achieved through knowing and hearing other people's stories and experiences. Contributors stated: "Just talking about it with other people, and just hearing other people's experiences and

what worked for them, in stopping the compulsive overeating, and learning that it takes as long as it takes, there's no quick fix."

> Knowing other people who were going through it helped me understand more… and then I just started reading books about it and trying to understand it, usually in every book there would be some part of it that would click with me…that helped just in understanding it.
>
> As I would know people who were going through it, [it helped] just to hear how it affected them…knowing other people who were going through it because whenever I would hear about eating disorders, it would always be more like anorexia, the more typical eating disorders, like bingeing and purging.

Some participants found it very helpful to have a framework through which to understand binge eating. A popular framework was the 12-steps of OA, as the following three participants related: "[One of] the two things that really helped was OA which provided this whole other context, this whole other framework…and a kind of structure and a way of understanding."

> The idea that binge eating was addictive behaviour and therefore was like alcoholics' behaviour or drug addicts' behaviour and that it was related to a lack of faith, a lack of faith in a loving world or a loving God…lack of a functional spiritual life.
>
> I used to think that there was something wrong with me because I couldn't stop eating…I thought I didn't have the right willpower, or I was lazy, or, you know, I wasn't trying hard enough. And when I started hearing about 12-step program, it all made sense – that the binge eating, the compulsive overeating is an addiction. In my mind it's an addiction and there are ways to treat addictions.

A couple of participants mentioned that it was helpful to understand binge eating as a life-time or a long-term process. For example: "You're looking at it to be healthy for life…looking at your life as a whole." Participants who were not part of OA also felt that binge eating was life-long as the following participant not associated with OA stated: "It's almost like looking at yourself as an alcoholic, this is an issue I'm going to have to

deal with for life." In fact, nine of the ten participants considered recovery from binge eating as a life-long process.

In summary, having a name for binge eating, knowing about and hearing other people's experiences of binge eating, and having a framework through which to understand binge eating have all facilitated individuals' process of recovery.

7. Becoming Aware of and Changing Thoughts and Behaviour around Food (17 incidents, 7 participants)

This category involves becoming more aware of and changing certain habits around food, as well as changing attitudes towards food.

Eating more balanced, not dieting or restricting foods, and having some structure around food were all helpful. Participants talked about "being more balanced" with what they ate, "eating a variety in foods", and "eating small meals throughout the day". Getting out of the diet mentality was very helpful, as the next two examples portray: "[One of] two things that really helped was getting off the diet cycle." "The thing that really started helping me was the idea of getting off the diet cycle and eating what you wanted to eat and making that o.k. She [Geneen Roth - author] had this idea that if you stopped restricting food, they would be less magical, they wouldn't be so special." It was important to reach a balance between no structure and too much structure, and no restrictions and too many restrictions. In the words of the participants: "I know that structuring food works in some ways… a structure that has worked for me is doing three meals a day and not restricting the type of food it is. Not eating my binge foods [triggers] but not focusing so much on calories and fat content." "[It is] helpful to have a bit of control over what I'm going to be eating, and there is a fine line between obsessing about

it." "Often it [planning ahead] means bringing my own food, or eating beforehand, or eating after [potluck meals]….Meals work better for me when they have a start and an end." "Just being aware of the triggers and the foods that are harmful for me, that make me binge. I haven't eaten chocolate for over a year and a half and that was my biggest trigger food." "Being willing to acknowledge that there are foods that I can't eat, and there are times of the day that I shouldn't eat. If I eat in the evening, I'm usually much hungrier the next day…so I try to stop eating with my dinner and not have anything else." As illustrated, the helpful behaviours around food were quite individual and even contradictory (not restricting any type of food vs. restricting trigger foods), but a common thread was that one became *aware* of a particular behaviour that was helpful, and then implemented it.

Changing attitudes towards food was also important. For some it was realizing that it was not about having the perfect formula. "It's not simply about eat this and this and this in these quantities at these times of day." For others it was changing the focus by eating for health rather than eating for a certain weight. "Focusing more on health helps not crave the foods as much rather than focusing on just being skinny, trying to focus on eating healthfully."

Creating an environment that encouraged helpful eating habits was also facilitative – for example, not having trigger foods available in the home, or having nutritious food easily accessible.

8. Feeling a Sense of Hope and Universality through Connection with Others (16 incidents, 6 participants)

This category is intricately part of connecting with people. It is separated from Disclosing to Others (category 5) and Having a Supportive Environment and Support

Networks (category 2) because the incidents under category 8 focussed more specifically on the feelings of universality and hope that were experienced.

Universality is when participants felt connection through knowing that others were struggling too. And through this knowing that others were struggling, participants did not feel so alone, they felt relief, and they felt encouraged. The following two examples touch on this concept of universality: "There's a definite feeling of connection, like oh wow, I'm not the only one." "It's knowing that I'm not alone, that there's other people out there that experience the same thing and are facing the same struggles." A couple other participants felt this universality through reading other's stories: "Reading can be helpful…reading about other people's stories…it gives encouragement that these feelings aren't solely my own." "I remember picking up a book and reading someone's story, and just being shocked that this was not unheard of [going from anorexia to binge eating]. And [this was] a huge sense of relief for me." Two more examples portrayed the importance of not feeling alone:

> The first thing that started me on the road to recovery was finding this program where I could meet, listen to, and talk with other people who had the same problem, And learn that I wasn't alone and that I wasn't crazy.
>
> I find it really helpful to hear what other people are going through because most of my issues with food have involved me being secretive and hiding and isolating [myself] in my home and not participating in life. So when I can be with a group or people who have the same problem I have, I don't feel alone. [It's helpful] just knowing that I'm not alone.

Participants also talked about feeling hope. This feeling of hope came, once again, through connecting with other people. Sometimes this meant feeling something in common with another person as the following participant found through reading: "I saw

myself in the author's description of her life, and so there's a feeling of being connected to other women…and out of that feeling, support and hope."

Often hope was felt when participants connected with others who believed in recovery and who believed that there was something that one could do about binge eating. Sometimes this came through reading: "Her [Geneen Roth, author] assurance that that [her particular method] would work [was helpful]. That this has worked for her and worked for other people…that they stabilize their weight." And sometimes this came from the fellowship of OA: "I might have been in pain, but they understood and they were saying there was something I could do that they believed in, they believed in the process." Hope came through talking to others, and through being with others that had experienced progress with or were in recovery from binge eating. The following three participants exemplified this: "When you see that other people have been there, but they have been able to break the cycle it gets you positive again." "[In OA], people may be at a different place in their recovery and it gives me hope to go on, that I can get to where they are, that I can keep getting better." "Seeing that other people have gotten better, I'm [also] going to make it past this binge…there were people [in OA] who were in recovery and I needed to know that there was a light at the end of the tunnel."

When participants connected with others, they felt not so alone and they felt a sense of universality. Connecting with others who had gone through similar experiences also led to a sense of hope. Both a sense of universality and hope facilitated participants' process of recovery from binge eating.

9. Finding Alternatives to Bingeing, Being Busy, and Engaging in Pleasurable Activities (15 incidents, 6 participants)

Participants found it helpful to substitute bingeing with other activities. For example: “When you feel like eating, replacing that with playing the piano or taking a walk, or writing in a journal.” Sometimes it was helpful to do something calming as the following participant illustrated: “Eating vegetables will give you that chewing sensation which will calm you down…it’s very calming, very comforting.”

Others found it helpful to engage in pleasurable activities simply to turn the negative thoughts or feelings around. The following four incidents demonstrate this: “Reading can be helpful, even just reading a novel for pleasure because that kind of takes me out of a particular thought pattern.” “[It helps when there’s] something that you can get excited about such as a trip in the future, meeting a new person, or a new project.” “Anything that changes moods, like music, movies, anything that changes your state, that helps.” “Exercise is quite helpful, being quite active helps me, going hiking and going for a walk. That kind of helps clear away and put into perspective those negative feelings. It takes me away from that kind of spiral downward.”

Being busy with pleasurable things really seemed to help take one’s mind off of bingeing and food. For some being busy provided a sense of purpose, for others it was a way of taking the focus off of themselves, and for many it was a way to break the isolation. Participants stated: “I didn’t really have time to get down in the dumps…there’s too much other fun things going on.” “Keeping myself busy…it’s like I’m always thinking of places I need to be, so that kind of takes my mind off the food.” “Someone says, ‘hey, let’s just go play basketball, let’s go play a round of golf’, I love that….It kind of occupies my time.” “[It helped] if I had a plan to do something, kind of a sense of purpose or something, and that could even be an appointment at a psychiatrist’s office.” “Something to look forward too [is helpful] because it [binge eating] is so isolating, it’s

so isolating and just having plans, something concrete that you can't get out of [helps decrease that isolation]." "Having distractions, other interests, going to school at times so I had people around me, I wasn't really close to those people, but it was a nice distraction. Just having people around, not being completely isolated was really important." "It's helpful to be social, to have a social life…it's helpful for me to go out in social situations…. it's getting outside of myself for a little bit, in a positive way."

So whether it was consciously attempting to replace the bingeing with another activity for the time being, or having other interests, plans and pleasurable activities going on, all assisted in taking the focus off of food. The main effects seemed to be the uplifting or calming nature of the activity, or the reduction of isolation and taking the focus off of self.

10. Feeling Cared for, Loved, and Accepted by Others (12 incidents, 6 participants)

Participants discussed how it was helpful when they felt cared for, loved, and accepted by others. Once again these incidents may seem to overlap with previous categories that also focussed on relationships with others, but the particular incidents exemplified here have an especially strong focus on care, love, and acceptance. Often this was in the context of intimate relationships. One participant talked about the importance of having a partner that would continue to love her unconditionally. Another participant said:

> He looked at me as someone that he deeply loved and cared for…the over enveloping love and care for me as a person is what I felt, and that's what he portrayed to me…he was completely non-judgemental and he never looked on me like it [binge eating] was a shameful disgusting awful thing.

Acceptance was also when a participant's partner did not focus on or judge her weight. She said: "It was all of a sudden somebody likes me, and it did not matter…it has nothing to do with my weight…even something like having sex, and for him to want to; that acceptance was there."

> It [eating] just never gets talked about in a judgmental way….He says, 'I love you anyhow, what are you worried about that [weight] for?'….Even though I am overweight, he never lets on that he cares about that at all, that he somehow links that to who I am, or feels any differently about me because of it.

Participants also talked about the "huge amount of caring" that went on in a support group. One participant explained how in a support group, in this case OA, there was no profit motive and so she felt their sincerity in really wanting to help her. She went on to say: "They weren't fazed by my suicidal feelings. The rest of the world doesn't make eye contact [with me]. So I actually started to talk about how I really was and the people in OA were quite accepting and said 'well keep coming back.'" Two final examples from participants who emphasized the importance of love and acceptance are: "Love and acceptance and compassion is what helps, an environment where I can 'tell on myself' about things that I still think are just terrible awful things." "I have friends who love me even when I'm late…I need the love and support of others who don't judge and who don't tell me what to do."

Feeling love, acceptance, and care were especially important in relationships that participants had a lot of invested energy in, most often in the context of a partner, a very close friend, or a support group.

11. Reaching a Point of Desperation (6 incidents, 4 participants)

Some participants talked of reaching a desperate hour, and that in feeling total desperation, the conditions were right for change or progress to occur. One individual said: "It's my opinion that everyone has to hit a bottom, an emotional, spiritual, physical bottom, where they're just so hopeless that they know they can't do it on their own." Four participants illustrated reaching a point of despair in the following quotes: "I was feeling desperate. I felt out of control with eating, it started to remind me of the way I would feel out of control with alcohol or smoking pot." "Something just broke inside, I was afraid of completely falling apart. They [employees of a weight loss program] had taken away what I thought was my last hope…and I just burst into tears and I sat there and cried a long time. I was desperate, I was really disheartened, I felt like a failure, I felt very isolated." "I think a lot of people have to get to the point where it's too painful to keep eating, before they can start climbing out of the hole. They [alcoholics] have to hit bottom before they can get sober and I think it's the same thing with food, people have to get to a certain level of pain before they'll stop."

> The timing has to be right for me to feel to be open to it, and maybe part of the conditions necessary were for me to feel like I was at an all time low, or that I was feeling powerless or hopeless about things. And that was an extreme situation in which I could then receive some kind of message about life.

It seemed that reaching a point of desperation was ironically a type of catalyst that spurred the process of recovery from binge eating for some participants.

