

Experiences in the Lives of Women with Binge Eating Disorder

by

Kristina Julyanna Sandy
B.A., University of Victoria, 1998
M.A., University of Victoria, 2002

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of the Requirements for the Degree of

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Abstract

The purpose of this paper is to explore the experiences in the lives of women with binge eating disorder (BED). Eating disorders affect 5 to 10 million individuals in North America and 70 million worldwide. In Canada, approximately 3% of all women will be affected by an eating disorder during their lifetime. Due to the secretive nature of this illness these statistics are most likely under-reported rendering these illnesses difficult to treat. The complexity of eating disorders and potential for long-term side effects warrants attention from the mental health community. There are many theories as to the origins of this illness but no known causes or cures. BED is the most recent eating disorder included in the DSM-IV, (Diagnostic and Statistical Manual of Mental Disorders). This research explored the phenomenon from the perspective of nine women who suffer from BED. These women were interviewed as to their emotional, psychological, physical, and cognitive experience of this illness and its effects in their everyday lives. The results found a number of distinctive themes emerging from the data; emotional connection to food; loss of control; isolative behaviour and secrets; cognitive obsessions; sense of not belonging/not fitting-in; feelings of not being good enough and weight issues/poor body image. The women felt strongly that BED was often misdiagnosed and misunderstood by both the general public and health professionals. They experienced a lack of adequate resources and support groups that offer relevant information and that were not "diet" related. Some women with BED who were also overweight or obese suffered the additional stigma and negative attitudes of "weight-ism" in North American culture where thinness is equated with success and happiness. This study provides a unique opportunity for these women to express their concerns, and offers valuable insights and information for mental health professionals working with the eating disorder population thus support the development of much needed programs for BED. This paper provides an opportunity for greater understanding of compulsive over-eating and challenges stereotypical attitudes while promoting self-reflection on the part of the reader.

Table of Contents

Supervisory Committee	ii
Abstract	iii
Table of Contents	iv
Acknowledgements	vii
Dedication	viii
Chapter 1. Introduction	1
The Problem of Eating Disorders in Western Culture	1
Purpose of Study	2
Our Relationship to Food	3
What Are Eating Disorders?	5
Defining Eating Disorder	6
Bulimia Nervosa	7
Anorexia Nervosa	9
Binge Eating Disorder	11
Factors Contributing to Eating Disorders	14
Biological and Medical Factors	14
Socio-Cultural Factors	15
Individual / Emotional Factors	17
“Not Good Enough”	18
Perfectionist	18
Need to Control	19
No Boundaries	19
Family Factors	20
Spiritual Approach	20
Sense of Disconnection and Eating Disorders	22
Chapter 2. Literature Review	24
Historical Overview of Eating Disorders	24
Anorexia Nervosa	24
Bulimia Nervosa	25
Binge Eating Disorder	26
Etiology of Binge Eating Disorder (BED)	29
Gender Issues and Eating Disorders	30
Studies in Binge Eating Disorder	33
Goal of Treatment	37
Treatment for Binge Eating Disorder	39
Cognitive Behavioural Therapy	39
Interpersonal Psychotherapy	39
Non-Dieting Approach	40
Hospitalization and Medication	42
Alternative Treatments	43
Meditation	45

Chapter 3. Methodology	50
Why Exclusively Women?	52
Asking the Questions	53
Research Design.....	55
Data Collection.....	56
Data Analysis	58
Subjectivity and Biases	59
Phenomenology	61
Why Phenomenology?.....	63
Basic Steps in Phenomenology	65
Phenomenology and Eating Disorder Research	69
Limitations.....	73
Strengths of Qualitative Research.....	75
Chapter 4. Results	77
Katherine's Story.....	78
Katherine's Experience of BED.....	78
Why Katherine Developed an Eating Disorder?	80
What Helped Katherine Alleviate Symptoms of This Illness?	81
What Katherine Would Like Others to Know About This Illness?	82
Stephanie's Story	83
Stephanie's Experience of BED.....	83
Why Stephanie Developed an Eating Disorder?	85
What Helped Stephanie Alleviate Symptoms of This Illness?	87
What Stephanie Would Like Others to Know About This Illness?.....	87
Tatiana's Story	88
Tatiana's Experience of BED	88
Why Tatiana Developed an Eating Disorder?	90
What Helped Tatiana Alleviate Symptoms of This Illness?.....	92
What Tatiana Would Like Others to Know About This Illness?.....	94
Lilah's Story	95
Lilah's Experience of BED	95
Why Lilah Developed an Eating Disorder?.....	97
What Helped Lilah Alleviate Symptoms of This Illness?.....	97
What Lilah Would Like Others to Know About This Illness?	98
Patricia's Story	98
Patricia's Experience of BED	98
Why Patricia Developed BED	100
What Helped Patricia Alleviate Symptoms of This Illness?.....	101
What Patricia Would Like Others to Know About This Illness?.....	102
Amber's Story.....	103
Amber's Experience of BED	103
Why Amber Developed an Eating Disorder?.....	104
What Helped Amber Alleviate Symptoms of This Illness?.....	106
What Amber Would Like Others to Know About This Illness?	106

Debbie's Story.....	107
Debbie's Experience of BED.....	107
Why Debbie Developed an Eating Disorder?.....	110
What Helped Debbie Alleviate Symptoms of This Illness?.....	111
What Debbie Would Like Others to Know About This Illness?.....	112
Pearl's Story.....	113
Pearl's Experience of BED.....	113
Why Pearl Developed an Eating Disorder?.....	116
What Helped Pearl Alleviate Symptoms of This Illness?.....	117
What Pearl Would Like Others to Know About This Illness?.....	118
Priscilla's Story.....	119
Priscilla's Experience of BED.....	119
Why Priscilla Developed an Eating Disorder?.....	121
What Helped Priscilla Alleviate Symptoms of This Illness?.....	122
What Priscilla Would Like Others to Know About This Illness?.....	123
Chapter 5. Discussion.....	124
Themes.....	124
Food and Emotions Connection.....	124
Loss of Control.....	126
Not Good Enough.....	127
Isolative Behaviour and Secrets.....	128
Cognitive Obsessions.....	130
Poor Body Image/Weight Issues.....	131
Not Belonging or Not Fitting-in.....	134
Spirituality and BED.....	135
Eating Disorder as an Addiction.....	136
Family Relationships.....	137
Earliest Memories of Food.....	140
Why These Women Developed an Eating Disorder?.....	141
Coping Mechanism.....	143
What Helped Alleviate Symptoms?.....	143
Medication/Counselling/Connection/Movement.....	143
BED Served a Purpose.....	145
What These Women Wanted Others to Know About This Illness?.....	147
Message to Other Women.....	147
Message to Other People.....	148
Message to Professionals.....	149
Counselling Interventions for BED.....	151
Limitations.....	152
Recommendations.....	152
Future Research.....	154
References.....	156
Appendix "A". Criteria for Binge Eating Disorder.....	170
Appendix "B". Themes.....	171

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I am deeply grateful for the opportunity to be a voice for the silent longings and unnamed desires for many women who struggle with eating disorders. It is my hope that within these pages a glimmer of hope shines and another heart may be lightened in the knowledge that you are not alone.

Dedication

This paper is dedicated to my husband Khan for his enduring patience and fabulous sense of humour, keeping me motivated by six simple words that embodied my career options should I fail to complete this degree; Do you want fries with that? ; to my loving parents Peter & Louise (Apu & Anyu) for their love and support thanks for being so proud of me; (see you at the convocation); to my most beautiful and brilliant daughters Suzannah & Julianna the eternal lights of my soul; thanks for being so understanding of my desire to complete this degree; to my mother-in-law Bodil, thank you for making me feel like I belong and for always believing in me; and a final thank you to my grandfather edes nagypapa who passed away many years ago but whose love of knowledge and spirit of curiosity runs through my veins.

Chapter 1.

Introduction

The Problem of Eating Disorders in Western Culture

Eating disorders affect 5 to 10 million individuals in North America and 70 million individuals worldwide (Crowther, Wolf, & Sherwood, 1992; Fairburn, Hay, & Welch 1993; Gordon 1990, Hoek, 1995; Shisslak, Crago, & Estes, 1995). In a nation where food is abundant and food choices are endless, there exists more obesity, eating disorders and other food related illnesses today than ever before in North America (Mattlehart, 1986). We are a nation obsessed with staying young, being healthier and "looking good" (Hesse-Biber, 1998). What price are we willing to pay to reach this goal?

The complexity of eating disorders and the potential for long-term side effects warrants attention from the mental health community. The search for effective ways to treat this disorder is an important one. North American attitudes regarding weight, dieting and body image are influential in creating a context within which eating disorders develop. In one survey, one out of every five women reported having a bingeing relationship with food (Siegel, Brisman, & Weinshel, 1997).

The mortality rate for eating disorders is approximately 18% in 20-year studies, and 20% in 30-year follow up studies. For females between 15 and 24 years of age the annual death rate with anorexia is more than 12 times higher than the annual death rate due to all other causes (Cavanaugh & Lemberg, 1999; Sullivan, 1995).

In a study in Ontario of 2483 female students; significant symptoms of eating disorders and bingeing and purging, or both, were reported by 27% of girls aged 12 to 18 years of age. Dieting was the most prevalent weight-loss behaviour, also common were

other unhealthy weight-loss behaviours such as self-induced vomiting (Jones, Bennett, Olmstead, Lawson, & Rodin, 2001).

In fact 37% of Canadian females age 11, 42% of Canadian females age 13 and 48% of Canadian females age 15 say they “need to lose weight” (Health and Welfare Canada (1992). The fear of being fat is so overwhelming that young girls have indicated in surveys that they are more afraid of becoming fat than they are of cancer, nuclear war, or losing their parents (Berzins, 1997). What values are being upheld as important in our society?

Eating disorders know no boundaries. The stereotypical profile of an eating disordered patient, as an “affluent Caucasian female” is no longer the norm. Current research shows that different economic, educational and ethnic backgrounds, such as First Nations, Latino and Asian populations, (including both males and females) are seeking help for eating disorders (Croll, Neumark-Sztainer, Story, & Ireland, 2002). Fifty percent of people suffering with binge eating disorder are overweight and 20-40% of people in weight loss programs suffer with BED (Costin, 1999). Due to the secretive nature of this illness these statistics are most likely underestimated, rendering these illnesses difficult to treat.

Purpose of Study

The purpose of this research is to gain a deeper understanding of the experience of women who suffer from binge eating disorder (also know as compulsive overeating). Binge eating disorder is the most recent eating disorder included in the DSM-1V, the standard for mental health set by the American Psychological Association. There are many theories as to the origin of eating disorders but still no known causes or cures for

this illness. Over the past years studying and working with this population, the author has found women to be struggling with lack of recognition for their illness amongst family, friends and even professional health givers. They suffer with feelings of anger, frustration and powerlessness in a society where women with BED (especially if women are overweight or obese) are judged negatively, misdiagnosed by professionals and thus unable to access adequate and effective resources.

A phenomenological approach is able to capture the meaning of their experiences. This very process of asking women with BED their personal experiences may provide an empowering opportunity for them to express their perceptions and have their voices heard. This research may serve to assist professionals to recognize BED symptoms in their own patients and gain understanding of this illness and the negative impact that recommending "diets" can create for this population. Eating disordered individuals who are obese (as many as 50% of individuals with BED) rarely find empathetic support and are often judged to have character flaws such as laziness or lack of willpower over food. Hopefully the results of this research will challenge normative assumptions or stereotypes resulting in better treatment response, the development of much needed programs and improved client satisfaction.

Our Relationship to Food

Most people in Western culture realize that we need an adequate volume and variety of food in order to survive. We choose our foods based on a variety of factors; because of their nutritional value and also because of the sensual pleasures and emotional comfort they offer.

"Comfort foods" are foods that console us when we are sad or depressed. The warm sweet taste of chocolate, soft macaroni with lots of cheese and the soothing taste of ice cream are examples of the enormous pleasure that food can provide. The feeling of fullness is associated with feelings of peace, calm, and relief from anxiety and thus our eating habits and our emotions are closely connected. The consumer, faced with a myriad of products to choose from, evaluates the value and benefits of each product. These products are connected to psychological states of happiness, success and love. Who can resist?

We don't have to look far to see examples of the importance that food and the process of eating has in our lives. Eating is an important social event that we share with our communities. We have passed down our traditions around celebrations, such as Thanksgiving, birthdays and the many special meals we serve each other as symbols of love (Kirkpatrick & Caldwell, 2001).

Food is also found among our spiritual and religious traditions. For example, Christians ate fish on Friday, Jews and Moslems avoid pork, whereas Hindus avoid beef. Some foods are morally judged to be "good", while others are deemed "bad" (Kirkpatrick & Caldwell, 2001). What is the difference between the average person's relationships with food as compared to the person who develops an eating disorder? It is not uncommon that in Western society where thinness has become a symbol of attractiveness and success, the average woman at least occasionally worries about her weight. Therapists have reported that their eating disordered patients take these concerns to extremes, developing abnormal eating habits (Brownell, Holte, Lowe, & Rayfield, 1998).

For some, particularly young women food is no longer a pleasurable daily requirement; rather, it becomes associated with a complex web of emotions. For the

anorexic woman, food is something to be feared and avoided. For the bulimic, it is a forbidden temptation that cannot be enjoyed. For the binge eater it is a solution to something that they may not even be able to name. Binge eating disorder is often experienced as a nameless hunger; a vast hole that is temporarily relieved through the “process addiction” of eating disorders (Johnston, 1996).

Some feminists hold the view that all women have an eating disorder of some kind, varying only by degree. They question the integrity of Western culture in labelling anorexia, bulimia and binge eating as pathologies on the one hand, while simultaneously supporting the constant dieting and weight pre-occupied behaviour of women in general (Brown & Jasper, 1993). It becomes evident that, in order to have a complete understanding of eating disorders, it must be placed within the context of Western culture and within the context of the importance for mind/body/spirit connection.

What Are Eating Disorders?

Eating disorders are defined as “maladaptive coping strategies” (Heffernan, 1994; Katzman & Wolchik, 1984; Telch, 1997) used by individuals when they are struggling with a life situation that leaves them feeling powerless. Eating disorders are devastating behavioural maladies brought on by a complex interplay of factors. These factors may include emotional and personality disorders, family pressures, a possible genetic or biological vulnerability, and a culture in which there is both an abundance of food and an obsession with thinness. A maladaptive coping mechanism is defined here as a destructive and ineffective strategy used by an individual to establish a sense of self and to experience a sense of one’s own power, agency and worth (Reindl & Repetto, 1991).

There are several different types of eating disorders characterized: anorexia nervosa, bulimia nervosa and "eating disorders not otherwise specified." This final group of disorders is called "compulsive overeating" and "binge eating disorder" as well as "binge eating without purging". The more research is done on eating disorders, the more researchers realize that these disorders are on a continuum of disordered eating (Rodin, Silburstein, & Streigel-Moore, 1985). At one end of the continuum there is the normative eating pattern of behaviour and at the other end there are abnormal eating patterns of behaviour such as anorexia, bulimia and binge eating disorder. In between there exist variations of dieting, fasting or purging behaviour (Mintz & Betz, 1988).

Anorexia, Bulimia and Binge Eating have been accepted as the true eating disorders, well defined and studied. Therefore, for the sake of convenience, the term "eating disorders" will be used to refer to these three most commonly accepted conditions (Kirkpatrick & Caldwell, 2001). This paper explores eating disorders in general and moves on to focus on the newest diagnosed eating disorders; binge eating disorder (compulsive overeating).

Defining Eating Disorder

Deborah Kuehnel, a licensed clinical social worker, and her colleagues at the Eating Disorder Recovery Center in St. Louis, Missouri, have extensive experience in the area of addictions. They have characterized eating disorder patients as having: low self-esteem, a distorted body image, obsessions involving food, binge-eating and purging behaviours, difficulties with relationships, increased isolation, feelings of self-loathing, feelings of hopelessness and helplessness, and feelings of being out-of-control (Kuehnel, 1998).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), used by the medical community in mental health and treatment assessment, views eating disorders as self-destructive and potentially life-threatening behaviour. In order to provide a diagnostic assessment, there is a minimum criterion for Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder.

Bulimia Nervosa

Bulimia nervosa is a disease defined as a behaviour whereby individuals consume large amounts of food (binge) and then attempts to rid their bodies (purge) of the excess calories by either vomiting or the use of laxatives and diuretics (Hughes, 1996). The word "purge" comes from the Latin *purgare*, which means, "to cleanse". In the past, bulimia has been thought of as hyperorexia where "hyper" means an excessive or a heightened exaggerated hunger. Bulimia has been identified by many different names. It has been called boalmot (Hebrew), bulimy (Greek), morbid hunger, phegedaena, hound's appetite, canine appetite, bolilsmus, bolimos, cynorexia, Ess Sucht (German for "craving for eating") and gluttony (Kirkpatrick & Caldwell, 2001).

The word bulimia is derived from the Greek word bous, meaning "ox," and limos meaning "hunger" implying someone who possesses an appetite as big as an ox's, or has the capacity of eating a whole ox. Bulimia nervosa typically begins early in adolescence, when young women react to failing attempts at restrictive dieting by binge eating. Many bulimics progress on to anorexia by starving themselves to lose weight or to prevent weight gain. To the bulimic, body shape and weight are considered important factors in defining their self-worth (Kirkpatrick & Caldwell, 2001)

One of the most noticeable physical signs of bulimia is the swelling of the salivary glands creating puffy cheeks (resembling a chipmunk) (Kirkpatrick & Caldwell 2001).

This condition is brought about by the frequency of bingeing and purging, creating dramatic weight fluctuations of 10 pounds or more. Scars on the back of the hands appear, caused by the teeth rubbing against the skin during purging. This symptom, called "Russell's Sign," is named after Dr. Gerald Russell, who first observed and described this symptom in his practice (Blair, Robinson, Fleming, McCloy, & Mollenhauer, 1998).

Bingeing and purging behaviour causes severe stress to the body. Over a period of time, purging or frequent self-induced vomiting may result in dehydration and possible disturbances in the electrolyte levels in the blood. This places patients at risk for heart attacks, renal problems and possible death (Abraham & Llewellyn-Jones, 1992). There are also dangers in vomiting (purging), such as choking as well as the involuntary vomiting of foods at other times when the patient is attempting to eat. Purging through the use of laxatives can lead to potassium deficiencies and electrolyte imbalances (Kirkpatrick & Caldwell, 2001). The above-mentioned physical dangers are also present in the anorexic and bulimic patient.

The Eating Disorder Association Inc. (Qld) (a non-profit organization in Queensland, Australia) that promotes education and support for people affected by eating disorders, finds that the physical symptoms of bulimia, such as forced vomiting, is a potentially dangerous and life threatening behaviour. Stomach acids that are forced back up the oesophagus may cause blistering, tearing, and bleeding of the throat. This acid causes rapid dental decay, sometimes noticeable during a routine dental check-up. Menstrual cycles can become irregular, or stop altogether, as the body's chemical and hormonal levels become imbalanced. The purging behaviours of the woman with an eating disorder, usually kept secret, create feelings of shame and guilt. It is not

uncommon for someone with this illness to withdraw from social activities, especially those related to food, for example family dinners and picnics (Blair et al., 1998).

From a psychological perspective, eating disordered clients are described as having low self-esteem and poor self-image. They are constantly battling the unreasonable and overwhelming fear of becoming fat. They may experience severe mood swings and increased irritability as their bodies are thrown into a state of chemical imbalance. This disorder is highly correlated with psychological illnesses such as depression, anxiety and substance abuse (Denmark & Paludi, 1993). The Eating Disorder Association (Qld) found that some patients suffering with bulimia nervosa have feelings of guilt, shame and self-loathing that may spiral further into deep states of depression and perhaps towards suicidal thoughts (Blair et al., 1998).

Anorexia Nervosa

The word Anorexia comes from the Greek and meaning "not" and *orexis* meaning "desire," thus a "loss of desire for eating." Nervosa comes from the French word, *nerveux*, meaning "having to do with the nerves"; in other words, having a psychological cause. Thus, anorexia nervosa means "loss of appetite caused by psychological illness." Although many details of the disease have only recently begun to be understood, anorexia nervosa was actually first documented about three centuries ago (Kirkpatrick & Caldwell, 2001).

The Diagnostic and Statistical Manual (DSM IV) used as the criteria for setting standards for mental illness by the American Psychological Association (1994) for anorexia nervosa is as follows:

1. Refusal to maintain body weight at or above a normal weight for age and height.

2. Intense fear of gaining weight or becoming "fat".
3. The absence of at least three consecutive menstrual cycles.

Anorexia Nervosa leads to a state of starvation and emaciation with a woman losing as much as 15% to 60% of her normal body weight (Denmark & Paludi, 1993). This marked weight loss accompanies a pallid unhealthy look to the skin. Due to a decreased metabolic rate, the anorexic is more sensitive to cold temperatures. Insomnia becomes a problem as the body tries to fight off hunger. The prolonged lack of nutrition leaves the hair and nails noticeably unhealthy. Later in life, the anorexic may find their self at greater risk for osteoporosis and hormonal imbalance (Kirkpatrick & Caldwell, 2001).

Dr. Jim Kirkpatrick (a family physician, who has been working with eating disordered patients for more than 15 years and is a founding member of the British Columbia Eating Disorders Association) and Dr. Paul Caldwell (a family practitioner for over 25 years) have defined the behaviour that characterizes an anorexic (Kirkpatrick & Caldwell, 2001). The first noticeable sign is an unusually low intake of food. One can observe odd eating habits with unusual food rituals, such as cutting up food into tiny pieces or refusing to eat in public. Some anorexics eat normal amounts of food and then exercise excessively in order to burn off calories.

Some anorexic women obsess about reading nutritional information on packages, hiding behind claims of food intolerance or restrictive diets. As with bulimia, anorexics at times vomit or use laxatives to rid their body of food. Many eating disordered individuals weigh themselves constantly, hiding their body shape beneath layers of clothing (Kirkpatrick & Caldwell, 2001; Garner & Garfinkel, 1997).

Women suffering with anorexia nervosa feel insecure about their abilities even though they may excel in performance. This tendency towards perfectionism may push them to obsess over issues around food and weight. It is disturbing to see people with this disease suffering under the delusion that they are "fat" when, in reality, they are bone-thin (Denmark & Paludi, 1993).

Binge Eating Disorder

Binge Eating Disorder (BED) is the most recently recognized eating disorder. Some researchers believe it is the most common of the eating disorders affecting millions of Americans. Similar to bulimia nervosa, those with BED frequently consume large amounts of food while feeling a lack of control over their eating. This disorder is different than bulimia nervosa, as people with BED do not usually purge their bodies of the excess food. BED was estimated to represent the general population between 1- 2 percent and as high as 25 percent in obese patients (Fairburn et al. 1993).

According to the Diagnostic and Statistical Manual of Mental Disorders (1994) the criteria for binge eating disorder is as follows: Recurrent episodes of binge eating: An episode is characterized by the following;

1. Eating a larger amount of food than normal during a short period of time (within any 2-hour period)
2. Lack of control over caloric intake during the binge episode (i.e., the feeling that one cannot stop eating).
3. Binge eating episodes are associated with three or more of the following:
 - Eating until feeling uncomfortably full
 - Eating large amounts of food when not physically hungry
 - Eating much more rapidly than normal
 - Eating alone because one is embarrassed by how much they are eating
 - Feeling disgusted, depressed, or guilty after overeating
 - Marked distress regarding binge eating

- The binge eating occurs on average at least 2 days per week for a 6-month period.
4. The binge eating is not associated with the regular use of inappropriate compensatory behaviour (i.e., purging, excessive exercise, etc.) and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

According to Siegel, Brisman, and Weinshel (1997), who are family therapists, lecturers and authors specializing in eating disorders, the term “binge eating” was established to define eating disorders that are not specifically defined as anorexia or bulimia. This category may include binge eating without purging or infrequent binge-purge episodes (occurring less than twice a week or, when such behaviour lasts, less than three months). Repeated chewing and spitting out food are also indicative of people who suffer with this illness.