12. Stabilizing with Medication (2 incidents, 2 participants)

Two participants talked about how medication was helpful because it provided stabilization, which in turn facilitated progress. "Now that I have dealt with the

biochemical issues (I'm on antidepressants which has helped enormously) now that that has stabilized, now I'm able to do a lot more, to be a lot more aware."

> I was also on medication, on topomax actually, and I found that helpful….It was definitely helpful at the beginning when I was so distressed and so emotionally disturbed that I wanted the medication…I felt that I am so over the edge now that I don't have the energy or the emotional wherewithal to work this out psychologically analyzing and thinking it through. I felt that I needed something from the outside that was going to stabilize me. It was only once that that was brought down to more manageable levels that I felt, o.k., that now I have the energy to go forward.

For these two participants, pharmacological intervention was helpful because of the stabilization it provided.

13. The Absence of Financial Blocks (2 incidents, 2 participants)

One participant talked about how being financially secure decreased the amount of stress. "When the money is o.k., then I don't have to stress out about working hours to make money, because money is there, that stress doesn't build which creates bingeing. So when the money is there, it really helps to keep the balance." She also talked about how financial security made it easier to make positive food choices, because the cost was not an issue.

Another participant found it helpful to be welcomed into a support group no matter what one's financial situation was. "Where if you had money you could donate as much or as little as you had, or nothing. You were welcome no matter what. There's no business structure to it, there's no one making money off of it."

It seems that the absence of financial blocks supported participants' process of recovery from binge eating.

This completes the 13 categories that describe what facilitates the process of recovery from binge eating. It is acknowledged that there may seem to be some overlap among the categories. Rather than creating fewer but extremely large categories, the researchers attempted to categorize the incidents in such a way as to highlight the distinctiveness of certain facilitative factors. However, in the discussion chapter (following this chapter), the categories have been combined into eight general themes, and are discussed as such.

Categories that Describe what Hinders the Process of Recovery from Binge Eating

The following 13 categories were found to be unhelpful in the process of recovery from binge eating. As the helpful categories were organized, these categories will also be presented in descending order of incident frequency.

1. Societal, Media, Peer, and Personal Pressure Surrounding Excessive Attachment to Appearance and External Validation (23 incidents, 7 participants)

This category describes how the unbalanced emphasis on appearance and external validation, whether through society, media, peers, or one's self, has been unhelpful. Some participants talked about the pressure from society to be or look a certain way, and how this led to binges. One participant explained this as follows:

> [What is unhelpful] is the pressure of society, to be a certain way…the image of what I am supposed to be as a woman…I wonder if that pressure wasn't there, if this [binge eating] would even be an issue. It seems to be an issue because it's constantly on my mind. I should look a certain way, I should be a certain way, and so I end up depriving myself of foods that I really enjoy because I'm afraid to gain weight…and then it gets to the point where I've gone two weeks without…and then pffff [binge].

This participant also talked about the unhelpfulness of the mixed messages one receives. For example:

> The stress of the pressure from society is very unhelpful, it's a mixed message. You need to be thin, and you need to be ripped, you need to be this to be an attractive woman, but then all of the marketing is for places like McDonalds.

Another participant also talked about the unhelpful messages individuals receives from society, messages that focus on unrealistic body types as norms, and how this perpetuates eating disorders.

> We're taught from an early age that this [being skinny] is what it is to be beautiful, and it's not o.k. to be a little bigger…it's the twisted ways young women, and men these days are told [that] to have it all, they have to have a perfect body....All the women's magazines, and all the media focus on skinny girls, it certainly is not helpful…it just becomes another reminder that I'm not one of those and that even when I lose weight I'm not going to be one of those…I think there's so many eating disorders created by seeing these perfect television stars or models and thinking we have to be like them to be accepted and thought well of…we're told this is the average, we're told this is what everybody looks like.

Another participant summed up the media and present day culture as having quite a superficial focus, while lacking a focus on spirituality and meaning: "This culture is not a culture that embraces wholeness, it's very focussed on unrealistic models, and also it's not very spiritually focussed, it doesn't encourage a spiritual interpretation of life."

Participants also talked about how it was unhelpful to personally overly focus on physical appearance. For example: "Focussing on the physical only is unhelpful…[and being] overly attached to my physical experience, what other people thought of me, and how my thighs looked in this particular set of tights." One participant illustrated this when she said the following: "Trying to lose weight for an event, trying to look good, rather than thinking of eating healthy long-term [is unhelpful]". Participants also found it unhelpful to be around others who overly focussed on appearance, for example: "For me it was cause to binge if people noticed that I had gained weight". For the following

participant, it was unhelpful to be in situations where appearances were likely to be emphasized. She said:

> Exposing myself to situations where there's a lot of dependence or focus on appearance [such as] going to bars where the cool people go….Even if I'm going to the beach or to the pool, just revealing my body can be triggersome or difficult.

A heightened focus on appearance led to comparison which led to competitiveness. Some contributors stated: "My peer group was pretty obsessed with their bodies…I remember being very competitive in school in terms of looks."

> What was unhelpful were comments about my shape, but more specifically comparing my body to other women's bodies. And whether I did that myself or my partner did that explicitly, both were equally unhelpful…the comparison with other women perpetuated the need to compete…this whole competitive behaviour around food and eating less and exercising more and trying to look better…and that definitely made things worse. It fed [into] a lower sense of my self, which made me feel more vulnerable and of course the cycle continued.

For a couple of participants, it was not only focussing too much on appearance that was unhelpful, but also too much attachment to external validation in general. The following two examples illustrate this:

> I could make myself feel better temporarily by going out and buying new clothes, having a new phone…material items were used to appease, there was a great deal of meaning attached to them, overly so, and so the focus became about having really nice things as part of creating this illusion of happiness.

> It was this attachment to something on the outside [that was unhelpful]…a perception of what others thought of me, an attachment to external validation….If I'm overly attached to a man I love, or a job I have, or even the size on my jeans, I'm going to suffer because all those things could change.

In summary, societal pressure of what a women should look like, and influences from the media portraying unbalanced and often unrealistic images of women were found to hinder the process of recovery from binge eating. Being in the company of peers who

were overly focussed on appearance, as well as personal attachment to appearance and other forms of external validation were also found to be unhelpful.

2. Overly Focussing on and Controlling Eating Habits, and Eating Trigger Foods (21 incidents, 7 participants)

This category discusses how dieting, restricting food, and trying to eat too healthily was unhelpful. This category also discusses trigger foods that were unhelpful for some participants.

Many of the participants explicitly stated that dieting, a diet mentality, or restricting food was unhelpful. The following two participants illustrated the unhelpfulness of dieting:

> I had tried many diets. I tried diets out of books, I had gone to organizations for support…and I would get down to a low weight and then I would gain it back, plus a little more, so each time I would have a little more to lose.

> What has not been helpful has been conventional diets…it [dieting] would just spiral into a binge or eating junk food for several days in a row and not eating much else…they [people at a weight loss center] try and give you support but it's not a high level of support.

Participants talked about how it was unhelpful "trying to be too good", too healthy, too disciplined, too strict, or too controlling with the food they ate. Examples from two participants: "The bingeing might happen because I would be so strict and restrict myself so much."

> I'll be eating really healthy…and then I start getting tired of it…and it's almost like my body goes through withdrawals…I'll eat healthy for a week and because I've eaten so healthy for that week, it's like my body…it's almost like an addiction, when you think about addicts that go through withdrawals and they'll do anything to get their fix, and it's to that point [with me] and then I'll just be ridiculous.

Similar to restricting food, it was also unhelpful to "count" calories as the following participant described:

> I found the more I started learning about food from a scientific point of view, the worse my eating became, I became even more preoccupied and focused on calories and restricting…and then bingeing…I engaged in a lot of counting [calories, etc.] and this totally distracted me from my hunger cues, it totally distracted me from a regular pattern of eating and taking care of myself, it just made things a lot worse.

Feeling deprived as a result of dieting or restricting food was common, as the following participant illustrated: "Anytime I was on a diet I felt very very deprived, and part of the reason I ate [binged] in the first place was because I felt deprived." Another negative repercussion of dieting, restricting food, or trying to eat too healthily was the feeling of "blowing it", which often led to a down cycle as the following two participants described: "Just as soon as I made a little slip [in a diet], I threw in the towel and just went for it." "Sometimes even once I've blown it, [I think] well, I've already blown it so I might as well keep going….[which is] another unhelpful thing, that idea that I've blown it so I might as well keep blowing it."

Whereas for some participants it was not helpful to restrict any kind of food, some participants found that it was helpful to restrict trigger foods. Trigger foods are certain foods that one craves, and that usually lead to a binge. Examples: "Trigger foods don't help, [such as foods with] a lot of sugar, a lot of carbohydrates, caffeine [and] anything with a lot of salt or a lot of fat." "I do have trigger foods, ice-cream, a lot of baked goods, sweet stuff, and if I had a couple of bites of those, they would set me off."

In summary, participants found it unhelpful to diet, to restrict too much, to eat too healthily, and to eat trigger foods. Sometimes the situation participants were in was unhelpful, such as being in an environment where there was only junk food available.

3. Feelings of Inadequacy and Low Self-Esteem, and Fear of Failure (19 incidents, 8 participants)

Many participants talked about how they simply felt not "good enough" as a person, and that this hindered their process of recovery. For example: "I have some foundational pain that I'm not o.k., or if people don't like me it's devastating." Another participant felt that, "I'm not good enough the way I am." One participant talked about how she repeatedly felt she was "never going to be a good enough daughter", and when she went to professionals for help, she "always felt like the one who was sick or broken or bad". Frequently this feeling of inadequacy and low self-esteem was deeply rooted in childhood, for example: "I remember growing up I always had inferiority issues…I always felt like the less worthy one and the less lovable one."

Often, feelings of inadequacy would be more pronounced in the midst of relationship difficulties. One participant talked about the sexual rejection she experienced with a partner: "There was a lot of sexual rejection, and that just tore me down…I saw it as a very clear message that my body is not good enough, my body is not loving or beautiful enough, I'm not lovable enough." Another participant discussed feeling inadequate in her friendships, as the following example illustrates: "[When] I have a fight with my best friend and we're just not seeing eye to eye, I feel crappy about myself as a person, as a friend…[I feel that] I'm not a good enough friend, I'm not good enough just plain and simple."

Feelings of inadequacy also came up in work or social situations, as did "fear of failure". Two participants commented as follows: "Whatever happened within a work situation that made me feel inadequate [would lead to a binge]." "I would binge if I felt like I wasn't coming through on the social scene as was expected."

Three participants also talked about feeling inadequate because they did not meet up to societal beauty standards that are portrayed in the media. They expressed: "Woman's magazines and the media which focuses on skinny girls just becomes another reminder that I'm not one of those, and that even when I lose weight I'm not going to be one of those." "When looking at magazines and seeing so many different diet ideas; it's the combination of the diet with the size 4 model on the front…that was the ideal I was supposed to reach and I was failing at it."

> If I buy a lot of fashion magazines I know I'm getting into a pattern of self-sabotage. I've used the media in such a way that if I'm feeling poorly about myself, I'll go out and buy magazines and do the whole watching celebrity stuff… my sensors are completely into the 'I'm not good enough, or this is what I should look like, these are all happy people' even though I know it's bullshit….Those articles on weight loss, how to make your life better, how to be rich, how to be fabulous, how to be everything that you feel that you're not, it's almost like a quick injection of low self-esteem.

The following participant talked about feeling shame:

> I felt a lot of shame and I felt foolish too because it [bingeing] seemed like such an insignificant thing compared to what I was already in recovery for…I felt like I should be able to handle it, I should just be able to put down the fork, I should just be able to go on a diet…I thought I was just really weak willed and I had a lot of shame about it.

Feelings of inadequacy and low self-esteem were a hindrance to participants' recovery from binge eating. Whether these feelings came from childhood, troubles in relationships, or social or work situations, all had the same effect of feeling that one was not a good enough human being.

4. Lack of Understanding of Binge Eating, and Well-Meaning but Unhelpful Advice from Others (19 incidents, 6 participants)

This category talks about the lack of understanding that professionals, friends, and family had of binge eating, and that this lack of understanding often led to unhelpful guidance or advice. One participant talked about professionals in her life who tried to help her, but "they just didn't have the resources or ability." She continued: "I had a guidance counsellor who said, 'you want to be thin, well just put pictures of what you want to look like on your wall and work towards that goal', [she was] really missing the point." She had a counsellor in University who "was a Skinnerian and really didn't get the problem". She also had a doctor at one point who was "really not getting it". This participant said:

> I encountered a lot of health professionals who didn't know what they were doing…lots of people didn't get the problem….A lot of people just don't get it, or there isn't a clear cut method for recovery so a lot of people are kind of shooting in the dark.

Apart from the unhelpfulness of professionals who didn't seem to understand the deeper issues behind binge eating, there was also the lack of general public knowledge concerning eating disorders and their root causes.

> There wasn't a huge amount of information on it [binge eating] in school, there was nothing to counteract the media….There's not a huge amount of information out there generally that's helpful in dealing with the root causes of eating disorders, there's really a low level of awareness….And the addictive quality, there's not a lot of understanding of that.

A few participants discussed how it was unhelpful when others did not understand that binge eating was not a matter of willpower or discipline. The following two examples illustrate this: "[It's] very hard for someone to understand who's never gone through it, to them it's like…'why can't you just have discipline?'" "My mother is

overweight as well and my grandmother from time to time says, 'if you guys just had willpower, you'd lose weight', and it's so not about that."

Other participants discussed how it was unhelpful when they were encouraged to lose weight, or when people commented on what they were eating. Some examples from contributors include: "Family members encouraging me to lose weight didn't' help…I didn't need other people pointing it out to me, all it did was point out yet again that 'you're overweight and you need to lose weight'."

> An unhelpful thing was people commenting on what I was eating and that it was time to stop, because usually that would just postpone a binge for later on….I got very resentful and very defiant, I saw it as other people laying down restrictions.

Usually this "advice" came from "well-meaning friends and families who think they're helping by encouraging you to diet", or to the contrary, encouraging one to eat more as in the following example: "Sometimes family is unhelpful, like my mother really wants to understand but often she doesn't…she's always pushing food on me, pushing me to eat, and that's very triggering for me."

So whether it is from family, friends or professionals, participants found it unhelpful to be given advice or help that clearly circumvented the root issues of binge eating, as well as to be *told* what to do, usually concerning dieting, stopping a binge, or eating more.

5. Experiencing Low Emotions such as Frustration, Anger, Sadness, Anxiety, and Guilt (17 incidents, 8 participants)

This category is about how low emotions such as frustration, anger, sadness, anxiety, and guilt were unhelpful because they often led to binge eating. They often led to binge eating because this was a way to cope with or to not feel these feelings. For example: "Most of us eat for emotional reasons, to stuff down feelings." Another

participant said that binge eating was to "cope with really strong feelings that I hadn't learned how to cope with before, such as anger, sadness, frustration, and self doubt…but over the long run it wasn't serving a purpose."

Often a lot of frustration, tension, and anger came up through work. One participant talked about how she had a boss who was especially difficult to work with, which created anger, which led to bingeing. Another participant talked about working for a boss that she did not respect much and how the negative feelings towards him would build. She also experienced conflicts with her co-workers, as well as with difficult customers. She illustrated this in the following quote:

> I would have that frustration and tension, so I would eat…when things were going wrong in the day [such as] conflicts with co-workers, supervisors, or customers. You can't yell at people at work, and so instead of expressing what I was feeling, I would go to the vending machine and get a chocolate bar.

Individuals talked about feeling sad, unhappy, or depressed, to a point where they would use bingeing to feel better temporarily. The following two examples portrayed this: "Relationship difficulties put an emotional spin on me and so I would be more inclined to binge during those times as a way to cheer myself up."

> If something upsetting happened, bingeing numbed the feeling of it all…it's a way to not have to feel for a minute….When I was sad about something, or depressed…even through I knew later I'd feel so bad about it [bingeing], at the time it just relaxed me and I didn't have to think about it and it felt good for a few minutes.

The next quote is from a participant who felt guilt around her responsibilities as a parent, "There's a lot of guilt around that [being a parent], a lot of sense of responsibility to be at home". This guilt or sense of responsibility would also prevent her from getting together with friends or nurturing herself.

Feeling anxious or stressed was a hindrance for some participants. For one participant, "anything performance related" was unhelpful. She said: "It's anxiety around performance, I'll be stressed out which causes me to eat and it's very comforting to eat when I'm stressed." Another participant also talked about "feeling really uncomfortable socially". She continued: "Situations with large gatherings and food set me off a lot because I didn't really know how to deal with groups."

In general, experiencing low emotions and not being able to express them in a healthy way was unhelpful because this often led to a binge. Neither repressing low feelings through eating or eating to feel better temporarily, were helpful in the long-run.

6. Feeling Incongruence in Self and Others, Being Unfulfilled with One's Path in Life, and Feeling there is No Way Out (17 incidents, 5 participants).

Participants found it unhelpful when they felt stuck in situations where there seemed to be no way out or nothing they could do. It was also unhelpful when participants felt incongruence, and unfulfilment in their path in life. Feeling incongruence could result from not expressing one's self truthfully, or witnessing others masking the truth of a situation.

The following participant illustrated feeling stuck in a situation, and not being able to express herself truthfully:

> I felt very trapped in my childhood home…my parents were quite violent and controlling…I remember thinking [after a fight], 'I can't go back [to school] and pretend that I'm this overachiever when I've just been in this horrible fight with my mother', [yet] there was really no option.

Another participant talked about how unhelpful it was to be in situations that she didn't want to be in, but she felt committed to. She said:

> Another time I would binge was when I would commit myself to do something that I didn't want to do, I felt like I was being forced to do something that I really didn't want to do but I had no way out of it because I said I was going to do it…it was unhelpful committing myself to things that I didn't want to do.

This participant also talked about feeling stuck in her career as in the following example:

> When I was working for the family business, for three years, that was a bad time because I felt obligated to help the family, but I did and I didn't like it....Maybe [it was] some despair that comes with doing something you don't want to be doing but you don't really see a way out of it, it feels like at the time there's no way out of it.

Some participants felt stuck, or in a rut when they were bingeing, and so the bingeing itself would continue. For example:

> Once it's started being bad [the bingeing], it's hard to turn the cycle around. So even though maybe there's been no specific negative incident, I was already kind of in a rut, and so the bingeing would continue, out of being in a rut.

The following participants felt incongruence when she didn't speak the truth about her feelings in a situation where others objectified her.

> I thought about how my action, or my inaction [concerning situations where I felt objectified] actually made things worse because I kept perpetuating a stereotype that says woman are here to be objectified and sexualized and there's no space for them to express themselves…and I realized that I'm an independent woman but my actions were contradictory.

Along similar lines, participants found it unhelpful when others were masking the truth. For example: "When people talk only about superficial stuff, it feels like everything is getting masked, and that's the type of stuff I would eat over because [real] stuff wasn't getting addressed."

Recovering from binge eating was also more difficult when participants were questioning where they were in life and contemplating difficult changes. Another

participant said it was unhelpful when she wasn't fulfilling what she wanted from her life. For example:

> Binge eating was at it's worse whenever I was really unhappy with just how my life was going, if I didn't think I was fulfilling what I really wanted to do with my job, whenever I felt like I was just accomplishing nothing…[when] I wasn't working towards what I wanted my life to be.

So whether it was feeling stuck, questioning where one was at in life, or feeling incongruence, these were generally situations in which participants were feeling or being less authentic, and thus further away from their potential.

7. Too Much or too Little Activity (16 incidents, 7 participants)

This category is about being too busy and feeling overwhelmed, tired, and stressed. This category also includes not having enough to do and feeling bored.

Participants said it was unhelpful when they had stress from "having to do too much and having to please too many people". Often the stress was from "just having too much work". It was unhelpful to get to the point where one felt overwhelmed, as the following two participants illustrated: "There's definitely a fine balance for me [between doing too much and not doing enough]….because being too busy and just feeling very overwhelmed can be a trigger." "A lot of times it was just sheer exhaustion, overload, and a feeling of being overwhelmed, everything was just too much and I didn't want to think anymore, I basically wanted to shut off." Another participant said that it was unhelpful if she "didn't take breaks during the day and was trying to get too much done". Sometimes it was the overall stress that built up as in the following example: "[I would] binge later on in the day when I was tired and when I was very hungry and when the stress of the day had also built up." Two other participants stated the following about stress, busyness, and

tiredness: “Being stressed out is unhelpful…and being occupied can also create a binge because I’m so busy I don’t have time to prepare food…all of this busyness really disrupts the balance, the busyness is very unhelpful.” “It [being tired] deludes my ability to think myself through it [a binge], and if I’m tired, emotions take over.”

One participant talked about how she would end up denying herself because she was working so much. Although she knew it was helpful to go out and connect with friends, she wouldn’t because she was working so much and going out became too much of an effort. She illustrated: “It’s easy to get caught up in working, working 12 or 14 hours, and then not go out socially, even for months at a time, because this takes too much effort. If you deny yourself for so long, then you almost don’t miss it.”

Although being too busy, tired, and overwhelmed was definitely seen as unhelpful, it was also unhelpful to not have enough to do and to feel bored. The following three participants demonstrated this: “It’s the boredom, and that desire to eat because there’s nothing else to do.” “It was really hard for me when I didn’t have anything to do, [when there was] extra time or too much time. I often binged when I was bored.”

> I went through a period where I didn’t have a lot of friends, I didn’t have much going on in my social life…and I would eat and be bored and not know what to do with myself, and food made me feel better.

So the general theme of this category is having too much or too little activity. Too much going on would create stress, tiredness, and feelings of being overwhelmed, whereas too little activity would lead to boredom.

8. Being Alone, and Feeling Alone and Hopeless (13 incidents, 6 participants)

This category encompasses physically being alone, and feeling alone and hopeless because there is no one around who understands or who can help. A couple participants

talked about being physically alone, as well as being alone from support from family and friends. For example: “I know I get worse often when I’m alone…and one of my worst times was when I was alone [away] from support as in family and friends”. One participant talked about her geographical isolation: “[I was] isolated in terms of geography, without transportation, so it was really hard for me to get the motivation to do anything and if I couldn’t get out of the house, I was more prone to binge.”

The next few participants talked about feeling alone because of relationship tension, because they could not get help, or because they felt hopeless, let down, and forgotten about. Some examples include: “I would feel lonely or alone in dealing with that [partner] relationship tension…and I was not connected to my family during this time.” “I felt I was let down…I was so hopeless, I was in a really dark place when I was bingeing and I felt like I had been forgotten about…I felt really alone.” One participant talked about growing up in a violent and controlling family life. During this time she tried to get help through various means, but no one seemed to be able to help. She told how this led to isolation and hopelessness in the following quote:

> My teenage years were really just about survival and feeling increasingly insane. I was very frustrated because I did try to get help [went to guidance counsellors and social services]. And teachers didn’t get it, or they didn’t want to see, I mean I went to school with black eyes and people didn’t ask, like not only to have that kind of insanity in my family, but to have the rest of the world [not acknowledge what was happening], people were clearly ignoring what was going on for me…so that was really isolating and alienating and created a lot of hopelessness.

Several other participants talked about the unhelpfulness of not being able to access support for binge eating in general. One participant was refused help by a mental health center because she was not seen as sick enough. Another participant talked about

unsuccessfully trying to connect with others who were struggling with binge eating through an on-line support group. She related:

> It seemed like whenever I would start down the avenue of trying to correspond with people who had the same issues, it would kind of shut down or peter out… whenever I needed to talk to someone about it [binge eating], I couldn't find somebody….It would have been nice to have some kind of support group for it [binge eating], or someone to talk to about it…it's just now a super common thing where it's easy to find support.

So whether it was not being able to access support from professionals or from a support group, being alone, or feeling alone and hopeless because no one seemed to be able to help, or to even care, all were unhelpful and increased the sense of isolation for the participants. One participant succinctly portrayed the essence of this category when she said "the condition is isolating".

9. Not Receiving Respect, Love, or Acceptance from Others (8 incidents, 4 participants)

Participants talked about how it was unhelpful to be treated badly by others. Sometimes this meant being "shamed or judged", and sometimes this meant "being talked to rudely". Another participant talked about a supervisor who was "extremely belittling and demeaning". All these examples illustrate a general lack of love and respect.

One participant talked about how she had an assumption as a child that a parent's love was unconditional, but contradictory to that, her mother placed a condition on it. She said: "Her [my mother's] religious beliefs came between her love for me and it affected the way she cared about me…she still doesn't fully accept or celebrate who I am." Another participant talked about the breakdown of an intimate relationship in which she saw that her partner's love was not unconditional. She described it as the "worst rejection" she has ever felt in her life.

The last example is of a participant who talked about how it was unhelpful to be part of a relationship in which she was not fully respected. This lack of respect was very similar to lack of acceptance. She talked about how there were "very explicit statements from my partner about how I should look, how I should dress, how much I should weigh, and how much I should eat".