In the extreme, Siegel and her colleagues (1997) recall one of their clients, an impeccably well-dressed executive who worked on Wall Street in New York City, spending evenings rummaging for food through garbage bins in the alley behind her apartment building. Binge eating, usually occurring in secret, is accompanied by feelings of guilt and shame. A person who is bingeing may eat over 50,000 calories at one time (20 to 25 times the normal daily energy intake the average person needs in order to function). For example, one episode of bingeing might consist of eating two-dozen chocolate chip cookies, two large boxes of cereal and eight pints of ice cream (Kirkpatrick & Caldwell, 2001).

Similar to anorexics and bulimics, binge eaters describe a loss of control over food followed by feelings of guilt, shame and disgust. Many who develop this problem have also failed at restrictive dieting. These feelings of failure may lead to depression and possible long-term risks associated with obesity. Even though binge eaters can be

of normal weight about 30% of this population have problems with obesity (Abraham & Llewellyn-Jones, 1992).

Some characteristics of this illness can be recognized by several behaviours and psychological manifestations. An individual suffering with BED may find that their weight fluctuates. They have feelings of a loss of control over their eating and avoid social situations that involve food. These individuals eat alone, perhaps late at night and some also hide and hoard food. Research has shown that people with binge eating disorder report more health problems, stress, suicidal thoughts and trouble sleeping than people without an eating disorder. They may miss time at work, school or social activities in order to binge eat (Shuman, 1994).

A person suffering with binge eating disorder does not decide to eat a meal dependent on whether or not they experience feelings of hunger. Many researchers have found that these maladaptive strategies are utilized as a response to emotional and psychological states such as stress, unhappiness or disappointment. Often family members or friends may suspect that something is wrong but they are unable to understand or know how to handle the situation. BED may lead to weight gain that can lead to obesity thus raising the risk for health problems. The consequences to the individual of eating large quantities of food is the increased risk for a greater number of illnesses including: diabetes, high blood pressure, high cholesterol, kidney disease, gallbladder disease, arthritis, bone deterioration, stroke, upper respiratory problems, skin disorders, menstrual irregularities, ovarian abnormalities, suicidal thoughts, substance abuse, complications of pregnancy, depression, anxiety and other mood disorders (Costin, 1999).

Factors Contributing to Eating Disorders

No one cause for an eating disorder has been found, there are many factors that contribute to these illnesses. Researchers have studied the personalities, genetics, environment and biochemistry of individuals with these illnesses. Eating disorders, as mentioned before, are not about food, rather they are "maladaptive coping mechanisms" used by women to alleviate stress and anxiety (Hughes, 1996).

According to current medical reports from Harvard Medical School and Massachusetts General Hospital, some are rooted in emotions triggered by factors and/or events, such as cultural attitudes towards body image, family pressures, chemical imbalance, and emotional disorder (Harvey, 2001). These physicians, psychiatrists and psychologists found the causes of eating disorders to be divided into four areas:

1. Biological/medical
2. Social/cultural
3. Individual/emotional
4. Family

Spiritual (self-development) theories that focus on a woman's search for meaning, connectedness and purpose are becoming more commonly accepted as factors in the etiology and treatment of eating disorders.

Biological and Medical Factors

A number of biological factors, found in the brain of eating disordered women, are considered to be abnormal. Some of these abnormalities are the result of malnutrition. Changes in the hormonal, neurological and immune systems of the individual are common to anyone suffering from anxiety, stress and anorexia. A number

of studies have detected abnormally low levels of neurotransmitters (particularly serotonin) in severe anorexics and bulimics. This lack of neurotransmitters has been associated with depression and obsessive-compulsive disorder (OCD) as well. 40% and 96% of eating disordered patients suffer from some degree of depression and anxiety disorders. For example the amino acid tryptophan, a component found in food, is essential for the production of serotonin which is lacking in the chemistry of an anorexic. Serotonin and endorphins are associated with the regulation of sleep, libido, drinking and eating. Serotonin decreases anxiety, creates calmness, relieves pain and may play a role in the level of an individual's depression. People with BED feel bad and thus may crave (and subconsciously seek out) the foods that make them "feel better". The answer to the question "did the eating disorder cause the imbalance or did the imbalance cause the eating disorder?" is uncertain (Harvey, 2001).

New research suggests genetic tendencies can contribute to eating disorders. This genetic predisposition may be triggered by the dieting behaviours of the adolescent who is reacting to socio-cultural pressures. The development and maintenance of binge eating disorder and other disordered eating patterns are multi-faceted. Anne Katherine (1996), "Anatomy of a food addiction" asserts that certain foods are like drugs and that addiction to these foods can "cloud the brain, imprison the soul and steal freedoms."

Socio-Cultural Factors

Many people living in Western culture are aware of the pressures to be thin and the prejudices against "being fat". The media, a powerful force in our culture, reflects an attitude that feeds this illness. The myth "if one achieves thinness, then one will be beautiful, successful and loved" holds great appeal to the millions who are inundated

with the potent messages of media advertisers who market consumer products (Harvey, 2001).

This very same culture questions the worth of a woman who does not have a good education, successful job, happy husband, and well-behaved children. Any woman "worth her salt" is expected to accomplish these tasks as she aspires to emulate the models on the magazine covers, even if she must get help from the plastic surgeon. In fashion magazines, these symbolic images can be obvious and overpowering but, more often, they are subliminal, establishing themselves in our subconscious minds associating these attributes with the desires for happiness and success (Kirkpatrick & Caldwell, 2001).

The combination of increased body dissatisfaction and the conforming to restrictive social rules have a dramatic negative impact on female socialization (Hart & Thompson, 1996). In technically advanced cultures, advertisers use the media to market their products. They promote the image of a young anorexic model as the paragon of sexual desirability, and then flood the market with ads for high fat junk food. A young woman, who achieves this ideal thinness, believes that she has accomplished a major cultural and personal victory. She has overcome the temptations of junk food and created a body image that is idealized by the media, creating a sense of accomplishment reinforced by the praise and envy of her heavier friends (Harvey, 2001).

What about the binge eater? Studies have found that people with BED may find it harder than other people to continue in weight loss programs. Given the enormous pressure in our culture to be "perfect", what effect does this have on the individual who does not lose weight and in fact is behaving in an uncontrolled manner that could lead them to weight gain and obesity? Compulsive overeating and in some cases visibly higher weight is one of our culture's unspoken "sins". Young children are only too aware

of this phenomenon. Third to sixth grade girls are worried about becoming overweight, and are dissatisfied with their bodies. Over half want to be thinner and 40% of these girls have already attempted to lose weight (Thelen, Powell, Lawrence, & Kuhnert, 1992).

Women must take into consideration the expectations of society, stereotypes, and the limitations placed upon them, their status relative to men and the symbols and concepts of femininity within the culture (Gross, 1996). Therefore research on anorexia nervosa and bulimia nervosa and binge eating disorder cannot be understood without an awareness of the socio-cultural setting that encompasses the value system and assumptions implicit in a particular cultural context (Hesse-Biber, 1998).

Individual / Emotional Factors

The British Columbia Eating Disorders Association (1994) claims that negative internal thoughts and feelings contribute to the development of an eating disorder. These negative internal thoughts and feelings may manifest as a lack of assertiveness, withdrawal, isolation and depression (Harvey, 2001).

What is the personality profile of eating disordered patients? Dr. Jim Kirkpatrick, agrees with other health professionals who found that eating disordered women share some common characteristics, such as low self-esteem, feelings of helplessness and fears of becoming fat (Gross, 1996). They have a tendency towards perfectionism and they are achievement oriented, living in high stress familial settings, experiencing unstable intimate relationships, and suffering a history of trauma, sexual, physical or mental abuse. It is incorrect to assume that each woman fits into all of the above categories; however, some of these characteristics are found to be true in an extremely high percentage of these women.

“Not Good Enough”

Dr. Kirkpatrick found that his eating disordered patients, even though they may have been good athletes or good students, felt like they had nothing to offer the world. They are often blind to their own strengths and abilities, even though family and friends may tell them how wonderful they are (Kirkpatrick & Caldwell, 2001).

When patients attempt to go against this illness, the negative voices within them increase in frequency and harshness telling them that “they will never be good enough”. This “negative mind” is at the core of eating disorders (Claude-Pierre, 1997; Poppink, 2001; Johnston, 1996).

Perfectionist

The eating disordered individual often believes that any job must be done to some impossible preconceived notion of perfection. When unable to meet these unrealistic demands, the eating disordered individual is faced with failure and depression (Kirkpatrick & Caldwell, 2001). The combination of the setting of unattainably high standards and the fear of failure fuels the development of poor self-esteem and a low sense of worth. It is difficult for an eating disordered individual to state their negative feelings because they believe that their own needs and feelings are not deserving of the attention of others (Kirkpatrick & Caldwell, 2001; Johnston, 1996).

To add to her confusion, this combination of nurturing and self-sacrifice is considered a strong positive feminine characteristic on the BEMs Personality Test. However, on assessment tests measuring depression, the act of sacrificing oneself is considered a negative trait that increases the chance of depression. It is easy to see how women may be torn between what are and what are not considered positive attributes in Western culture.

Need to Control

Eating disordered individuals would describe themselves as passive, powerless and controlled by others. Some practitioners believe that eating disordered women use the disorder to gain control over some aspect of their lives in order to combat feelings of helplessness. This sense of control may also extend into feelings such as anger, anxiety, shame or guilt (Harvey, 2001). Anorexics react to any difficulty in interpersonal relationships by attempting to control their physical weight. This allows them to experience the illusion that a portion of their world is predictable and manageable. The eating disorder acts as a substitute for deeper feelings of unworthiness (Kirkpatrick & Caldwell, 2001). As with bulimics, BED sufferers eat excessively in order to cope with the stresses in their lives and feel very much out-of-control afterwards (Siegel, Brisman, & Weinshel, 1997; Costin, 1999).

No Boundaries

Joanna Poppink, a practising licensed psychotherapist believes that boundary issues are at the core of the problem for women with this illness. She posits that relentless boundary invasions on every level are recurring themes in eating disorders. She refers to "boundaries" as the physical, emotional, psychological, intellectual, sexual and creative boundaries of individuals. The eating disordered individual experiences her boundaries as being consistently ignored and penetrated by others. Boundary transgressions can vary in degree from the extreme (as in sexual and physical abuse) to lesser degrees such as a lack of privacy, not being listened to, or when one's goals or ideas are not taken seriously (Poppink, 2001).

With so many boundaries disrespected, the eating disordered individual does not develop the knowledge or skills for creating, recognizing or honouring her boundaries.

With this loss of control, she experiences the previously mentioned helplessness, despair and feelings of worthlessness (Poppink, 2001). Without learning to set healthy limits, the anorexic will starve herself to death in search of relief from her emotional pain. How can she stop herself when she is not able to stop anything or anyone outside of herself? During a bingeing episode, bulimics will often describe themselves as being "numbed out." Eating is experienced as a blur, allowing them to be temporarily removed from negative feelings and emotions (Kirkpatrick & Caldwell, 2001).

Family Factors

Sir William Gull and Dr. Charles Lasegue, Parisian neurologists who published papers in the 1870's on a number of cases of self-starvation, found that treating anorexia nervosa was more effective when the patients were treated away from their families. They theorized that a lack of conflict resolution was a major challenge for family members. Speculations were also made that there was too much protectiveness and control of the child by the parents. Today the "blame and shame" mentality is not as prevalent in the mental health community. Genetic predisposition, emotional makeup and life experiences are not within the power of the family to control. Eating disorders are complex and confusing afflictions in their cause and cure. These new findings have brought relief to families who have carried the burden and shame of these illnesses for years (Kirkpatrick & Caldwell, 2001).

Spiritual Approach

The term "spirituality" is often associated with religious affiliations. The Random House Webster's Dictionary defines spirituality as the "animating principle of life, the mind or soul of humans" (Braham, 1998). The word spirituality comes from the Latin

root "*spiritus*" that means "breath" referring to the "breath of life." It involves opening our hearts and cultivating our capacity for experiencing awe, reverence and gratitude. It is the ability to see the sacred in the ordinary, to feel the poignancy of life, to know the passion of existence and to give ourselves over to something greater than we are (Elkins, 1998).

Newberg and D'Aquili (2001) have been exploring the relationship between spirituality and the human brain, and have found that mystical experiences are observable and can be explained through human biology. Dr. Newberg is an assistant professor working in the Department of Radiology in the Division of Nuclear Medicine and an instructor in the Department of Religious Studies at the University of Pennsylvania; Dr. D'Aquili was a clinical assistant professor at the Department of Psychiatry at the University of Pennsylvania for over 20 years. These researchers believe that our physical brains are arranged in such a way that the mind is able to sense a deeper reality. "As long as our brains are arranged the way they are, as long as our minds are capable of sensing this deeper reality, spirituality will continue to shape the human experience" (Newberg & D'Aquili, 2001, p.172).

Jung's theory of archetypes posits that the collective unconscious, deep within the instincts of mankind, manifests itself through instinctive actions, recurrent themes, images and symbols (Wehr, 1987). He believed that spirituality is an essential ingredient in psychological health. He went so far as to say that he could heal only those people who embraced a spiritual or religious perspective toward life (Elkins, 1999).

Individuals who may communicate with whatever the object of belief, Brahman or the "larger Self", the Tao or Jesus, all testify to the immediate experience of the smaller self that expands into a larger self. It is a loss of many "small selves" in union with a greater whole that is at the root of this experience (Pratt, 1907). It is this definition of

spirituality that seeks to express itself from the deepest possible source of each human soul.

Perhaps women who suffer from eating disorders have become disconnected from this larger Self? Practising counsellors Carol Normandi and Lauralee Roarke, (who have both recovered from an eating disorder themselves), believe that true and permanent recovery must address the emotional, physical and spiritual wounds beneath the surface. They are the founders of Beyond Hunger, a non-profit organization in San Rafael, California. The name "Beyond Hunger" signifies the importance of looking beyond the hunger of our physical body, to the hunger of our soul. They believe that at the core of every eating disorder is a cry for help from the deepest part of the soul (Normandi & Roarke, 1998).

Sense of Disconnection and Eating Disorders

Perhaps women who suffer with eating disorders ignore powerful answers that are within themselves. For many women the journey to recovery often involves some degree of spiritual crisis. No amount of starvation, makeup, clothing, dieting; no amount of removing or altering body parts, making bigger, smaller, rounder, firmer; and no amount of money, status, number of children or houses can ever give a woman the answers she so desperately seeks. This crisis may be the beginning of her spiritual emergence.

Like Carol Normandi and Lauralee Roarke, many women find inadequate solutions for dealing with their problem of eating disorders. Perhaps the traditional medical approach that focuses on healing the physical body and the psychological approach that focuses on the emotions and cognitive functions is not a complete

prescription. The use of meditation, dance, yoga, visualization exercises or simply learning to connect and trust one's inner intuition are valuable tools in the healing of eating disorders. Perhaps when women begin to listen to their inner voices, they will also find their outer voices (Normandi & Roarke, 1998).

Chapter 2.

Literature Review

Historical Overview of Eating Disorders

Anorexia Nervosa

The earliest written descriptions of anorexia nervosa were written in 1689 by Dr. Morton, an English physician, in his book called "Wasting Disease of Nervous Origins". Morton considered the condition "nervous consumption" to be caused by "sadness and cares" (Morton, 1689).

In the 1870s, Sir William Gull and a Parisian neurologist, Dr. Charles Lasegue, published papers on a number of cases of self-starvation, now clearly recognizable as anorexia nervosa. Gull coined the term "anorexia nervosa" to distinguish the disorder from tuberculosis, just as Morton had tried to do two centuries previously. Gull felt that the disorder resulted from a "morbid mental state" and a "pervasion of the ego." Lasegue decided anorexia could be "hysteria," a common psychiatric grouping of female neurotic disorders at this time (Kirkpatrick & Caldwell, 2001).

Eating disorders, such as anorexia, have their roots at least as far back as the 13th century. They were seen in religious women who were canonized as saints for their fasting practices. These women were referred to as "holy anorexics." The women of this time seem to value spiritual health, fasting and self-denial much as contemporary times values thinness, self-control and athleticism. Holy anorexia provided women with a highly prized status in both church and society (Kuehnel, 1998; Brumberg, 1988).

Saint Catherine of Siena, a religious devotee who lived in the 14th century, starved herself for very long periods of time as a form of spiritual fulfillment. When she did eat, she stuck twigs down her throat and forced herself to vomit as a punishment for breaking her sacred vow to not eat. She gained notoriety as a result of these practices, enabling her to affect the political and religious government of her time, until she eventually starved to death (Lelwica, 1999).

In the 1980's, Joan Brumberg (1988), a historian, dispelled beliefs among many who thought that anorexia was simply a fad that would pass with time. She believed that "fasting girls" were medieval martyrs who used starvation to demonstrate religious devotion. Still today, a remarkable number of young women regard their body as the best vehicle for making a statement about their identity and personal dreams. Themes of self-denial, asceticism and abstinence are common to many religions. Purification of the body and soul through rituals involving fasting or avoidance of certain foods is well known. In many faiths, this is still a method used to reach higher and altered states of consciousness and to "purify oneself in the eyes of God" (Brumberg, 1988; Lelwica, 1999).

Bulimia Nervosa

Descriptions of extreme overeating have been recorded for over two millennia. Seneca, a Roman Philosopher and statesman, is quoted as saying "men eat to vomit and vomit to eat." In the time of Caesar (100 BC), bulimia was evidenced by the presence of "vomitoriums." "Eat, drink and be merry" included vomiting, which allowed one to return for further eating, drinking and merriment. The ancient Egyptians would consume substances, called emetics, to make them vomit for a few days each month for the purpose of preventing diseases attributed to food (Kuehnel, 1998). In 1979, Dr.

Gerald Russell, a psychiatrist working at the Royal Free Hospital in London, England, was the first person to officially define bulimia nervosa with a specific set of behaviours. One such behaviour was the deliberate or forced vomiting, which dated back to ancient times.

Binge Eating Disorder

BED was first identified in the year 1959. The American Psychological Association officially introduced the phenomena known as binge eating disorder in 1992 at an International Eating Disorder Conference. It was included in the medical diagnostic category in 1994 as distinct from anorexia nervosa and bulimia nervosa. BED is the least recognized and likely the most common eating disorder (Hassink, 2000; Costin, 1999). Compulsive overeaters, emotional eaters, food addicts and "bingers" are terms used to label people who engage in uncontrollable, impulsive and continuous eating well past the point of being full with a desperate, insatiable hunger that drives the binge eater to eat more (Sinton, 2005).

Studies suggest that BED is associated with a much broader demographic distribution in terms of gender, race and age than is the case with bulimia nervosa or anorexia nervosa. It is still however far more frequent in females than males. BED appears to occur at twice the rate of bulimia nervosa and at five times the rate of anorexia nervosa. The mean age of onset of BED occurs in late teens to twenties as compared to anorexia nervosa or bulimia nervosa that is diagnosed in the early to mid teens (Spitzer, Devlin, Walsh, Hasin, Wing, Marcus, Stunkard, Wadden, Agras, Mitchell, & Nonas, 1992; Castonguay, Eldredge, & Agras, 1995). Binge eating disorder is not well understood although recognized as a significant problem. Individuals with binge eating

disorders have a number of differences from both bulimia nervosa and obese non-bingeing (Lacaille, 2002).

A characteristic of BED is the person expressing marked distress about binge eating. They do not engage in regular self-induced purging behaviour, such as vomiting, fasting or the abuse of laxatives. BED is more than an occasional overeating episode that some people may experience over the holidays or family gatherings; it consumes the person's physical, mental and emotional health. Unlike anorexia or bulimia, BED appears to be equally prevalent among black and white individuals and in those who seek help for weight control. Early binge eating field trials suggest that as many as 30% of people who participate in weight control programs actually have BED and more than 70% of participants in Overeaters Anonymous (Spitzer, Yanovski, Wadden, Wing, Marus, Stunkard, Devlin, Mitchell, & Hasin, 1993; Castonguay et al., 1995).

BED is found both among people of average weight as well as among people who are severely overweight. It is typical for a BED sufferer to have a history of dieting. Dieting behaviour is found to contribute to the development of this disorder (Fairburn & Brownell, 1995). Even as a distinct entity, BED share features from both anorexia and bulimia. For example, individuals share feelings of suffering and shame and have deep conflicts with and obsession towards food. Eating disorders in general consist of a complex system of beliefs, thoughts, feelings and behaviours developed around self-image and body image that is played out in the sufferer's relationship with food (Marx, 1989). Anorexia nervosa and bulimia nervosa are potentially fatal due to heart irregularities or the effects of starvation. It is important to remember that not all binge eaters are obese and not all obese people have BED (Costin, 1999).

Although BED is not necessarily fatal, it is considered dangerous. Obesity is an epidemic in America with over one third of Americans classified as overweight or obese.

In Canada the rates for adult obesity is 14.9% and 33.3% for overweight adults. An estimated 49.1% were in the normal range, and about 2.7% were underweight. Rates of obesity were highest in the age group 45 to 64. The rate was below the national average in British Columbia; in Quebec, Ontario and Alberta the difference from the national average was not statistically significant. In all other provinces and territories, the rate of obesity was above the national average. Being overweight is considered to harbour the same health risks as being underweight. As noted in the Joint Canada–US Survey of Health, released June 2, 2004 in obesity rates are higher in the United States than in Canada, especially among women (Statistics Canada, 2004).

Many suffer the physical complications of fluctuating weight in additions to psychological and emotional difficulties. After smoking, being overweight is the second leading cause of preventable death and it can increase potential for death from other causes by 60%. BED increases the risk of disease (many are related to being overweight) such as heart disease, high blood pressure, high cholesterol, diabetes, kidney disease or kidney failure, gall bladder disease, various cancers, arthritis and other joint problems, osteoporosis, reproductive system and pregnancy complications and malnutrition (Sinton, 2005; Hassink, 2000; ANRED, 2001). Binge eaters often engage in “yo-yo dieting” that sets the stage for binge eating (Bloom, Kogel, & Zaphiropoulos, 1994; Sinton, 2005). Sadly the obese population is often ignored, ridiculed or regarded with disdain by an ignorant and fearful public.

The researcher first experienced this phenomenon when she questioned a young girl as to why she was eating her lunch while sitting on the floor next to the toilet stalls in the high school washroom. What would make a person take refuge in such an inappropriate environment as the school bathroom to eat a meal? In seeking an answer to that question the researcher befriended the girl whose only “crime” was to weigh

significantly more than the average student. This relationship gave the researcher valuable insight into the experiences of a young girl and her struggles to survive in a "thin" world.

Etiology of Binge Eating Disorder (BED)

A number of people who seek treatment for obesity may also have problems with recurrent binge eating disorder. The causes of these conditions are complex and thought to be environmental, familial, genetic, biochemical, cultural, and psychological (Shuman, 1994). Eating disorders are complex in both cause and cure. It is not uncommon to have a team of medical professionals treating this illness.

Director Ellen Shuman, and licensed psychologist, Dr. Sandy Matthews operate the Acoria Eating Disorders Treatment Center in Cincinnati, a multi-disciplinary treatment team consisting of 12 clinicians: a psychiatrist, psychotherapists, personal coaches, a dietician, and a physical conditioning specialist offering full range of problems associated with overeating; such as depression, anxiety, obsessive-compulsive and impulse control problems, substance abuse, and personality disorders. Patients with BED feel negatively towards their bodies. They also feel self-conscious about the size of their body as well as having distorted attitudes about eating, shape, and weight. By the time they arrive at the treatment Centre they feel out-of-control and desperate. Most people with BED have a long history of attempting restrictive diets in an effort to "regain control." Weight however is only a symptom, not the problem. Thus any intervention that involves dieting alone is met with poor success (Shuman, 1994).