10. Being around Others who have Unbalanced Eating Habits (7 incidents, 4 participants)

Participants talked about how it was unhelpful to be around people who excessively focussed on eating healthy, restricted food or binged with food. Some contributors stated: "I have friends that I used to binge with and sometimes it can be dangerous for me to go out with them because it brings back old habits."

> I've been in a partnership almost a decade with somebody who is restrictive with their food…so that's been one of the least helpful things…being involved with somebody else who has very strict eating habits. It kind of adds fuel to my own negative feelings towards what food is and eating food.
>
> It's that way with my family and with my friends [a lot of focus on weight and eating healthy]…and so it makes me so strict [with food]…it [weight, and eating healthy] would always be an issue, it was always being talked about, and because it seemed to be such a big part of my discussions with my family and with my friends, it just became part of who I was [someone who was always struggling with weight and trying to eat healthy].

Some participants also found it unhelpful to be around people who did not eat well, or to be in situations where healthy food was not available. For example: "[It's] unhelpful being around people who eat really badly…all they eat is junk…it's like I can't control myself, I can't stop myself, it's tempting me."

11. Unsupportive Perspectives on Living (4 incidents, 3 participants)

This category includes perspectives on living life that are unsupportive to the process of recovery from binge eating. For one individual, this unsupportive perspective was operating under "no-win paradigms". One example she gave was as follows: "I think at the root of my binge eating was a lot of no win paradigms, like [I] must be perfect to be o.k., but [I] can't be perfect, therefore [I] escape into binge eating." Two participants talked about the unhelpfulness of trying to control their life too much, and operating solely on their will (versus relying on the will of God or a higher power). One stated: "Operating with my will trying to run everything has only gotten me chaos and unhappiness." A third perspective on life that was unhelpful was a "victimized orientation".

12. Disconnected from Hunger and Satiety Cues (3 incidents, 2 participants)

Two participants mentioned that it was unhelpful to be disconnected from their hunger and satiety cues. For example: "[Sometimes] my body feels unresponsive…it feels like my body has a delay somehow in telling me that it's satisfied."

13. Financial Limitations (1 incident, 1 participant)

One participant commented on how being limited financially was unhelpful because it was too expensive to buy healthy food. She would then buy fast food or other unhealthy food which would often lead to a binge.

This concludes the categories that describe what hinders the process of recovery from binge eating. As in the helping categories, there is some degree of overlap. These 13 categories are also part of the eight themes that are discussed in the next chapter.

Recommendations

At the close of each interview, the following question was asked: "From your personal experiences, in a paragraph or two, what would be the foremost recommendations that you would share with others who are struggling with binge eating?" Each participant gave anywhere from two to six recommendations, totalling 36 in all. Below is a list of the recommendations which are written in a close paraphrase of what the contributors expressed. Similar recommendations have been grouped together. At least one participant expressed each of the following recommendations unless otherwise noted.

1. Realize that no person's way is going to be your way; it's a personal journey. There are many paths to healing, check in with yourself and find what fits with your own kind of integrity and kind of being in the world, try some things and see what fits you. (2 participants)
2. It is going to take a lot of work, and a lot of energy but it's worth it to invest that work in yourself. It's not until you work on yourself intensely, that you can give more of you (a truer you) to others. It takes self-examination – looking at what's not going right, what's making you unhappy, and then dealing with that. Be willing to do the work, to work on yourself. (3 participants)
3. Learn about self-love and self-acknowledgement.
4. There will be relapses, but the easier, the softer, and the kinder you are on yourself when that happens, the easier it is to get back, go on, and move forward. It's a slow process, not one of those cold turkey things. Give yourself license to fail and to succeed. Look at your life as a whole. (4 participants)

5. Get involved with a group, like a12-step program. Explore a support group. Find a support group of some sort so you know you are not alone. Connect with people who are in recovery. Get support through the fellowship of Overeaters Anonymous. Surround yourself with positive people, people who encourage you to be balanced. Find a way in which you can find company and companionship, and love and support for the person you are right now, find someone you can talk to about binge eating and who can love you for who you are. Find people who have struggled similarly, but have found hope, strength, and freedom (8 participants)
6. Explore one-on-one therapy and group therapy. Find help through a counsellor or a psychologist, the combination of this and a support group is very important. (2 participants)
8. Concentrate on being healthy rather than being skinny or having the perfect body. Get off the diet cycle. (2 participants)
9. Find things that relieve stress for your personality. Take time during the day and try not to do too much no matter what others say. Learn how to take time for yourself. Manage your time appropriately to facilitate the maintenance of balance. (3 participants)
10. Identify why you eat and when you eat and chart this so you can plan and do things to prevent it. Don't fix binge eating by stopping eating; don't treat the bingeing, but rather what's causing it. (2 participants)
11. It's a process of making changes in life to where you're happy, doing what you want to do, and making choices you want to have the life you want.
12. Connect in your own spiritual way, thinking about what makes you balanced.
13. Find hope, know that people get better. Know that there is treatment available. (2 participants)

14. Antidepressants were a huge help in terms of making life tolerable.
15. Listen to women's voices, read and listen to women's stories about their lives.
16. Understand that there's a much bigger project going on than just trying to compete for resources, whether that be relationship resources or material resources.

Summary

From the ten interviews that were conducted, 423 incidents were extracted. Of the 423 incidents, 255 incidents were found to be helpful, and 168 incidents were found to be unhelpful in the process of recovery from binge eating. Validity procedures were used to ensure the trustworthiness of the categories, and reliability procedures were used to ensure the comprehensiveness and consistency of the categorization process.

The following table is a summary of the 13 helping categories and the 13 hindering categories that were described above. The incident frequencies and participant frequencies are the number of incidents and the number of participants each category respectively had. The incident rates and the participation rates are the percentage of the incidents and the percentage of the participants that were respectively represented in each category.

Table 1
Table of Incident and Participant Frequencies and Rates

Incidents that facilitate the process of recovery from binge eating	***Incident Frequency and Incident Rate***	***Participant Frequency and Participant Rate***
1. Developing a healthy relationship with self	*54, 21%*	*10, 100%*
2. Having a supportive environment and support networks	*35, 14%*	*8, 80%*
3. Changing major perspectives on life and embracing new worldviews	*28, 11%*	*6, 60%*

4. Developing a spiritual connection	*27, 11%*	*5, 50%*
5. Disclosing to others	*23, 9%*	*8, 80%*
6. Increased knowledge, awareness, and ways of understanding binge eating	*20, 8%*	*5, 50%*
7. Becoming aware of and changing thoughts and behaviours around food	*17, 7%*	*7, 70%*
8. Feeling a sense of hope and universality through connections with others	*16, 6%*	*6, 60%*
9. Finding alternatives to bingeing, being busy, and engaging in pleasurable activities	*15, 6%*	*6, 60%*
10.Feeling cared for, loved, and accepted by others	*12, 5%*	*6, 60%*
11.Reaching a point of desperation	*6, 2%*	*4, 40%*
12.Stabalizing with medication	*2, 1%*	*2, 20%*
13.The absence of financial blocks	*2, 1%*	*2, 20%*

Table 1 (continued)

Incidents that hinder the process of recovery from binge eating	***Incident Frequency and Incident Rate***	***Participant Frequency and Participant Rate***
1. Societal, media, peer, and personal pressure surrounding excessive attachment to appearance and external validation	*23, 14%*	*7, 70%*
2. Overly focussing on and controlling eating habits, and eating trigger foods	*21, 13%*	*7, 70%*
3. Feelings of inadequacy and low self-esteem, and fear of failure	*19, 11%*	*8, 80%*

4. Lack of understanding of binge eating and well-meaning but unhelpful advice from others	*19, 11%*	*6, 60%*
5. Experiencing low emotions such as frustration, anger, sadness, anxiety, and guilt	*17, 10%*	*8, 80%*
6. Feeling incongruence in self and others, being unfulfilled with one's path in life, and feeling there is no way out	*17, 10%*	*5, 50%*
7. Too much or too little activity	*16, 10%*	*7, 70%*
8. Being alone, and feeling alone and hopeless	*13, 8%*	*6, 60%*
9. Not receiving respect, love, or acceptance from others	*8, 5%*	*4, 40%*
10.Being around others who have unbalanced eating habits	*7, 4%*	*4, 40%*
11. Unsupportive perspectives on living	*4, 2%*	*3, 30%*
12. Disconnected from hunger and satiety cues	*3, 2%*	*2, 2%*
13. Financial Limitations	*1, 1%*	*1, 10%*

Number of participants: 10 Number of helping incidents: 255
Total number of incidents: 423 Number of hindering incidents: 168

CHAPTER V: DISCUSSION

The critical incident technique was used to learn about the helping and hindering factors involved in the process of recovery from binge eating. With the semi-structured, open-ended format of the interview, the participants were able to express, explain, and expand on their thoughts in a way that is not usually conducive to quantitative research. Ten individuals shared their personal experiences, which included events, thoughts, feelings, and behaviours, concerning what was helpful and unhelpful throughout their process of recovery. At the conclusion of each interview, the participants also shared their top recommendations for others who are struggling with binge eating. Of the 423 incidents reported, 255 were helpful, and 168 were unhelpful in the process of recovery from binge eating. The 423 incidents were sorted into 26 categories, 13 that were helpful, and 13 that were unhelpful. In addition to the 423 incidents, there were 36 recommendations offered by the participants.

This chapter is a discussion of the 26 categories in light of existing research, which is also a form of cross-validation. Andersson and Nilsson (1964) stated that an analysis of the literature can determine if the critical incident method succeeded in including all the important aspects of the research question, which is primarily connected with validity. Eight general themes emerged that seemed to capture the essence of the 26 categories: (a) relationship with self, (b) relationship with others, (c) knowledge and understanding as related to binge eating, (d) evolution of perspectives and worldviews, (e) developing a spiritual connection, (f) relationship and connection with food, (g) reaching a point of desperation, and (h) external resources. To facilitate clarity and cohesiveness, the 26 categories will be discussed within these eight themes. As the unhelpful and helpful categories are both numbered from 1-13, a positive sign (+) for the

helpful categories and a negative sign (-) for the unhelpful categories will be added for clarification when they are discussed below. This chapter also covers new findings, practical implications, limitations of this research, benefits of this research, and implications for future research.

Literature Cross-Validation

Relationship with Self

Relationship with self was a common theme across several categories. The categories that are discussed under this theme include the following: Developing a healthy relationship with self (category 1+), Feelings of inadequacy and low self-esteem, and fear of failure (category 3-), Experiencing low emotions such as frustration, anger, sadness, anxiety, and guilt (category 5-), Feeling incongruence in self and others, being unfulfilled with one's path in life, and feeling there is no way out (category 6-), and Too much or too little activity (category 7-). These categories have been grouped together because of the numerous similarities and connections among them.

It is commonly known that low emotions such as frustration, anger, sadness, anxiety, and guilt (category 5-) are associated with binge eating. Hudson and her colleagues (1996, p.38) boldly stated that, "What all women with eating problems have in common is that they are using food and the body in very concrete ways to cope with emotional distress and a sense of emotional emptiness. Their symptoms reflect their longing to fill this emptiness as well as their fear of experiencing it and thinking about it". Binge eating has also been understood as a means of emotional regulation. For example, Hsu (as cited in Orford, 2001) stated that women described feeling less anxious, nervous, and tense as an episode of binge eating went on, as well as less depressed and unhappy

during the early part of a binge. However, this is somewhat contrary to other findings that found negative affect escalated following a binge (Lynch et al., 2000). Participants in this current study often talked about how feeling various distressing or low emotions hindered their process of recovery. Instances in which they could not express these feelings were especially unhelpful, whether they be in a situation at work, in an intimate relationship, or in a common friendship.

Often paired with low emotions such as anxiety, sadness and anger, was the stress and tiredness that came from too much activity or boredom from too little activity (category 7-). In Lyons's (1998) phenomenological study, participants stated that anxiety, being mad, stress, and boredom were reasons for overeating. Lynch et al.'s (2000) study supported anxiety as being a hindering factor as their participants reported that anxiety significantly predicted binge eating and loss of control during binge eating for women. Depression appeared to be less important but still significantly predicted binge eating, but not loss of control. Greeno et al. (2000) also reported that poor mood and low alertness preceded binge eating episodes. Participants in this current study affirmed all this previous research.

Further connected with low emotions, stress and tiredness, and boredom, were feelings of inadequacy, low self-esteem, and fear of failure (category 3-). Participants in this study described feeling inadequate and unworthy, as well as feeling fear of being inadequate or unworthy, and that these feelings hindered their process of recovery. Hudson and her colleagues (1996) asserted that eating problems are better described as problems of the self, a self that is unknown, feared, or hated. Individuals in this current study discussed how feeling badly about themselves often prompted a binge. Walsh (1997) added that those who binge eat see themselves as a failure partly because they

have tried so many diets, losing and regaining the weight over and over again. This was also affirmed in this study as participants discussed not being able to stay on diets and therefore failing to attain societal standards of beauty. Similar to feeling inadequate, many individuals struggling with binge eating did not talk about their eating habits with care providers because of the shame and embarrassment they felt (Baker & Brownell, 1999), which was further validated by participants in this study.

Participants also talked about how they struggled more with binge eating when they felt dissatisfied with where they were going in life (category 6-). This is supported in Dominy, Johnson, and Koch's (2000) research that found that women with BED reported lower satisfaction with life on the Satisfaction with Life Scale (SWLS) when compared with other groups that did not struggle with BED. Dominy, Johnson, and Koch pointed out that researchers may want to "rethink the axiom that higher body weight in obese individuals leads to lower satisfaction with life" (p. 31) because the scores on the SWLS were lower for obese women with BED than obese women without BED, suggesting that more than obesity is lowering one's satisfaction with life.

These four hindering categories mentioned above can contribute to an unhealthy relationship with self – emotionally, behaviourally, and cognitively. Cognitively, one thinks of one's self as unworthy. Behaviourally, one is not happy with what one is doing in life. Emotionally, one is experiencing low emotions as well as general stress and overtiredness. Low emotions do not inherently imply an unhealthy relationship with self, but they do when one is responding/not responding to them or expressing/not expressing them in a healthy way.

The facilitative counterpart to these hindering categories is developing a healthy relationship with self (category 1+), which includes four subcategories: a) Developing

greater confidence, self-efficacy, and self-esteem, b) Acknowledging one's worth and expressing that in loving action towards self, c) Learning about, recognizing, and expressing one's emotions, and d) Personal exploration, self-introspection, and working on self. In light of the four hindering categories previously discussed, it is clear that developing a healthy relationship with self is essential. Koski-Jannes (2002) found that successful recovery from addictions involved finding more personally satisfying, honest, and authentic modes of being in the world, which is implicitly part of category 1: Developing a healthy relationship with self.

Participants were facilitated in their process of recovery as they gained greater confidence, self-efficacy, and self-esteem (category 1a+). According to this study, this was most often achieved through following one's passion in life and through self-improvement. When participants were doing what was in their heart to do and what was congruent with who they were, they gained confidence, self-efficacy, and self-esteem. Participants also felt this when they saw themselves moving forward in their personal struggles, or simply experiencing little successes in life. When they saw little improvements and changes in themselves that were for the better (sometimes through reading past journal entries, sometimes through therapy), their self-esteem and confidence was lifted.

Category 1b—acknowledging one's worth and expressing that in loving action towards self—was another facilitating factor. Part of this category included taking time for one's self which involved resting, relaxing, and practicing yoga or meditation. Meditation was found to decrease binge frequency and severity, lessen feelings of depression and anxiety, and increase sense of control in Kristeller and Hallett's (1999) study. Yoga, as a movement meditation, is known to have similar benefits as mindful

meditation (the meditation form used in the cited study). Loving action towards self is about self-care which includes nurturing one's self. Participants who realized their self-worth were then more likely to engage in self-care, as well as honour their feelings. Learning about, recognizing, and expressing one's emotions (category 1c+) is in contrast to not being able to feel, know, or express one's emotions. As already mentioned, it is well recognized that low emotions are associated with binge eating, and it makes sense that this category would be essential to the process of recovery. In the context of a support group, Hudson's research group (1996) noticed that those who compulsively overate would project their own unmet needs on others, meaning that they felt very responsible for one another in the group and would give support to everyone while not expressing their own feelings and needs. Being able to express personal feelings and needs was an important facilitative factor for participants of this current study.

Personal exploration, self-introspection, and working on self (category 1d+) is highly interconnected with the previous three subcategories as it is through this effort of self-introspection that one discovers hidden emotions, passions, talents, and ultimately, worth. Sometimes personal exploration meant working through past experiences such as chaotic or unstable childhoods. Hudson's research group (1996) agreed that individuals' present difficulties with food can relate to how they were physically and emotionally fed in the past. Participants recognized that it was necessary to put in a certain amount of effort and that they had to be willing to do the work, and not only then, but continually throughout life.

Relationship with Self was one of the two most prominent themes in this study. Gilligan, C. (1982) in her study of psychological theory and women's development, commented on a paradoxical truth of human experience, "We know ourselves as separate

only insofar as we live in connection with others, and that we experience relationship only insofar as we differentiate other from self." (p. 63). Relationship with Others, the second of the two most prominent themes, is discussed next.

Relationship with Others

Relationship with others is another theme that includes six closely related categories. They are: Having a supportive environment and support networks (category2+), Disclosing to others (category 5+), Feeling a sense of hope and universality through connections with others (category 8+), Feeling cared for, loved, and accepted by others (category 10+), Being alone, and feeling alone and hopeless (category 8-), and Not receiving respect, love, or acceptance from others (category 9-). Using a relational approach to understanding psychological development and psychotherapy, Miller and Stiver (1997, p. 22) asserted:

> The goal of development is not forming a separated self or finding gratification, but something else altogether – the ability to participate actively in relationships that foster the well-being of everyone involved. Our fundamental notions of who we are are not formed in the process of separation from others, but within the mutual interplay of relationships with others. In short, the goal is not for the individual to grow out of relationships, but to grow into them. As the relationships grow, so grows the individual. Participating in growth fostering relationships is both the source and the goal of development.

Having a supportive environment and support networks (category 2+), which was often found in the context of a support group—but also through friends, family, partners, and therapy—was very central for most participants' process of recovery. This was affirmed in Lyons's (1998) study, as she found that "support from self-help groups such as Weight Watchers and the love and support that could be provided by family members was considered to be of utmost importance" (p. 1163). The main difference was that

Lyons's participants said Weight Watchers was a helpful support group, whereas in this study, participant's preferred or experienced Overeaters Anonymous and group therapy as a support group.

Feeling cared for, loved, and accepted by others (category 10+) was part of having a support network, and the counterpart, not receiving respect, love, or acceptance from others (category 9-) hindered recovery. Similarly, when Hanninen and Koski-Jannes (1999) studied autobiographical stories of individuals who had recovered from binge eating, they found binge eating was compensation for lack of love, and that the key to recovery was receiving love and care. Part of having a support network was participants surrounding themselves with people who fully accepted them, at present, as they were. Love and acceptance went hand in hand; when participants felt truly accepted, they also felt loved. With this feeling of love, care, and acceptance, participants could open up, share, heal, and grow; all through building relationships with others.

Feeling hope and universality through connections with others (category 8+), also interrelated with having support networks, further facilitated the process of recovery from binge eating. The opposite, being alone and feeling alone and hopeless (category 8-) hindered this process. Loneliness and isolation were reasons to overeat, as reported by adult professional women who struggled with compulsive overeating (Lyons, 1998). The struggle with binge eating is isolating not only because of the feelings of shame involved, but also because of the "social climate" that sees eating problems as trivial, and denies the real pain, distress, and emotional cost involved (Hudson et al., 1996). It is important to note that the loneliness and isolation felt by individuals in this current study was not only because of the nature of the struggle, but also because of geographical isolation and lack of access to transportation.

Group therapy is recommended because of the feelings of isolation that are so common with those who binge eat (Walsh, 1997). The immense benefits that come from support groups or group therapy are presently quite well-recognized. Groups are often a setting where previously private experiences can be shared and validated, and where common underlying factors can be identified (Hudson et al., 1996). In addition, they are opportunities for individuals to see their difficulties reflected in others, which decreases the isolation and facilitates a sense of universality.

Some participants felt that counselling with a professional was a necessary and helpful part of recovery, and others felt that the benefits they gained through friends and non-professional support groups were equally helpful. Whether from a counselling relationship, group therapy, a support group, friends, family, or a partner, the benefits of disclosing to others (category 5+) were the same. The benefits reported in this study included decreased isolation, feedback, catharsis, gratitude, and support. Of greater importance were the characteristics of the individuals participants disclosed to. It was essential that the individuals participants disclosed to were caring, loving, accepting, non-judgemental, and with whom they could trust and feel safe.

Building positive relationships with others was such a vital aspect of the process of recovery for participants in this study. Miller and Stiver (1997) both discuss how relationships are *the* integral source of psychological health. Although relationships with others and relationship with self have been discussed separately, it is important to note that these two types of relationship develop interdependently.

> Engagement in growth-enhancing relationships is precisely the process that leads to the possibility of speaking one's true thoughts and feelings. Here lies the empowerment that allows each person to risk such truthfulness and, in turn, leads each person on to more knowledge of her-/himself – the knowledge that emerges only out of true engagement with others (Miller & Stiver, p. 54).

Knowledge and Understanding as Related to Binge Eating

This theme included the following two categories: Increased knowledge, awareness, and ways of understanding binge eating (category 6+) and Lack of understanding of binge eating and well-meaning but unhelpful advice from others (category 4-). Lack of knowledge and understanding of binge eating often led to well-meaning but unhelpful advice, which is why the latter is included in this theme.

For some participants, it helped to know that binge eating existed as a mental health issue. Baker and Brownell (1999) commented on how many individuals with binge eating simply do not know that their pattern of eating has a name, let alone treatment, and that a challenge is to increase awareness among health professionals and the general population. Some participants were hindered in their process of recovery because of the apparent lack of knowledge and understanding of binge eating from professionals and friends alike, and the general lack of information or resources that existed. "The relatively newly described syndrome of binge eating disorder (BED) is not yet readily recognized by many clinicians", (Dwyer, Schauster, & Seed, 1999, p. 325). In an earlier study before binge eating was even given a name, it was acknowledged that those that binge ate but did not purge had been an ignored population for years (Saunders, 1993). Concerning the entire field of eating disorders, BED included, Fairburn and Harrison (2003) commented that "too few patients receive evidence-based treatment and too many receive suboptimal or inappropriate therapy" (p. 414).

As participants struggled with and learned more about binge eating, their understanding of it changed. For example, all but one participant in this study saw recovery from binge eating as a life-long process. This way of looking at binge eating was

also supported in Lyons's (1998) study in which participants reported that compulsive overeating had been and continued to be a difficult struggle. Furthermore, Lyons commented that the struggle of binge eating can be thought of as an addictive process where food is thought of constantly and eaten compulsively despite the consequences. Understanding binge eating as an addiction, and/or following the 12-step program was helpful for several participants in this current study. Participants commented on the wealth of resources that was available through OA. Interestingly, several participants who had no association with OA also felt that binge eating was like an addiction.

Often the general lack of information and understanding of binge eating led to well-meaning but unhelpful advice from others. No specific research was found on how partners, friends, and familys can hinder the process of recovery, but many participants in this study discussed how it was definitely unhelpful when others commented on their weight, on how much food they were eating, on what they looked like, or when they assumed binge eating was a matter of will-power and sticking to a diet.

Evolution of Perspectives and Worldviews

This theme included the following three categories: Societal, media, peer, and personal pressure surrounding excessive attachment to appearance and external validation (category 1-), Changing major perspectives on life and embracing new worldviews (category 3+), and Unsupportive perspectives on living (category 11-).

Participants in this study often commented on how societal influences hindered their process of recovery. This included unrealistic and unattainable standards of beauty, an over emphasis on materialism and external validation, and conflicting messages such as advertising thinness and fitness along with fast foods. Hudson and her colleagues

(1986) asserted that there is the "broader contest of Western culture which fears and denigrates fat while idealizing thinness" (p. 50). Hudson added that we are all affected by this culture and everyone – therapists, clients, friends, and family, need to work through issues about food and body size. This was affirmed by this current study, as the well-meaning but unhelpful advice from others previously discussed often had to do with people's assumption that one should be or wants to be thin, and that fat is less than acceptable. "Media images have equated thinness with peer acceptance, beauty, sexual fulfillment, financial success, self-esteem, morality, and good health" (Cumella, 2002, p.12). A recent community cohort study supported the association of mass media influences with eating disorders when results showed that there was a higher risk of developing eating disorders for participants who frequently listened to the radio and read teen magazines (Martinez-Gonzales, et al., 2003).