BED, as well as anorexia nervosa and bulimia nervosa are a disorder of disconnection; disconnection from one's feelings and from one's self. These obsessive

"food thoughts" are used to manage intense states. For example, an individual who faces a difficult conversation with his mother may disconnect from the anxiety he is feeling by thinking about the ice cream in his freezer. Another individual, when faced with stress at work or feelings of anger towards her supervisor retreated to the staff lounge and bought candy bars from the vending machines. The moment she started to think obsessively about the food in the vending machines, she successfully disconnected from her life stresses and from her emotions of anger (Shuman, 1994). Another individual faces an evening of being alone. Tired and hungry, she turns into a drive-through lane and buys enough food to "numb" her transition from work to home. She already knew that she would overeat throughout the evening. People with BED use "food thoughts" in reaction to and as a defence against stressful life situations. Using food thoughts, they "disconnect" from the intensity of feeling. This way of managing their moods becomes a way of life (Shulman, 1994). Gene Roth in "When Food is Love" (1992) described the way people eat as a metaphor for the way they live and love. Many people with BED live in a fantasy world in which food is their friend and protector (Roth, 1992).

Gender Issues and Eating Disorders

"We've come along way baby!" is a familiar cliché used by advertisers since the suffragettes' great advances toward emancipation and self-empowerment in the 1920's. This was one of the most significant social phenomena of the past century, having universal importance for the achievement of a separate identity for women (Angeloni, 1990). This quest for identity gave women the potential to enjoy both their freedom and independence they perceived men to have had. Or has it?

More than 90% of eating disordered patients are female (Denmark & Paludi, 1993). If the assumptions one makes about the nature of one's truth and reality shape the way we see the world and our participation in it, then it is important for women to examine their beliefs and the way they think and feel, to understand the impact of these beliefs on their lives.

In the past, social and cultural systems have encouraged the control of appetite in women for different reasons. In the earlier era, control of appetite was linked to piety and belief achieved through fasting. The medieval ascetic wished for perfection in the eyes of her God. In Western culture, the modern female's control of appetite is embedded in the social structure of family, class and gender. The anorexic today seeks perfection in terms of society's ideal of physical, rather than spiritual beauty (Lelwica, 1996).

Feminist author and lecturer Sandra Friedman, proposes that in a male-oriented culture (based on competition, independence and detachment), qualities that were once encouraged in females, such as consideration, co-operation, nurturing and politeness are now framed as needy, dependent, hysterical and indecisive (Friedman, 1997). It is not surprising that women are held to be at greater risk for developing depression as compared with men. In a gender role study by Hart and Thompson (1996) on depressive symptomology, women were found to be depressed slightly more than twice as often as men. Researchers concluded that the most significant factor in depression studies is that women judge themselves more harshly by external standards than men do. They see themselves through the eyes of societal norms to a greater extent (Hart & Thompson, 1996).

It has been found that women are more dissatisfied with their bodies than men are with their bodies. In fact, dissatisfaction with one's body is so commonplace among

women that it has been labelled the "normative discontent" (Bergeron & Senn, 1998; Denmark & Paludi 1993). However, there is growing evidence that males are becoming increasingly dissatisfied with their weight and body image. Dr. Arnold Andersen, a leading figure and pioneer in identifying eating disorders among males, believes that males are under-represented in most eating disorder statistics due to a lack of professional knowledge, and a reluctance of eating disordered males to seek help (Andersen, Cohn, & Holbrook, 2000).

Eating disordered males suffer stigma of shame and embarrassment (Mann, 2000) as eating disorders are seen as a "women's disease" (i.e., diagnosis of anorexia is the lack of three consecutive menstrual cycles, an impossibility for males) (Andersen et al., 2000). Also, bingeing behaviour and compulsive exercising is considered more acceptable and normal in males than in females (Swan, 2000).

Even though the attitude "we've come a long way baby" is theoretically embraced by our society, female gender roles strongly emphasize a young women's physical appearance over many other possible attributes. Well-intentioned family members, fearing the uncertain future of young women who are not considered "thin" or "attractive" by society's standards, often perpetuate stereotypical female images (Kirkpatrick & Caldwell, 2001). It is not uncommon to hear adolescent females talk about breast implants and the latest diet fads, perceiving physical attractiveness as having great value and reward.

Eating disorders are a complex interplay of socio-cultural, environmental and individual factors (Thompson, 1996). Eating disorders most often diagnosed in the early teens to late twenties are considered a young woman's illness. Results of a new area of research finds that it is not uncommon for middle-aged women to also suffer with body image disturbances and eating disorders that are likely under-diagnosed in this

population (Hall & Driscoll, 1993; Lewis & Cachelin, 2001). Why is this? Are they not encouraged to embrace facial wrinkles and sagging breasts as signs of a deeper wisdom earned through years of loving and living? Apparently not as there is more plastic surgery, liposuction and laser treatment to regain youthful appearance (Hesse-Biber, 1998). Media tends to depict older women and the aging processes primarily in negative and critical terms sending a clear message that aging in women leads to a loss of attractiveness, desirability and ultimately love (Zerbe, 2003).

The importance of physical beauty, perfectionist personality traits and high levels of anxiety caused by a multitude of midlife changes, loss of marriage, family, parents, children (empty-nest-syndrome) are implicated in the development of eating disorders in middle-aged women (Streigel-Moore & Marcus, 1995; Allaz, Bernstein, Rouglet, Archinard, & Morabia, 1998; Lewis & Cachelin, 2001).

Studies in Binge Eating Disorder

Due to its relatively new status as a recognized eating disorder, research is still in its infancy for BED. Recently, Adrienne Krentz, Judy Chew, & Nancy Arthur (2005), psychologists and researchers at University of Calgary, Alberta, conducted a qualitative study on the subjective experiences of women who had recovered from BED. This study resulted in the development of a model for the recovery from binge eating disorder under an overarching concept of Self-Awakening. Self-awakening is the process that women go through to resolve the disconnection between themselves and the world. This is achieved through separate stages described as:

1. Self-reflecting (setting the stage for the possibility of recovery)
2. Assessing present life situation (reaching the point of dissatisfaction and seeking information)

3. Healing/restoring oneself (striving for personal happiness, changing relationship to body and food and breaking isolation)
4. Creating balance (practicing prevention, maintaining changes and experiencing self-acceptance)

(Krentz, Chew, & Arthur, 2005 p.122)

The researchers drew connections and relationships between these categories (Strauss & Corbin, 1990). The experience of the splitting of one's body from the self is a core issue for compulsive overeaters who are left feeling powerless, out-of-control and unable to change. These misperceptions of body image interfere with healthy development and lead to feelings of "not being good enough", unworthiness, and shame. The development of a healthy self-concept and increased ability to accept oneself as a whole and integrated person is a powerful theme in the recovery of eating disordered women (Hardy, 1982).

Dr. Elizabeth Rieger, psychologist at University of Sydney, Australia and Dr. Rick Stein, Research Assistant Professor and Behavioural Director of the Washington University Weight Management Program, Dr. Denise E. Wilfley, Department of Psychiatry, Washington University School of Medicine, St. Louis, Missouri; Dr. Valentina Marino, Department of Psychiatry, University of Tor Vergata School of Medicine, Rome, Italy; and Dr. Scott Crow, Department of Psychiatry, University of Minnesota, Minneapolis, compared the quality of life in obese individuals who have BED with obese individuals who do not have BED. Results found that obese individuals with BED were associated with greater psychosocial impairment as compared to those with obesity alone (Rieger, Wilfley, Stein, Marino, & Crow, 2005).

Dr. Pamela Crant Owen, University of Cincinnati, U.S., in her dissertation embraced the phenomenological research model to illuminate the experiences of women

with binge eating disorder currently undergoing psychotherapy/counselling. This study explored women's experiences of depression, chronic dieting, personal loss, and the perceptions of how society views women and their body size. Recurrent themes of loss of control, dissociation from food, feeling comforted and safe, ritualistic behaviour, being alone and consuming large quantities were discussed. Topics addressed the struggles of women to find help (Owens, 2004).

Researchers from the Psychiatry Institute, Department of Neurosciences specializing in Eating Disorders at the University of Turin in Italy explored the anger levels in obese patients with and without an eating disorder. Results found that the score on the Beck Depression Inventory is higher for obese women with BED as compared to the obese non-bingeing group. Results interpreted these findings as signifying impulsivity in the group of obese binge eaters (Fassino, Leombruni, Piero, Abbate-Daga, & Rovera, 2003).

Dr. Tiffany R. Mimms during a postdoctoral internship at Fuller Theology Seminary School of Psychology, U.S., examined the effects of social support and spirituality on BED and depression in black college females. It was found that social isolation due to racial discrimination increased vulnerability to depression and eating disorders. However, many black women have traditionally relied on religion and spirituality to cope with life's stressors. Thus, spirituality and religious attendance were found to moderate the effects of social support on depression (Mimms, 2004).

Very little is known about the short and long-term outcome of BED following intervention. Dr. Manfred Fichter, Dr. Norbert Quadflieg and Dr. Klinik Rosenberg from the Department of Psychiatry in Munich, Germany evaluated BED outcomes over a six-year period after eating disordered women received therapy. Therapy consisted of biological, serotonin reuptake inhibitors and tricyclic antidepressants, cognitive

behavioural therapy and interpersonal therapy. Results found that approximately half of the women showed significant positive outcomes. It concluded that the attitudes towards dieting and the unrealistic cultural standards for the female body shape were factors in the prevalence of eating disorders. Furthermore, BED was acknowledged as a severe eating disorder requiring intensive treatment (Fichter, Quadflieg, & Gnutzmann 1998).

According to researchers at the Academic Unit of Psychiatry and Behavioural Sciences School of Medicine University of Leeds found that the cravings of eating disordered individuals that led to binge eating behaviour were associated with higher tension, lower mood and lower actual hunger levels as compared to cravings that did not lead to a binge. The level of tension and hunger were critical discriminating variables (Waters, Hill, & Waller, 2001). BED seems to render people incapable of making healthful changes; not because they prefer binge eating, but rather because they feel helpless against an insatiable and unstoppable craving for massive amounts of food (Sinton, 2005).

People with BED believe that they are caught up in a dangerous cycle of craving, resisting, giving in, bingeing, feeling guilt and being angry. Binge eating is seen as a way to alleviate stress, express "bad" emotions such as anger as well as the previously mentioned dissociation from the pain and memories of past trauma. It can provide a false sense of protection from the very things they are most hungry for; love, intimacy and trust. Using food in place of self-love and love for others leads to emotional and psychological starvation (Sinton, 2005).

Goal of Treatment

The American Psychiatric Association's (APA), based in Washington D.C, and is the pre-eminent scientific and professional organization that represents psychologists in the United States. Their practice guidelines for the treatment of eating disorders states that patients with eating disorders may display a broad range of symptoms that occur along a continuum between those of anorexia nervosa and those of bulimia nervosa and binge eating disorder.

The goal for the treatment of anorexia nervosa is to restore patients to a healthy weight, reduce the threat of physical complications, enhance the patients' motivation to cooperate (usually administering antidepressants, for example, serotonin reuptake inhibitors) and provide education about healthy nutrition. Other goals of treatment include the correcting of maladaptive thoughts, attitudes and feelings related to the eating disorder, enlisting family support and attempting to prevent a relapse (Miller, 2000). A multidisciplinary team, consisting of physicians, dieticians, behavioural-cognitive therapists, psychotherapists or nurses may be required, depending on the severity of the disorder. A physician is needed to determine that the patient is not in immediate physical danger. A nutritionist is assigned to help assess and improve the nutritional intake.

The goal of treatment for binge eating disorder is to assist the client in addressing their binge-eating disorder, any associated obesity, and any associated psychopathology through both individual therapy and group therapy.