Orford (2001), who likened binge eating to an addiction, discussed the concept of deterrence and restraint, and that when one has an addiction, there is some kind of deterrent, restraint, control, or conformity. In this case, this deterrent or control could be explained as societal pressure to look a certain way. Messages from the media and from peers which are personally internalized, are a type of message of conformity or control by implying that everyone should look a certain way (thin and fit) to be successful and well thought of. Orford asserted that the "pleasures and escapes" associated with addictions, in this case binge eating, are highly varied depending on "the setting and the wider environmental and socio-cultural context" (p. 22).

Societal pressure was a hindering factor in the process of recovery from binge eating, as was peer and personal pressure surrounding excessive attachment to appearance and external validation. What helped participants insulate themselves from this pressure

was changing their own perspectives on life and embracing new worldviews. This meant changing their focus from external to internal validation, being o.k. with imperfection, letting go of the victimization approach, letting go of needing to control everything, and understanding the world through voices that have often been misrepresented, or not represented at all – most specifically *women's* voices. Empirical research in these areas, as they relate to binge eating, is lacking, but it is clear that these perspective changes and worldview adaptations have been significant in the process of recovery for individuals in this study.

Developing a Spiritual Connection

Developing a spiritual connection (category 4+) was a dependable source of strength, love, and hope for participants. A spiritual connection also facilitated major perspective changes in life, such as shifting away from a victimized orientation, external validation, and perfectionism. Developing a spiritual connection also helped participants feel that there was purpose in life, and that there was a plan and therefore meaning in whatever happened, however undesirable. This "faith" gave a certain amount of contentedness (not to be confused with passivity) with how things were, knowing there was a *reason*. This faith also gave freedom from feeling or thinking one had to be in charge of and control everything.

Of the five participants that discussed their development of a spiritual connection, four were part of an OA group. Traditional 12-step programs promote recovery through reliance on a Higher Power (Pittman, 1993). For example, step two states: Came to believe that a Power greater than ourselves could restore us to wholeness, step three states: Made a decision to turn our will and our lives over to the care of God as we

understood God, and step 11 states: Sought through prayer and meditation to improve our conscious contact with God as we understood God, praying only for knowledge of God's will for us and for the power to carry that out. It was quite apparent that the 12-step program that OA adopted was a powerful facilitative factor for the four participants involved. Progress in recovery was largely attributed to gaining a greater understanding of and growth in their personal spiritual connection. The researcher was inspired by hearing such powerful and authentic affirmations of positive spirituality. It seems clear that OA has much to offer in facilitating one's growth and connection in spirituality, which in turn facilitates recovery.

The author could not find research on the association of spirituality and binge eating. However, Cumella (2003), director of the largest facility for the treatment of women and girls suffering from eating disorders in the United States asserted the following:

> A transformation is needed from a worldview in which self-worth is defined by appearance or achievement, to one that values people as unique individuals. 'Outer-directedness' must give way to inner-directed self-respect. A person's faith often helps in this spiritual transformation, and offers hope and strength for the difficult journey of recovery (p. 13).

This theme of developing a spiritual connection is further explored in later sections on new findings and practical implications.

Relationship and Connection with Food

Five categories fit into this particular theme. They are: Becoming aware of and changing thoughts and behaviours around food (category 7+), Finding alternatives to bingeing, being busy, and engaging in pleasurable activities (category 9+) Overly focussing on and controlling eating habits, and eating trigger foods (category 2-), Being

around others who have unbalanced eating habits (category 10-), and Disconnected from huger and satiety cues (category 12-).

Participants talked about how it was sometimes helpful to substitute different activities for binge eating, as well as to journal their eating, and to maintain a certain degree of balance and structure to their meals such as ensuring that they ate at least three times a day. These are also components of cognitive behavioural therapy which has been reported as the most effective, though not sufficient, treatment for binge eating. Saunder's (1993) study reported that developing behavioural techniques to deal with [eating] urges, and monitoring behaviour through the use of a daily eating and exercise diary as part of a structured 16-week CBT program facilitated significant improvement in eating behaviours, feelings, and life functioning at follow-up.

Eating in a balanced way and especially *not* dieting was found to be helpful for most participants. This is consistent with the results of Timmerman's (1998) study on the caloric intake of women who binge ate. He found that participants with more chaotic eating patterns (extreme fluctuations in caloric intake) had more severe binge eating, and that restricting caloric intake preceded binge eating. Participants in this current study also talked about how they felt deprived when they dieted, or tried to eat too healthily. Similarly, Timmerman found that the low caloric intake that preceded binge days was not low enough to cause actual physiological deprivation, and that therefore bingeing could be a result of the participants' perception that they ate less than desired, and so they felt cognitively deprived. In addition, Walsh (1997) mentioned that at the Renfrew Center (a treatment center), all foods are "legalized" so clients do not label food as good or bad which can cause feelings of deprivation that can lead to a binge. A study conducted by Hagan's research group (1999) also supported the negative effects of dieting; they found

that how often women dieted was strongly related to how often they engaged in semistarvation-associated behaviours. As demonstrated, there is substantial literature that supports why dieting may not be helpful, as further validated by the participants of this study.

A couple of participants talked about when they dieted or restricted food, but then "messed up", they fell into a down cycle with the feeling that they had blown it so they might as well keep going. This was validated in light of what Lynch's research group (2000) found when they studied how negative and positive affect changed before, during, and after a binge; contrary to what they expected, negative affect did not lessen, but rather escalated following a binge. This could be an explanation for why once a binge had started, it was difficult to stop.

Some of the respondents talked about trigger foods that were unhelpful, and that the trigger foods were often high in fat, sugar, salt, or caffeine content. In Lyons's (1998) phenomenological study, it was also reported that individuals struggling with binge eating had difficulty with the same types of foods, foods that were high in fat, sugar, and salt.

Participants also mentioned that it was unhelpful to be around situations where a lot of food, and especially junk food, was available because this could lead to a binge. Lyons (1998) also reported that, "Few informants were able to turn down food that was offered to them in social settings or that they knew was on hand in the house" (p. 1162).

Lastly, participants described that it was unhelpful when they could not tell when they were full (satiety cues). In Timmerman's (1998) study, it was found that individuals who binge ate often had extreme fluctuations in their caloric intake and therefore were not receiving nutrients with consistency. This has been theorized to "disrupt the regulation of appetite from physiological responses" (p. 109). In addition, Fairburn and

Wilson (as cited in Kristeller & Hallett, 1999) asserted that lack of awareness of normal physiological cues related to food intake contributed to binge eating. One of the reasons meditation is helpful for binge eating is that it promotes awareness of physiological signals and so increases the ability to recognize and respond to normal hunger and satiety cues, as was demonstrated in Kristeller and Hallett's research.

This theme included a fair bit of contradiction. For example, some participants found it helpful not to restrict any type of food, whereas others found it helpful to restrict trigger foods. Some participants found it unhelpful to be around people who ate a lot of junk food whereas others found it unhelpful to be around people who ate too healthily. Often it was a balance between two extremes that was sought after. For example, it was helpful to have structure to meals, but not too much structure where it led to "diet mentality". There tended to be a lot of research in this particular area of thoughts and behaviours concerning food. Although this theme was important to many participants, it was not the one discussed the most frequently. A general trend was that participants in the beginning of the process of recovery (<5 years) discussed food behaviours and habits more often, whereas participants further into the process of recovery (>5 years) discussed incidents that were part of the themes of developing a spiritual connection, and evolution of perspectives and worldviews more often. Unfortunately research is lacking on these latter two themes.

Reaching a Point of Desperation

Reaching a point of desperation (category 11+) has not been mentioned in the literature as part of the conditions that facilitate recovery from binge eating, yet several participants mentioned that by getting to the point of feeling utterly desperate, they had an

intense desire to change, even if it meant trying something they would not normally consider. This concept of a change or transformation occurring as a result of reaching a point of desperation is not uncommon. For example, "bottoming out" was a facilitative factor for homeless people's transition off the streets in another critical incident study (MacKnee & Mervyn, 2002).

External Resources

This final theme included the following three categories: Stabilizing with medication (category 12+), The absence of financial blocks (category 13+), and Financial limitations (category 13-).

Two of the participants found that medication was a helpful part of recovery, but that it was not sufficient in and of itself. Antidepressant medications have been useful for treating binge eating because of their association with feeling depressed (Baker & Brownell, 1999), but it has been found to work better when used in conjunction with CBT. According to the "Harvard Mental Health Letter" (2002), only one of six controlled studies of BED have shown any response to antidepressants, and two studies showed that the combination of psychotherapy and an antidepressant was slightly more effective than psychotherapy alone. In a recent study, McElroy, Arnold, and Shapira (2003) found that topiramate was relatively efficacious in a short-term treatment study of binge eating. Participants experienced less bingeing, and lost weight, although there were some negative side effects of the antiepileptic drug, which caused a number of participants to drop out. The two participants of this study felt that the medication provided them with necessary stabilization.

Two participants also mentioned financial resources as an important factor in the process of recovery from binge eating. It is important to keep in mind the socio-economic status of individuals, and how this plays in to whatever struggles they are dealing with. In a study on food insecurity (Lang, 1998), it was found that "poor rural women who don't always have enough food in their homes exhibit binge eating patterns" (p. 24). It was found that women in food insecure households ate less fruits and vegetables than other women, and the more food insecure the household, the higher they scored on the eating disorder scale. In this current study, financial limitations made it more difficult for a participant to purchase healthy food. Financial blocks also narrowed treatment possibilities for another participant.

Summary

As demonstrated, there are many factors that facilitate recovery from binge eating, and certainly not one factor or combination of factors that fit all individuals. Perhaps one of the most important observations noted by the participants of this study was that the process of recovery is a life-long process, and that continual work is needed. This observation was affirmed in Prochaska, DiClemente and Norcross's (1992) transtheroretical model of change when they indicated that the fifth stage of change, maintenance, is often life-long. Prochaska et al. discussed particular processed of change (in this current study, processes of change were described as factors that facilitated recovery) that occurred throughout the different stages of change. Incidentally, many of these processes of change were similar or identical to what participants of this current study found helpful in their process of recovery from binge eating. Some of these processes of change, as defined by Prochaska et al. are: Consciousness raising, self-re-

evaluation, self-liberation, counter-conditioning, stimulus control, reinforcement management, helping relationships, dramatic relief, environmental re-evaluation, and social liberation. However, Orford (2001) felt that this process model left out three important aspects of natural change: the social, the spiritual, and the moral. These three aspects were also discussed by the participants of this study. The social aspect was discussed in light of societal influences and pressures surrounding standards of beauty and success, as well as the lack of representation of women's voices. The spiritual aspect was discussed in light of developing a spiritual connection which often led to a dependable source of hope, love, and strength. And thirdly, the moral element was partially discussed in light of characteristic change such as acceptance, love, surrender or forgiveness, which are also components of the 12-step program.

It was also noticed that depending on where one was or how long one was in recovery, different incidents were focussed on. For example, a general observation was that participants who were in recovery for less than 5 years, focussed more of their discussion on concrete factors that were helpful or unhelpful. They talked more about thoughts and behaviours surrounding food, financial blocks, and media and peer influences. Factors that were helpful were often changing and regulating food habits, substituting other activities for binges, finding ways to produce good feelings, and staying busy. Consistent with this, Prochaska et al. (1992) found that certain processes of change – reinforcement management, counter-conditioning, and stimulus control – were frequently used in the action and maintenance stages, but that the longer individuals were in the maintenance stage, the less they focussed on these particular processes of change. In contrast, participants who were in recovery for 5 or more years focussed a large part of their discussion on how they changed major perspectives in life, adopted new

worldviews, and developed a spiritual connection. This included shifting from external to internal validation, looking at the world through a feminist perspective, letting go of perfectionism and control, and finding a source of strength, hope, and love that is real through spirituality. Common across all participants, regardless of where they were in the process of recovery, was developing healthy relationships with others, and developing a healthy relationship with self.

New Findings

It is hard to assert that any finding in the current research is new or absolutely unique. Anything true stands the test of time, and therefore is not new, but simply validated and/or expressed in a different way according to how it makes sense to the particular issue at hand (in this case binge eating) and how it makes sense in the present cultural context. Additionally, there are general trends of what is seen as important, showing up in cycles, through time. For example, in psychology we have seen a movement from psychoanalysis, to behaviouralism, to humanism, to existentialism. Basic truths of each are maintained, adopted, or integrated, but greater emphasis is placed on that which the different theories espouse in particular.

With this in mind, the researcher asserts that Developing a Spiritual Connection (category 4+) as a facilitating factor in the process of recovery from binge eating is a relatively new finding. This is a new finding in the sense that little, if any, attention has been given to spirituality in the field of research, as it relates to binge eating. There is anecdotal knowledge that developing spirituality is important, but there has not been attention given to this in research to further its validation.