The primary goals of treatment are to:

- Reconnect with the body and with feelings
- Identify cognitive distortions
- Recognize perfectionism and "all or nothing" thinking

- Identify physical vs. emotional hunger
- Increase capacity to tolerate feeling states
- Learn how to communicate needs and set boundaries
- Improve body image
- Learn self-care
- Recognize recovery as a "process" filled with ups and downs

As treatment continues, clients are encouraged to use other services, such as psychiatrist, psycho-educational programming, support groups and nutritionist (Porzelius & Bolton, 1999).

Psychology plays an important role in the successful treatment of eating disorders. The psychologist identifies issues that need attention and develops a treatment plan. They may help the patient replace destructive thoughts and behaviours with more positive ones. For example, a psychologist and patient might work together to focus on health issues rather than weight, or a patient might keep a food diary as a way of becoming aware of the types of situations that trigger bingeing. Once the patient's pattern of behaviour has changed, psychologists and patients may explore the psychological issues underlying the eating disorder. This may improve the patient's personal relationships and may explore the situation that initially triggered the disorder (Brownell et al., 1998). Many popular treatments for compulsive overeating advise people to give up their focus on losing weight if they are to gain control of their eating patterns. Instead they focus on the individual's ability to accept their weight addressing their poor body image (Porzelius & Bolton, 1999).

Treatment for Binge Eating Disorder

As binge eating disorder is a relatively new diagnosed eating disorder, the established treatments are thus far quite limited. A few studies have focuses on the recovery of BED through cognitive behaviour therapy (CBT), Interpersonal psychotherapy (IPT) (Fairburn, Cooper, Doll, Norman, & O'Connor, 2000). These are psychological treatments that appear to have a success rate in between one and two thirds of cases (defined as achieving remission) (Wilson & Fairburn, 2000).

Cognitive Behavioural Therapy

Current cognitive behavioural therapy (CBT) of BED resembles treatment developed for bulimia nervosa. It involves keeping a diary of relevant themes (what foods are eaten and what time of day), bingeing behaviour (identify feelings and thoughts before and after binge episode). Individuals are taught coping skills to help deal with stressors that are identified as contributor to binge eating pattern (Porzelius & Bolton, 1999). Studies have found that individuals with BED may require treatment that focuses on their binge eating behaviour before they try to lose weight. Treatment for BED is well received when administered within a group format (Wilson & Fairburn, 2000).

Interpersonal Psychotherapy

Interpersonal psychotherapy (individually or in groups) has also been used to effectively treat BED. Interpersonal psychotherapy is effective for assisting the client to examine their relationships with friends and family and to make changes in problem areas.

Medications, such as, antidepressants, are prescribed for some individuals. Even though binge eating is the primary diagnosis, many clients have co-morbid conditions, such as depression, which may warrant pharmacological treatment. Anti-depressants that influence the levels of serotonin (SSRI) are often an important component of treatment. Research attempts to determine which method or combination of methods is the most effective in controlling binge eating disorder (International ED, 2005). Many initial studies have had significant shortcomings including the use of weak assessment measures, insufficient controls and lack of follow-up. Most of the research has been restricted to those patients with BED who also meet the criteria for obesity (Wilfley & Cohen, 1997; Wilson & Fairburn, 1998).

Non-Dieting Approach

When an individual is overweight, it is not uncommon for family and professionals to put considerable pressure on them to lose weight. This constant goading and advice giving contributes to the already self-deprecating emotion of shame that is characteristic of this eating disorder (Porzelius & Bolton, 1999). According to the results of a three-year Harvard study, children and young adults who dieted, gained more weight than those who never dieted at all (Field, Austin, Taylor, Malspeis, Rosner, Rockett, Gillman, & Colditz, 2003).

Scientific studies document that 95% of persons who lose weight dieting regain the weight within 5 years (with most regaining the weight within one year). Weight gain is often seen as “backsliding” and something within the control of the individual. Females are especially vulnerable to self-depreciation and self-castigation for failure to achieve the mythic “perfect body”. Therefore, any type of weight loss program for treating BED is not advised. It is stressed that the individuals learn to accept their current weight. Eating

disordered individuals need to learn that it is possible to feel good about themselves and their bodies despite weight (Porzelius & Bolton, 1999).

Health at Every Size (HAES) is a growing organization in the United States that supports the idea of a size acceptance approach to health promotion. In the Western medical model, people are often told that the only way they can be healthy is to lose weight through dieting. Health at any Size believes that an attitude change towards weight is necessary in Western society. They believe that it is more important that people are healthy and fit rather than focusing on weight (Matz & Frankel, 2005). The authors own assumptions were challenged while viewing a video of overweight people exercising and running marathons. These individuals weighed over 250 lbs and yet had normal cholesterol, blood pressure and healthy hearts. The promotion of body satisfaction commensurate with the achievement of realistic and attainable health goals without focus on weight change is a standard that is worth striving for in working with this population.

Obesity from compulsive eating has been theoretically linked to a number of interesting etiological possibilities, including obsessive-compulsive disorders (Mount, Neziroglu, & Taylor 1991) and addiction (Peele, 1989). The reality of this illness as more than a medical problem and an entity separate from other eating disorders describes people searching for a way to be freed from this battle with themselves over food. These people are distinguished from the population of compulsive eaters who are not obese and from the population of obese who are not compulsive eaters. Early experiences reported by compulsive eaters about dissatisfaction and embarrassment with their bodies and body image are a place to start looking for answers for the causes of this illness. Most compulsive eaters have developed a distorted view about themselves in

relationship to their bodies, often as a response to early parental or peer messages regarding the inadequacy of some aspect of their size or shape or self (Marx, 1989).

Hospitalization and Medication

The intervention for eating disorders depends upon the severity of the symptoms surrounding the eating disorder itself. If the client is seriously in danger (e.g., purging herself to the point of haemorrhaging, or suffering decreased body weight to the point of complete malnutrition), or severely depressed (suicidal), then immediate medical hospitalization may be required followed up by in-patient psychiatric hospitalization (Kuehnel, 1998).

The use of medication is a major part of the APA guidelines, but not all patients will respond to or even accept a recommendation to begin psychopharmacological treatment. The most widely used researched medication for eating disorders are antidepressants. These include tricyclic antidepressants, monoamine oxidase inhibitors, and the serotonin reuptake inhibitor fluoxetine (prozac, paxil). Anti-psychotics, lithium carbonate, appetite stimulants and anticonvulsants as well as neuroleptics are sometimes used to control the anorexic's bizarre eating patterns and delusional manifestations (Zerbe, 1995). There can be side effects to medications varying such as mild nausea, dry mouth headache, insomnia, sexual problems. Some of these side effects are temporary and others require a change in medication (Price, 2000).

It is not uncommon for a patient with an eating disorder to have additional maladies. Depression may be alleviated through the combined treatment of medication and counselling the client to express their emotions. Other common diagnoses involve mood disorders, chemical dependency as well as some personality disorders. Today's research supports a combination of different modalities. It suggests that no one single

form of treatment is necessarily effective. A combination of antidepressants, group therapy, nutritional counselling, cognitive-behavioural approach and psychodynamic techniques may provide the most beneficial treatment approaches in terms of recovery (Zerbe, 1995).

Alternative Treatments

The bio-psycho-socio-spiritual model has been widely accepted for several decades in understanding the etiology of mental disorders. It has not been widely applied to the area of eating disorders (Leichner, Brown, Atkinson, Henderson, & Jacek, 2001). The Center for Change, in Orem, Utah, is a treatment Centre that specializes in the treatment of women with eating disorders. Many patients feel a great deal of shame and remorse about their deception and lying, compounded by feelings of guilt for failed promises to give up their eating disorder (Hardman & Berrett, 1999). Results found deep spiritual struggles to be a major focus in their patient's ability to recover.

Dr. Pierre Leichner, Psychiatrist, and Dr. Ron Manley, Psychologist, at the Children's Hospital, in Vancouver, British Columbia found several recurring themes working with eating disordered patients. These patients were described as feeling hopeless, undeserving of help, worthless and unable to express their feelings. Eating disorders are a "leveller of experience, reducing life to a small caloric awareness and focus on food" (Leichner & Manley, 2002). According to Dr. Leichner and colleagues, establishing spiritual values can reinforce self-nurturing beliefs and behaviour that is necessary for healthy living.

Eating disorders represent a search for meaning, a desire for recognition and perfection and a hunger for a deeper and larger sense of themselves (Leichner et al., 2001). Can this hunger be satisfied by their personal connection with their

mind/body/spirit? Regardless of age, the women in this author's BED classes are searching for something that will allow them to feel whole, connected and complete in their bodies.

Compared to illnesses such as alcoholism and drug abuse, eating disorders are especially difficult and destructive because they deal with food and nourishment, a part of life that is fundamental to well being. One can give up smoking, taking drugs or drinking "cold turkey," however food is necessary for the survival of the body thus making this recovery very difficult (Hardman & Berrett, 1999). Women with eating disorders often speak about how fat they feel or of how undeserving of love they are, rather than the deeper, substantive issues of their feelings of pain, loneliness and emptiness (Hardman & Berrett, 1999). One can replace the negative mind with thoughts of hope and inspiration. To see the changes in an individual's life that come through thinking differently is truly magical.

An intervention used for patients with eating disorders at St. Paul's Hospital, Vancouver, British Columbia is learning the science of yoga. Inner control through meditation as well as physical control through different breathing method and posture brings together the mind and body in greater harmony. This type of practice supports the mind/body/spirit connection and can create a healthier body image for women.

The results of one study found that spiritual beliefs and practices, such as prayer, meditation and reading spiritual books were an under utilized resource for coping with body image concerns (Jacobs-Pilipski, Winzelberg, Wilfley, Bryson, & Taylor, 2005).

Much has been written about the importance of forgiveness in healing and therapy. According to Richards, Hardman, Frost, Berrett, Clark-Sly, and Anderson (1997), it is one of the most frequently used interventions in psychotherapy. Helping eating disordered patients to forgive parents, abusers, themselves and God is found to

be important in the healing process. The idea of forgiveness is explained as a gift or choice rather than a requirement. The patients are encouraged to be open to love and to understand self-forgiveness as a healing process requiring responsibility and accountability rather than self-punishment. True forgiveness is a result of inner understanding and compassion (Richards et al., 1997).

It is not surprising that for thousands of years, long before the advent of modern medicine, people looked to spirituality for cures. Contemplation, meditation, prayer, rituals and other spiritual practices have been known to release the life force in the deepest levels of the human soul. Similarly to the use of spiritual interventions at the Center for Change, Dr. David Elkins cites four ways to begin one's spiritual journey of healing without placing emphasis on mainstream religious dogma. They include some form of relaxation, meditation, prayer, spiritual readings and being in nature (Elkins, 1999).

Meditation

Meditation is a universal practice that promotes spiritual and practical wisdom by disengaging the mind from conditioned patterns, reactivity and self-concerns. It is also credited with promoting self-awareness, self-regulation, stress management, and cognitive and behavioural human functioning. In the medical model it has been used for promoting general well being as well as for treatment of anxiety, addictions and pain (Marlatt & Kristeller, 2000; Rubin, 1996; Kabat-Zinn, Massion, Kristeller, Peterson, Fletcher, Lenderking, & Santorelli, 1992). Numerous models (Austin, 1999; O'Connell & Alexander, 1994) have been presented regarding the mechanisms of the effects of meditation.

"There is no greater source of strength and power for me in my life now than going still, being quiet and recognizing what real power is," said Oprah Winfrey on her daily television show segment called "Remembering your Spirit." According to Dr. Kenneth Pelletier (1993), physician at Stanford Center for Research in Disease Prevention, the use of meditation, visualization, hypnosis, biofeedback and numerous relaxation techniques show promise in helping to prevent and treat diseases, such as heart disease, headaches, stomach pain, panic attacks, depression and psychological disorders (Pelletier, 1993). Teasdale, Segal, Williams, Ridgeway, Soubry, and Lau (2000) suggest a model in which mindfulness meditation allows the individual to interpret negative thinking differently.