Changing Major Perspectives on Life and Embracing New Worldviews (category 3+) has also not been given attention in the literature as a facilitative factor in the process

of recovery from binge eating, as well as how this worldview and perspective change comes about (i.e. through spirituality, through listening to women's voices, etc.). Indeed the whole basis for developing a woman's psychological theory of development is because women's voices have been missing in much of history up to present. This "new" understanding of psychological health as seen through women's eyes has beneficial repercussions: women presently in their own struggles, as demonstrated by participants in this study, connect with ideas that resonate much more intimately with who they are.

Reaching a Point of Desperation (category 11+) has also not previously been mentioned in the literature as a facilitating factor in the process of recovery from binge eating. But as mentioned earlier, this concept of bottoming out is not novel.

Finally, this sort of categorical map – 13 helping and 13 hindering factors in the process of recovery from binge eating – has not been developed before. Certainly many aspects contained within the helping and hindering factors have been studied, but this is perhaps the most comprehensive research to date regarding the helpful and unhelpful factors in the process of recovery from binge eating. Only within the past decade and a half has binge eating been accepted as a valid psychological health concern, as a result, most research has focussed on defining it, discovering possible associated causal factors, and CBT or pharmacological interventions because of the similarities with bulimia nervosa. The categorical map created in this study is a rich source of additional and under-researched information, giving valid and reliable factors involved in the process of recovery from binge eating.

Practical Implications

As previously mentioned, this study can be a source of encouragement for many people that struggle with binge eating. The results of this study can provide information

and inspiration to those struggling with binge eating, and to care-givers: parents, relatives, friends, partners, advocates, counsellors, and health workers who are in contact with individuals struggling with binge eating. This information can not only aid people in supporting others through the process of recovery but also provide general information to the public; building awareness of what exists and knowledge of what people struggle with that might otherwise be unknown. This knowledge can affect others to see the world differently, to rearrange their worldview, to see individuals differently, and to act on this new understanding. Awareness can bring compassion and compassion can promote recovery.

The most frequently discussed themes were those of relationship with self, and relationship with others. As previously mentioned, these two themes are intricately interwoven; people learn about themselves through connecting with others. Perhaps the less *acknowledged* of the above two categories is developing a positive relationship with self. Working on self, following one's dreams, expressing how one feels, and acknowledging one's worth may be difficult for many because it might be seen as selfish. And being selfish has often been seen as an undesirable characteristic trait. What this study may be implying is that perhaps more balance is needed in this area of self. Perhaps more attention to self is not selfish, but rather a natural desire to become who one was created to be. Those struggling with binge eating can be encouraged to unabashedly look at themselves, and develop a kinder view of who they are. Ways in which this is developed are numerous, but the fact remains that individuals should be encouraged to pay attention to themselves, nurture themselves, respect who they are and what who they are may be trying to tell them. When individuals learn about themselves, and start to develop compassion and love for who they are, it becomes easier to continue along the

path of recovery. Although this connection with self is almost always facilitated through connection with others, it is the *acknowledgement* that it is o.k. to pay attention to, learn about, and take care of self, which is missing.

Individuals struggling with binge eating can also be encouraged to find a suitable support group since this has been shown to be extremely helpful. Developing other support networks can also be encouraged, whether that be being with friends who can generally support where you are in life, creating healthy boundaries with partners, families, and friends, or even as drastic as moving to a more supportive environment. Who individuals' spend their time with is highly influential, and can positively or negatively effect one's growth and process of change. The benefits of developing healthy relationships are so numerous that the importance of making these connections can not be understated. Through healthy relationship individuals increasingly feel cared for, loved, and accepted, feel a sense of hope and universality, feel less alone, experience catharsis, and receive feedback and learn more about themselves.

Cognitive Behavioural Therapy and pharmacology have been cited as being the most frequently researched treatments for binge eating, though not extremely effective. The fact that Relationship with Self and Relationship with Others were the most frequently cited helping and hindering factors for the participants of this study leads one to believe that it is not a specific treatment that works, but rather a process of building healthy relationships, with self and others. This can be an explanation for why nine of the ten participants saw recovery from binge eating as a life long process – relationships are a life long process and are not "fixed" or "complete" in a certain amount of time, and require continual work and effort.

The third theme of Knowledge and Understanding as Related to Binge Eating has implications not only in practice but also in the educational system. Information on disordered eating is often offered in the school system, and teachers can be encouraged to ensure that the struggle of binge eating is also talked about. Hopefully care-givers can work to increase the general awareness of binge eating, specifically through learning more about it themselves, and acknowledging that it is a legitimate concern worthy of fair and compassionate attention. Those who struggle with binge eating can assist by sharing their personal stories with others. The more that individuals are willing and feel comfortable to let their voices be heard, the greater the chance that knowledge and understanding of binge eating will reach others.

The fourth theme – Evolution of Perspectives and Worldviews – is another theme that seems to emphasize that recovery is a *process*. Life experiences, which include relating to and learning from others, reading and gaining knowledge through books and other means, personal exploration and self-introspection, and nurturing a spiritual connection, all of these contribute to the gradual evolution of one's perspectives and worldviews. What implication does this have for care-givers and for those who struggle with binge eating? Perhaps the answer is to honour life and all the experiences therein, and to have patience in the process. Deep and true healing does not come quickly, and every experience (which is unique to each individual) leads somewhere. Through their various life experiences, participants adopted new ways of explaining life which facilitated their recovery. Care-givers can assist those who struggle with binge eating through knowing, understanding, and then *living* the sacredness of every experience, each moment. Care-givers and consumers can encourage those who struggle with binge eating to see the value in experiences, knowledge, and relationships and to see that these all are

developing and ever changing processes. Individuals can be encouraged to challenge their beliefs and to be open to learning, especially learning from sources that one is not usually accustomed to.

Furthermore, in discussing *contingencies* of self-worth, Crocker and Wolfe (2001) argued that it is not necessarily improving self-worth that should be focussed on, but rather what self-worth is *contingent* on. For example, self-worth may be contingent on receiving approval from others. Participants in this study found that it was helpful when they shifted their focus from external validation (approval from others) to more internal validation. In practice, individuals can be challenged to look at what they base their self-worth on, which may be a catalyst to an overall perspective change.

Developing a Spiritual Connection was the fifth theme discussed. Models of wellness are increasingly including the spiritual dimension (Miller, 1999) along with the physical, cognitive, behavioural, emotional, social, family, interpersonal, and intrapersonal domains. This study illustrated that developing a spiritual connection can be a powerful factor that facilitates the process of recovery. Care-givers and individuals who struggle with binge eating can be encouraged to acknowledge this spiritual dimension, and then spend more time exploring it. It is curious why asking about an individual's spiritual orientation is not part of standard intake interviews, and perhaps care-givers can attempt to implement this aspect more. Most individuals understand that nothing in life is permanent and that although many aspire to be sources of unconditional love, acceptance, and truth, that this is humanly impossible. If individuals can *feel* and *know* a permanent Source of unconditional love, acceptance, and truth through developing a spiritual connection, then this would seem to be a healthy connection to encourage in therapy, within support groups, and among friends. Often counsellors shirk away from creating or

nurturing any sort of dependence in their clients, but one must ask why this is so. Is it because dependence on anything human or material will eventually lead to disappointment? If this is the case, nurturing a healthy dependence on a spiritual source does not contradict this. Individuals can be encouraged to explore what spirituality means and *is* for them. Whether one acknowledges it or not, spirituality is part of who one is and individuals become more whole – more authentic – through nurturing this vital connection.

The sixth theme discussed was Relationship and Connection with Food. As previously elaborated on, there seemed to be numerous contradictions within this category, and various ways of being with food worked for different people. Generally, it would be helpful to encourage individuals to develop a balanced approach to food. Perhaps some education on the possible detrimental effects of dieting and the feelings of deprivation that ensue, as well as basic nutritional counselling would be helpful. It can be helpful to point out that even though one is not dieting, simply trying to eat too healthy can also be detrimental, especially if there is no space to "mess-up" (i.e., by eating junk food). Those who struggle with binge eating can also be encouraged to pre-plan when they know they are going to encounter difficult situations that involve food. Journaling is one way that has often been helpful in identifying situations in which one is prone to binge. Often participants mentioned that social situations where food was available were especially difficult. Care-givers can be encouraged to bring up such typical situations to see if there is a way to prepare for them.

Individuals can also be encouraged to practice mindful eating meditations – to take perhaps 15 minutes of their daily eating time to concentrate completely on the task of eating, being aware of all sensations that come up. This is one way that individuals can

tune into their natural satiety cues. Additionally, individuals can be questioned about how they view certain foods, such as “good” and “bad”, and why this is so. Some care-givers advocate legalizing all foods, whereas others support the idea of abstaining from trigger foods.

Relationship with and connection with food certainly is not the entire picture of the process of recovery from binge eating. Nevertheless, developing more balanced attitudes and behaviours with food, and sometimes creating a degree of structure, can greatly assist individuals in stabilizing their food patterns. Once a moderate degree of stability is achieved, energy can then be directed into exploring other areas that further assist the process of recovery.

Reaching a Point of Desperation and External Resources were the last two themes discussed. Concerning reaching a point of desperation, care-givers can provide a sense of hope to individuals who are at this point of despair through sharing that others too reached such depths, but that they were able to emerge. Care-givers can also share information on the process of change, the different stages that occur, and that how it is often the combination of all the right circumstances that make change and growth possible. Sometimes it may help to share such insights that in great pain and suffering, growth occurs. But other times it may be more helpful to simply be *with* and share *in* the pain and suffering that individual’s are going through. Participants talked about how they felt so alone, forgotten about, and worthless. At times the greatest help is to have the courage to simply *be with* an individual when he or she is in a place of despair.

The two external resources discussed in this study were finances and medication. This can help remind care-givers and those who struggle with binge eating of additional resources that may be helpful in the process of recovery. Financial resources should not

be overlooked as a contributing helping or hindering factor, and sometimes a change in this area can have significant repercussions. Likewise, medication is helpful for some individuals, and can provide the stabilization necessary for further growth. Care-givers and those who binge eat need to be willing to look at a multitude of factors – a multi-systemic approach – so as to be aware of as many possible routes to growth, change, and recovery. Every individual's path is different; the more routes to recovery that are shared, the more individuals that will be helped.

Overall, what can be accentuated is that recovery from binge eating is a process, and that the process of recovery evolves with or without professional help. There are many factors that facilitate recovery, and some factors seem to be more useful depending on where in the process of recovery one is. Although this research did not focus on what helping or hindering factors were more important at particular stages, care-givers and those who struggle with binge eating can be urged to recognize that the helping and hindering factors may be more or less relevant at certain stages.

Limitations of this Research

As with all types of research, there are limitations. The number of participants for this study was relatively small, which may have decreased the comprehensiveness of the results. Although attempts were made to recruit volunteers that varied in demographic information, the participants interviewed were not representative of those who struggle with binge eating. According to research, the sex ratio of those who struggle with binge eating is much more balanced (Fairburn & Harrison, 2003), yet no men were found for this study. Furthermore, only one ethnicity was represented apart from Caucasian. The lack of generalizability of this study may be seen as a limitation to some, but this is usually not a concern in qualitative research. Rather it is the quality of the researcher's

interpretation in the context in which the qualitative study took place that is important (Heppner et al., 1999). Context is intrinsic to qualitative research, and results have little meaning if stripped of their context. It is more important to draw meaning from and represent individual's stories than to generalize across large populations. This study is therefore generalizable to the extent that others can relate to and identify with aspects of the participants' experiences.

Furthermore, the stories told by the participants were retrospective. As memories change over time, some of the critical incidents may have faded, been distorted, or been forgotten. However, the retrospective nature of the study could also be of benefit as the passage of time could naturally allow for more reflection and understanding, and thus increase clarity when explaining what happened "back then".

This study also assumed the worldviews of constructivism and critical theory. This is not to say that this worldview is a limitation, but it may be seen as a limitation for individuals more orientated towards a positivistic or postpositivistic worldview (as described by Heppner et al., 1999). Qualitative research is based on a worldview that "recognizes that the mind actively ascribes meaning to events and behaviour, and that understanding these mental constructions is the purpose of scientific inquiry" (Heppner et al., p. 266).

Benefits of this Research

This research has provided information and encouragement for those who are struggling with binge eating, as well as for friends, family, and professionals who wish to help those who are struggling with binge eating. The ways in which this could come to fruition was already discussed in detail under the sub-heading Practical Implications.

This research has also hopefully benefited the participants simply in that they were able to share (disclose) their story with one more person and thereby facilitate a greater sense of connection with others. As well, perhaps some participants gained greater understanding and insight into their own process of recovery as they concretely put into words the helpful and unhelpful incidents. In addition, the researchers were able to learn and understand more the many factors involved in the process of recovery from binge eating.

Not only can this research help individuals understand in greater depth the process of recovery from binge eating, but it can also help individuals see the commonalities inherent to being human, regardless of what the specific struggle may be. Through sharing experiences, small connections are made in a multitude of ways which can increase overall understanding, compassion, and a sense of belonging.

Implications for Future Research

The implications for future research are numerous. Through a qualitative method of inquiry, the wealth of information learned from one participant alone leads to many more possibilities for similar research to be done: the existing categories could most certainly be extended and refined. Each of the 26 categories could be developed into a separate research question and expanded on in much more detail. It would be especially interesting to explore how spirituality and the evolution and adoption of new worldviews facilitate the process of recovery since these areas were notably lacking in existing research. It would be interesting to do a similar study with males, especially since many who struggle with binge eating are of this gender. A longitudinal study could explicate more clearly how the process of recovery evolves over time, as a few general differences were already noted in this research. For example, what sorts of factors are more likely to

be helpful and unhelpful at the beginning stages of recovery, and how do these factors change as one progresses through the process of recovery.

Qualitative research draws its meaning from the context of the situation. As context changes with every minute alteration of detail, and with the passage of time, research done on the same topic is bound to discover relatively "new" information as well as inspire curiosity for further research.

Conclusion

This research was a critical incident study of the helping and hindering factors in the process of recovery from binge eating. Through using a modified version of Flanagan's (1954) critical incident methodology, ten adult women who were in the process of recovery from binge eating were interviewed. From the transcribed interviews, 423 incidents were elicited, 255 that were helpful, and 168 that were unhelpful in the process of recovery from binge eating. These incidents were then coded into 13 helping and 13 hindering categories. Several reliability and validity checks were implemented to ensure the consistency and the believability of the categories.

The results indicated that individuals are facilitated in the process of recovery from binge eating through the following: (a) developing a healthy relationship with self, (b) having a supportive environment and support networks, (c) changing major perspectives on life and embracing new worldviews, (d) developing a spiritual connection, (e) disclosing to others, (f) increased knowledge, awareness, and ways of understanding binge eating, (g) becoming aware of and changing thoughts and behaviours around food, (h) feeling a sense of hope and universality through connections with others, (I) finding alternatives to bingeing , being busy, and engaging in pleasurable activities, (j)

feeling cared for, loved, and accepted by others, (k) reaching a point of desperation, (l) stabilizing with medication, and (m) the absence of financial blocks.

The results of this study also indicated that individuals are hindered in their process of recovery from binge eating through the following: (a) societal, media, peer, and personal pressure surrounding excessive attachment to appearance and external validation, (b) overly focussing on and controlling eating habits, and eating trigger foods, (c) feelings of inadequacy and low self-esteem, and fear of failure, (d) lack of understanding of binge eating and well-meaning but unhelpful advice from others, (e) experiencing low emotions such as frustration, anger, sadness, anxiety, and guilt, (f) feeling incongruence in self and others, being unfulfilled with one's path in life, and feeling there is no way out, (g) too much or too little activity, (h) being alone, and feeling alone and hopeless, (I) not receiving respect, love, or acceptance form others, (j) being around others who have unbalanced eating habits, (k) unsupportive perspectives on living, (l) disconnected from hunger and satiety cues, and (m) financial limitations.

This study contributes to the field of Counselling Psychology in that it gives a reasonably comprehensive categorical map of the helping and hindering factors involved in the process of recovery from binge eating. This categorical map gives many crucial areas of focus for counsellors to integrate into their practice; some areas that have been previously validated in research, and some areas that have been given relatively little attention in research. It is hoped that counsellors equally integrate and further validate in their practice the less traditionally focussed on areas. Additionally, this study offers relevant and meaningful information to those who struggle with binge eating, to partners, families, and friends of those who struggle with binge eating, as well as to the general

public. It is equally important that those not affected by this struggle learn about it as many of the helping and hindering factors are societal, not individual.

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Appendix A: Interview Introduction and Sample Interview Questions

Interview Introduction

Thank you for participating in this study. Before we start, I'll have you sign the consent form, if you haven't already, that I read over the phone. If you have any questions or concerns, please feel free to ask now.

The purpose of this study is to find out what helps and what hinders the process of recovery for those who have struggled with binge eating. This information is intended to benefit counsellors and other professionals assisting those with binge eating, the general public, individuals struggling with binge eating, and their friends and family members. I will ask you to think of and describe significant factors that helped or hindered your process of recovery from binge eating. Sometimes I will ask for more detail surrounding these factors to get a clearer picture. I will keep asking for significant helping and hindering factors until you cannot think of any more. Please report only factors that were significant and/or critical. They are critical or significant if there is little or no doubt in your mind that they directly affected your process of recovery from binge eating. Do you have any questions regarding the aim of this study, or the nature of the interview?

Sample Interview Questions

Establishing the aim

Think of a time during your struggle with binge eating in which you felt that you were helped or hindered in your process of recovery.

Critical Incident

Please describe a particular incident that significantly helped or hindered your process of recovery. What happened?

Additional information to clarify the incident

How was the incident helpful (unhelpful)?
What led up to it?
What were the consequences, or how did it turn out?
What did this incident mean to you?
How did you feel about it?

Search for further incidents and repeat the process until the interviewee cannot think of

any more.

Final Question

Based on your personal experiences, in a paragraph or two, what would you recommend for individuals in the process of recovery from binge eating?

Appendix B: Consent Form

June 26th, 03

Title of Study
Binge Eating: A Critical Incident Study on What Helps and What Hinders the Process of Recovery

Principle Investigator
Dawn Toews, Graduate student of Counselling Psychology at TWU (604) 514-6990
DawnToews@hotmail.com
Faculty Supervisor
Dr. Chuck MacKnee (604) 513-2121 ext. 3110 macknee@twu.ca

The purpose of this research project is to learn about the helping and hindering factors involved in the process of adults recovering from binge eating.

There will be an initial telephone conversation (no more than 30 minutes) in which you will be asked various questions concerning your history and present status of binge eating which ensures that you meet the criteria for this study. You will also be asked a few non-identifying demographic questions. Next, a time will be set up for an interview, which will take approximately 30-60 minutes. This is where you share the significant factors that helped and hindered your process of recovery from binge eating. Finally, you will receive a follow-up telephone call (no more than 30 minutes) to answer any additional questions or concerns, and to let you know how you can receive the results of the study if interested. This will all take place within a 3-8 month time-frame.

The interview will be taped and transcribed, and the non-identifying data will be reported in the final research project. All identifying data will be kept strictly confidential and all your information will be coded so that your name is not associated with your responses. Identifying information will not appear in any part of any draft of this research project, and will be kept in a secured chest only for the duration of the study so that you can be contacted. Exceptions to maintaining confidentiality are: 1) threat to harm yourself or others, 2) information of child abuse, and 3) if information is court ordered. Identifying information will be destroyed at the completion of this study. All non-identifying data will be kept for follow-up review or further research as needed.

You are under no obligation to answer any question/participate in any aspect of this study that you consider invasive.

The potential benefits for you in participating in this research project are that you will gain a greater understanding of your own process of recovery, as well as be able to share that with others. The potential risks are minimal; perhaps you may be troubled by bringing up past issues and talking about unpleasant and/or sensitive events. If you feel that you have been traumatized in any way by participating in this study, you can be referred to Fraser River Counselling which is provided at no cost.

Your participation in this study is voluntary and you may withdraw from the study at any time and for any reason without penalty. As a thank you for your participation, you will receive a $10.00 (cdn) gift certificate to a Starbucks or Chapters.

If you have any questions or concerns about your participation in the study, you can contact Dawn Toews at (604) 514-6990 or Dr. Chuck MacKnee at (604) 513-2121 ext. 3110.

If you have any questions about *ethical issues* involved in this project you may contact Sue Funk in the Research Office at 604-513-2142 or sue.funk@twu.ca.

I acknowledge that my responses may be kept in an anonymous form for further analysis after this study is completed.
I have read and understand the description of the study and I willingly consent to participate in this study.

Participant's signature _____

Date _____

I have fully explained the procedure for the study to the above participant.

Researcher's signature _____

Date _____

Appendix C: Recruiting Announcement

If you have ever struggled with Binge Eating/Compulsive Overeating…

I am looking for individuals who would be interested in telling their story of:

What has been helpful and what has been unhelpful in moving towards recovery/progress/wholeness.

This is a unique research project (anonymity assured) that focuses on the actual first-hand descriptions as told by individuals who have expertise on this topic; individuals who have struggled themselves with Binge Eating/Compulsive Overeating. If you have been working on recovery/progress in this area for at least a year, your insight would be greatly appreciated.

Other than a brief preliminary and follow-up telephone conversation, the time-commitment is approximately 45 minutes for a one time interview (at a time and place convenient for you) during which you tell your story of what has been helpful and unhelpful for you.

Each participant will receive a $10.00 gift certificate and the results of this research, if desired.

Your insight can be instrumental in assisting others (also struggling in this area) on their journey towards greater wholeness, as well as provide important information for friends/family/professionals wanting to effectively support those struggling with binge eating/compulsive overeating.

If you are interested or would like more information, please contact Dawn Toews (principle researcher and graduate student of Counselling Psychology) at 604-514-6990 or DawnToews@hotmail.com

Appendix D: Telephone Recruiting Script

Hello, this is Dawn Toews. I am a student of Counselling Psychology, and the principle researcher of this study. I am doing a study on what is helpful and what is unhelpful in the process of recovery from binge eating. This project is unique in that it focuses on stories told from the individuals who have the most expertise on this topic; those who have struggled with binge eating themselves. If you choose to participate in this study, you will receive a $10.00 gift certificate to Starbucks or Chapters. Other than a preliminary phone call and a follow up phone call, the time commitment will be approximately 30-60 minutes for an interview during which you tell your story as it pertains to the research question. Your participation in this study is voluntary and you may withdraw from the study at any time and for any reason without penalty.

There are certain criteria you have to meet in order to be eligible for this research. I will go over that now (Appendix E). If you are eligible, and would like to participate, we will set up a time for the interview. The interview will be taped and transcribed. Your anonymity is assured and all identifying data will remain confidential unless information is required by law. Before the interview, I will ask you to read and sign a consent form. The consent form covers such things as the nature of the project, confidentiality, risks and benefits, etc. I will go over that now (Appendix B). Then we will proceed with the interview. At the end of the interview, there will be a short debriefing during which you can ask me any questions you have or voice any concerns. I will contact you by telephone as a follow-up within 6 months time in case I need to verify any of your information, and for additional debriefing as necessary. If you are interested in the results of the research once it is finished, just let me know and I will send them to you.

Do you have any questions at this time? If you want to participate, lets set a date for the interview now. As preparation for the interview, I simple ask you to think of the significant helpful and unhelpful factors directly involved in the process of your recovery from binge eating.

Thank you for your time, and I'll leave you my contact information: 604-514-6990, DawnToews@hotmail.com

Appendix E: Binge Eating Preliminary Questionnaire for Participation in Study

History of binge eating (Criteria for Inclusion)

Please answer the following (not all criteria are necessary for inclusion):

Have you eaten large amounts of food when not hungry?
Have you eaten until physically uncomfortable?
Have you rapidly consumed large amounts of food?
When consuming food, did you have feelings of being out of control?
Have you eaten alone because of being embarrassed by how much you were eating?
Did you have negative emotions following a binge, such as shame, guilt, disgust, or depression?
Did you binge on average twice a week for at least six months?
Was the bingeing not associated with the regular use of inappropriate compensatory behaviours?

Recovery Status (Criteria for Inclusion)

Do you consider yourself to have been in the process of recovery for at least one year? Recovery is defined as acknowledging that you struggle with binge eating (as it is described above), as well as being actively engaged in working on your struggle with binge eating.

Exclusion Criteria

Are you below the age of 18?
Are you suicidal, or have you been suicidal in the past year?
Do you have any medical (mental, physical) reason not to participate in this study?

Non-Identifying Demographic Information

Please fill in the following:

Age: Gender: Ethnicity:

Province/State of Residence:

How many years have you struggled with binge eating (use *history of binge eating* from above as a guideline for binge eating)?

How many years have you been in the process of recovery from binge eating (use *recovery status* from above as a guideline for recovery)?

Do you consider yourself fully recovered, and if yes, for how long, or do you consider recovery as a life-long process?