Research on meditation with other addictive behaviours (Gelderloos, Walton, Orme-Johnson, & Alexander, 1991), including alcohol (Marlatt, Pagano, & Rose, 1984; Brooks & Scarano, 1985), smoking and other drugs addictions (O'Connell & Alexander, 1994; Monahan, 1977), suggest it to be effective for producing changes when applied in BED. Sensory deprivation research (Suedfeld & Kristeller, 1982; Kristeller, Schwartz, & Black, 1982) suggests that chronic dieters and compulsive eaters were dissociated from internal self-regulatory systems of eating control, and overly influenced by external cues, belief systems or emotional signals (Rodin, 1981; Kristeller & Rodin, 1989). This is supported by studies, including the results of the author's thesis paper about spirituality; themes of connection -disconnection are important recurring concepts in eating disordered women (Sandy, 2002).

Jon Kabat-Zinn (1990), at the University of Massachusetts Medical Center, developed an exercise called the "raisin" meditation. The goal of this exercise was to experience the eating of a single raisin as completely and mindfully as possible. He used this exercise to illustrate how mindfulness awareness can be brought to aspects of every

day life. Kabat-Zinn et al. (1992) found that an eight-week mindfulness meditation program had a long lasting effect in significantly lowering the anxiety, panic symptoms, and level of dysphoria of subjects. Meditation is a cognitive process that involves learning to shift and focus the attention to an object of choice. Compulsions and obsessive thoughts are experienced in eating disordered individuals as both uncontrollable and an inherent aspect of self.

Jean Kristeller, professor of psychology at Indiana State University and Brendan Hallett, counsellor and prevention specialist, evaluated 18 obese women using the techniques of standard and eating-specific mindfulness meditation exercises. Kristeller found that after 8-week program, episodes of bingeing reduced, mood improved and increased a general sense of self-control and self-worth (Kristeller & Hallett, 1999). They concluded that meditation training maybe an effective component in treating binge eating disorder. A surprising observation for the women was that giving up conscious control over their eating led them to feeling that they had greater control in their lives (Kristeller & Hallett, 1999).

According to Jennifer Keane, a registered clinical counsellor, the practice of meditation is beneficial for some women suffering with anorexia nervosa and bulimia nervosa. Women may achieve a greater sense of awareness, greater sense of presence in the body, increased acceptance of being "perfectly good enough" and a greater sense of self worth. It may give the women a greater ability to cope with stress in her life through physical and mental relaxation (Keane, 2002).

Eating disordered patients are ordinarily disengaged from physiological feedback (Heterington & Rolls, 1988; Hadigan, Walsh, Devin, LaChaussee, & Kissileff, 1992) and emotions. Mindfulness meditation is able to assist the participants by allowing them to see eating as "just eating" and food as "just food". There was an improvement in

participant self-concept and self-acceptance. A randomized seven-week mindfulness meditation program (Shapiro, Schwartz, & Bonner, 1998) with medical and premed students also resulted in an increased sense of well-being.

The Eating Disorder Research Centre in Vancouver, British Columbia offers referrals to anyone needing information. There are a variety of resources that involve nutrition, medical doctors, exercise management, dance therapy, bodywork, as well as art therapy, play therapy, support groups, family therapy, and psycho-education group. Complementary health models include homeopathy, meditation and spirituality as an alternative intervention (Miller, 2000).

This supports other studies that show that disconnection is an important characteristic of eating disordered women and that connection to community and with oneself through spirituality is a moderating force. Prayer may be the oldest spiritual practice and the most popular one in North America. It is defined as a mental and emotional release along with a sense of connection to a transcendent dimension and may be at the core of prayer's effectiveness. An emphasis on spirituality has been a key component in the 12-Step Program of recovery from addictions used by Alcoholics Anonymous and other related programmes (Walsh, 1999).

Eating disordered individuals often express an overwhelming aloneness with regard to their eating disorders. Group therapy that involves feedback and hearing the voices of others is immeasurable in terms of its supportive effect on the recovery of the eating disordered individual. Group work may also assist in establishing better interpersonal relationship skills. Many women begin to feel comfortable expressing their own feelings through having their primary emotional needs met. Supportive therapy can provide a safe environment in which the individual may try new ways of behaving while learning how to care for themselves in a healthier manner. Once the individual feels

safer, many deeper issues of sexuality and body image begin to arise (Kuehnel, 1998; Leichner et al., 2001).

Dr. Pierre Leichner and other therapists working with eating disordered patients have found that episodes of relapse are part of the recovery process and are incorporated into the healing process as a valuable learning tool. Teaching eating disordered individuals to be patient and gentle with themselves is essential in order that they may find their own understanding with the aim of making peace with food (Kuehnel, 1998). Through a process of listening, learning, and creative exercises many eating disordered women are finding their way out of "the aloneness".

Chapter 3.

Methodology

This study examines the personal experiences and perspectives of women who are suffering with binge eating disorder. In choosing a methodology for this study several factors were considered:

1. What method would be an effective and useful way of obtaining this information?
2. What type of methodology lends itself to creating a deeper understanding of the experiences of women who suffer with this illness?
3. Which women could articulate their experiences?
4. Could a safe and comfortable environment be provided that supports a connection and honest rapport to encourage women to speak freely and honestly?

The qualitative approach is both effective and relevant in studying and exploring the personal experiences of women with eating disorders. Little research has been conducted in the area of binge eating disorder and therefore a qualitative analysis would add depth to the existing body of knowledge, potentially revealing underlying causes and risks of this disorder and thus contribute to the development of future treatment and intervention.

The nature of qualitative formats may be effective in uncovering the essential truths about this illness. As important as it is to ascertain the number of women who suffer from this illness and measure the severity of eating disorder behaviours, it is equally important to understand the personal experiences of each woman in order to

gain deeper insight into how women suffering from this illness may be helped. It is in the understanding of the etiology of an illness that light is shed on the direction of a cure.

Guba and Lincoln (1985) support qualitative research as “naturalistic”. There is a greater interest by qualitative researchers in understanding how things occur rather than simply identifying outcomes (Padula & Miller, 1999). Qualitative research explores the experiences of the individual with the premise that we are all unique beings. In the midst of a snowstorm it is impossible to see that each snowflake is distinct and unique. Qualitative research acts as a sound backdrop against which to describe the personal experiences and expressions of these women.

Although both qualitative and quantitative methodology share the same fundamental goal (gaining a deeper understanding into the human condition), the tools of each differ. The understanding of personal experience may be better understood through the tools of qualitative research. It has the potential to provide deeper insights into the uniqueness of human experience. The process by which people construct meaning and describe those meanings enables psychologists, educators and counsellors to better meet the needs of the eating disordered population (Padula & Miller, 1999).

Qualitative researchers agree that reality is socially constructed. The variables are complex and interwoven thus making it difficult to measure (Campbell, 1996). This research gives careful consideration to the significance of this disorder and its meaningfulness in each individual’s life. The women would be asked to define and describe their experiences of having a binge eating disorder. Inferences will be drawn from the interviews with the women with the intention of increasing understanding of this illness.

Creswell (1994) posits that the qualitative researcher interacts with the participants and cannot function apart from context and participants. This adds sensitivity and responsiveness to the research process. Qualitative research focuses on the participant's perceptions, their experiences and how they make sense of their lives (Padula & Miller, 1999). The researcher and participants are acting as partners, as co-researchers and co-participants, explaining and sharing ideas and experiences.

The research design uses purposeful non-random sampling to increase the utility of the information obtained. The ideal participants are knowledgeable and informative about the topic under discussion (Schumacher & McMillian, 1993). The participants were recruited through word of mouth and through the Port Coquitlam Women's Resource Society that conducts the Binge Eating Disorder Psycho Educational Programme. Women who wished to volunteer for this study were invited to contact the researcher. There were nine women who expressed an interest in participating in the study. Volunteers were accepted on a "first come, first serve" basis. A more detailed description of the research process follows in this chapter from general qualitative research to specifically phenomenological hermeneutics and ending with strengths and limitations of qualitative methodology.

Why Exclusively Women?

This study interviewed women exclusively for the following reasons: In the current study of research it became evident that although eating disorders are not solely a female problem, ninety percent of eating disorders are statistically found to be within the female population (although it is a growing concern for the male population as well).

The fact that this study looks only at eating disordered women is in no way intended to diminish the seriousness of this illness in the lives of men who suffer from it.

A theoretical framework has never existed for the understanding of the development of women without having been based on a comparison to men. Carol Gilligan, renowned women's author in the area of women's development, observed that scientific research done primarily on men has been consistently generalized to women (Belenky, Clinchy, Goldberger, & Tarule, 1986). It is therefore important not to generalize across all populations without certain critical understanding and respect.

We must find a different voice, a new place currently unrecognized, from which to speak about the nature of our lives together (Shotter & Logan, 1988, p. 70). Belenky et al. (1986, p.18) wrote that "a sense of voice, mind and self (are) inextricably interwoven." In other words, if women are not able to speak with their own voices, perhaps they are not able to experience their selves in the way that self is generally defined in modern psychology (Kohut, 1980). The researcher has attempted to have the voices of these women heard to seek a deeper understanding of the nature and meaning of having a BED. Qualitative research design begins with a question. The researcher initiates the questions and is as integral part of the process and outcome as the participant. The participant and researcher both affect and create the depth and richness of the interview.

Asking the Questions

There are many theories about eating disorders but little is known about causes and cures, especially about BED the most recent and least researched eating disorder. The questions in this study were designed to explore the phenomena of BED from each of the women's perspective and to allow full expression of their life experiences living

with BED. Why they developed this illness and how the mental health community may provide the most effective resources to treat this illness.

The following questions in the study focus on several considerations. The first question explores the total experience (physical, cognitive, emotional and spiritual) of an individual living with binge eating disorder. How does this illness impact their relationships? Questions such as how they believe that they came to develop this illness or what if anything had improved the symptoms of this disorder provides insights into the causes of this illness and potential cures. The final question shares these women's insights as to how others may assist those with BED to heal and how to offer encouragement to others with BED to seek help. The questions were designed to fully describe the phenomena of BED; to understand the direction of the causes and cures for BED; and to assist professionals in developing more effective programs and promote future research.

Participants in qualitative research are co-researchers and experts in the phenomenon of BED. The answers to these questions give insight into the experience of binge eating in the lives of these women and the meaning that BED has had in their lives. It may shed light on areas for future research and effective treatment and provide insights and knowledge to professionals, to the public and increase general knowledge of BED.

The questions were as follows:

1. What is your experience of binge eating disorder? How has BED affected you in your everyday life: physically, emotionally, cognitively, spiritually and in relation to family and friends? This question examined the internal and external impact of this illness in the lives of these women. How does this illness affect their every day functioning physically (health issues), their feelings, thought processes and their spiritual awareness? This question further examined the impact of binge eating disorder on their

relationships to their family, friends or significant other. This question explored what it *meant* to the participant to have a BED.

2. What do you believe led you to having this disorder? There are many theories but still no known causes or cures of eating disorders. This question helps to shed light on this disorder from experts in this area, the participants themselves. This question explores the participants' own understanding and insights into how they believe that they came to develop an eating disorder. This question examined the circumstances and influences in the lives of these women at the time they developed this disorder. This concept was further explored through asking the participants to recall their earliest food related memories.
3. Has anything ever helped to alleviate symptoms of this disorder? If so, what? This question explores the understanding of the individual women regarding effective coping strategies found beneficial in the past in alleviating pathological symptoms of binge eating disorder. This gives insights into potential treatment for binge eating disorder.
4. Is there anything you would like others to know about this illness? Eating disorders are characteristically described as secretive. These women have the opportunity to break their silence and to provide insights to other women suffering with this disorder and to professionals working with binge eating disorder population. This question serves to empower participants and completes the interview on a self-empowering and purposeful note.

Research Design

Marshall and Rossman (1995) posit that the primary data sources for qualitative research are those which include some form of interview, informal, formal, ethnographic, observation (non-participant observer or a participant observer) or any combination of methods. Interviews allow the researcher to obtain large amounts of expansive and contextual data quickly. This research used semi-structured personal interviews as an effective method for gathering data. Reinharz (1992) identifies semi-structured interviews as the primary data-collection strategy used that allows women the

opportunity to construct data about their lives. This form of data collection allows for depth and the intimacy of personal feelings.

In understanding any situation the reader can read the words of the participants being interviewed as well as the words of the interviewer. This gives the reader a wider view as well as a larger, richer set of perceptions and subsequent understanding. Interviews allow researchers to more readily access women's perceptions, feelings, ideas and memories. Bogdan and Biklen (1992) described interviews as being purposeful conversations allowing researchers to gather descriptive data in the participant's own words that develops insights into the participant's world. Leahey (1989) describes the process of collecting and analyzing data in qualitative research as an important skill:

Being able to listen and interview in depth, being able to summarize and take the whole context into consideration during interpretation, being sensitive to implicit aspects of human expression, and finally being able to create a research situation of mutual trust and understanding. (p. 2)

Interactive interviewing enabled clients to verbally describe their experiences of binge eating phenomena; for example "What is your experience of a binge eating disorder"? A consideration with interviews is the amount of data that is produced and how to code it without losing important meaning and context. Although this process is time-consuming, the results are rich, descriptive first person information (Worthen, Sanders, & Fitzpatrick, 2004).

Data Collection

The criteria for potential participants are that they be adult females and have personal experiences with binge eating disorder. The researcher approached the Tri City

Women's Resource Society in Port Coquitlam, British Columbia, a facility that runs educational groups for women with BED, in order to contact women who may participate in this study. The potential participants had attended the Women's Centre Binge Eating Group over the past 2 years. Participants were also recruited through word-of-mouth. Nine women in total volunteered to participate in this study. Seven women responded to the letters sent by the Women's Resource Centre on the researcher's behalf and two women responded through word-of-mouth. Participants were recruited on a first come, first serve basis.

The women who were interested in volunteering for the study were given written directions to contact the researcher. The women who contacted the researcher were given an overview of the research and given an opportunity to ask questions. A date, time and place for the interview were agreed upon. During the first interview participants were asked questions in the same order and interviews were audio-taped. The researcher wrote down personal observations clarifying with questions, such as "tell me more about that" and "can you give me an example".

All nine women who volunteered were interviewed. It was the researchers' perception that each story would add an important unique perspective. All of the nine women who volunteered to participate in the interview process professed to having a binge eating disorder. The women who participated in this study varied in age from mid-thirties to mid-fifties. All the women asked to be included in the study and speak about their experiences with binge eating disorder. Some of the women commented that since so little is known about this disorder that it was "about time" that someone shed more light to bear on this illness.

During the interviews, observations of verbal and non-verbal behaviour are noted by the researcher. The researcher asked participants to read the transcripts and add anything that further increases understanding of their perceptions.

Data Analysis

Data analysis is an ongoing and iterative process. In qualitative research the data is transcribed and divided into meaningful segments that are coded (using symbol, words or category names). Researchers describe qualitative methodology as inductive because the hypotheses are not established before the theory emerges from the data (Padula & Miller, 1999).

Data analysis is achieved by searching and arranging the data from transcripts, field-notes and other sources to present results in a systematic and understandable manner (Bogden & Bilken, 1992). This is accomplished through a process of organizing the data, generating categories, searching for themes and patterns, separating categories into manageable units, discovering what is important, testing the emergent hypothesis against the data, searching for alternative explanations of the data and writing a report (Marshall & Rossman, 1995). Each phase of the process requires reduction of the massive amounts of data for the purpose of interpreting or assigning meaning to the words and actions of the members of the culture or site being studied (Campbell, 1996).

"Those who are not familiar with qualitative methodology may be surprised by the sheer volume of data and the detailed level of analysis that results even when research is confined to a small number of subjects" (Myers, 2000). Researchers spend a

considerable time collecting and reviewing data. During this process the researcher must confront their own prejudices and opinions.

Subjectivity and Biases

During the process of collecting and analyzing data, a researcher needs to be particularly vigilant with respect to personal biases. Qualitative researchers believe that it is impossible to be completely free and objective from all biases. We see our world through the lens of our belief systems that are based on past family, school and life experiences. It is difficult for two people to agree on a meaning for the same external event occurring right before their eyes and even more difficult to agree on past feelings and experiences that are internal and subjective in nature.

The integrity of this research has been protected through an extensive process of self-reflection and introspection (Denzin & Lincoln, 2003). In this study, the researcher has attempted to guard against personal biases through the recording of detailed notes and through the use of an audio-recorder. The researcher kept a journal and notes on thought processes, insights and observations during interviews and while transcribing audio tapes. The key factor in writing up qualitative research can be defined as 'an interpretive craft and that the text can take a variety of forms, researchers can be liberated from some of the conventions that inhibited their creative expressions" (Bogdan & Biklen, 1992, p. 197).

The researcher listened to the audio-tapes several times noting personal insights and perceptions. The transcripts were given to the participants to change and/or make comments thereby giving them an opportunity to portray their experiences accurately as well as the opportunity to omit any potential revealing of their identity.

Theoretical orientations affects the research and the assumptions people make about what values are important and how the world works. This mode of thinking influenced qualitative methodologists to shift their focus to the nature of interpretation and the position of the qualitative researcher as an interpreter. Taking this one step further some researchers hope to empower and encourage marginalized groups to gain control over their experiences in an attempt to promote social change (Roman & Apple, 1990; Lather, 1988). It is this researcher's hope that the women in this study will experience empowerment while giving voice to their binge eating experiences.

The data collected in qualitative research is elaborate in its description of people, places and conversations. The characteristic of qualitative research is primarily viewed as an inquiry-based process focused on building a complex understanding of a social problem i.e. eating disorders (Campbell, 1996). It is often characterized by data collection in a natural setting where the researcher acts as a key instrument. Furthermore the research contains deep, detailed description and is more concerned with process than specifying outcomes.

Through a process of describing meaningful cognitive and symbolic actions the data are analyzed in an inductive process so that the theories emerge out of the data. Qualitative researchers are concerned with understanding behaviour from the perspective of the individual research subject (Bogdan & Bilken, 1998; Wildemuth, 1993).

A variety of approaches are effective in qualitative research including ethnology, phenomenology, hermeneutics, feminism, ethnographies, interviews, psychoanalysis, cultural studies, survey research and participant observation (Nelson, Treichler, & Grossberg, 1992, p. 2). The researcher attempts to capture the essence of the meaning in data by understanding how these women make sense of their

lives (Bogdan & Bilken, 1998). This is achieved through qualitative methodology of phenomenology and hermeneutics. In order to examine women's personal experiences of binge eating disorder and to gain an in-depth and meaningful understanding of this phenomena; the approach that is best suited to this research is the phenomenological-hermeneutic one that seeks to reveal and understand phenomena from the participant's perspective.

Phenomenology

The term "phenomenology" is defined as the study of all possible appearances in human experience during which considerations of "objective reality" and of purely subjective response are temporarily left out of account (Morris, 1970). The word "phenomenology" is derived from the Greek word *phainein*, meaning "to show". Hermeneutics means *interpretation* coming from the Greek root *hermeneuo*, "to interpret". Hermeneutics is essential in this study as a tool to take the phenomenological data from the women who suffer with BED and interpret it meaningfully.

According to Osborne (1990), clinical diagnosis and the interpretation of phenomenological research data demand a hermeneutically oriented approach, which requires a perceptive intelligence and a empathic knowing enabling the researcher to read between the lines (in pursuit of intuition). In the phenomenological research the participants begin with their own experience. "It is important that the women start from their own experiences" (Miller, 1986, p. 142). The researchers' own experience working with eating disordered women has created a context of empathy with women who have an eating disorder.

The characteristics of researchers in qualitative research conformed to standards described as responsive and adaptable to changing circumstances, holistic, professional, sensitive, and able for clarification and summarization (Guba & Lincoln, 1981). Each researcher brings a unique perspective to the study. The researcher's experience working with eating disordered individuals offers a deeper perspective with women who suffer from this illness. An eating disorder affects every aspect of one's life. Many women raised in North America (including the author) have fallen prey to years of dieting and worrying to achieve a "perfect weight".

One of the researcher's earliest high school memories is of befriending a young teenage girl who regularly ate her lunch in the school bathroom. The researcher later discovered that this girl's behaviour was due to her embarrassed eating in front of her classmates because of her large size. She was 14 years of age and weighed over 200 pounds. This friendship gave the researcher insights into the desperate world of yo-yo diets and disordered eating that can spiral into isolation and despair.

These perceptions and insights allow the researcher to more easily enter the world of the eating disordered woman, speak their language and lend credence to the types of questions asked. Qualitative research values subjective involvement of researchers with their participants and emphasizes the meaning that participants give to and derive from their life experiences. In this paradigm, the separation between researcher and respondent is diminished (Munhall, 1989). The qualitative paradigm aims to understand the world from the viewpoint of the participant through the richness of meaning often associated with observable behaviour (Wildemuth, 1993).

Why Phenomenology?

There are many methodologies that encompass the qualitative design such as ethnographies, case studies, grounded theories and phenomenology. Phenomenological research has much in common with other essential qualitative approaches such as hermeneutics and symbolic interactionism. Pure phenomenological research intends to begin from a premise of being free from hypotheses or preconceptions (Husserl, 1970). More recent humanist and feminist researchers refute the possibility of starting without preconceptions and emphasize the importance of making clear how interpretations and meanings develop. It also stresses the importance of making the researchers visible in the research, as co-participants, or as an active and subjective participant rather than a detached impartial observer (Plummer, 1983; Stanely & Wise, 1993).

Originally, in the 18th century, the term "phenomenology" was used to describe the theory of appearances that were fundamental to empirical knowledge. Phenomenology refers to the basic intentional structure of consciousness that one uncovers during reflection or analysis (Smith, 2003).

Phenomenology studies conscious experience as experienced from the subjective or first person point of view (Smith, 2003). This approach is appropriate for studying individuals who binge eat in order to understand the meaning that binge eating disorder has in their lives. Phenomenological inquiry requires researchers to go through a series of steps to describe the internal themes of the phenomenon and at the same time hold back their own assumptions and biases (Marshall & Rossman, 1995).

Franz Brentano's (1874) described phenomena as whatever we are conscious of; things, people or events around us, even one's own conscious experiences as one self-reflects. In 1889 Brentano used the term "phenomenology" to mean descriptive

psychology that defined and classified the various types of mental phenomena, including perception, judgment, emotion, etc. Husserl's discovery of the method of *epoché* (from the Greek Skeptics' notion of abstaining from belief) that meant practicing phenomenology by "bracketing" the question of the existence of the world that surrounds one (Bretano, 1995).

In *Being and Time* Heidegger defined phenomenology as the practice of "letting things show themselves", "to let that which shows itself be seen from itself in the very way in which it shows itself from itself." (Heidegger, 1962). This aspect overlaps with heuristic methodology where patterns emerge from the research data.

A close link between phenomenology and hermeneutics has resulted in the terms being used interchangeably. Yet, philosophical beliefs differ among phenomenologists and hermeneutic philosophers. Phenomenologists focus on the lived experience of persons eliciting commonalities and shared meanings, whereas hermeneutics refer to an interpretation of language. Hermeneutics emphasizes the process of uncovering hidden meanings as an artful form of understanding (Allen, 1995; Kisiel, 1985; Wiehl, 1990).

Merleau-Ponty (1945) looked to experimental psychology to emphasize the role of the body in human experience through analyzing the reported experience of amputees who felt sensations in a phantom limb. He focused on the "body image", how one experiences their body and the importance that this has in one's activities. There is an aspect of this observed in patients with eating disorders who view themselves as being very large when in fact they are underweight or an average weight. A criterion in the assessment of eating disordered individuals is to assess the degree of body dysmorphic perceptions. Comments such as "I feel fat" have nothing to do with actual size of a person's physical body. Even though "feeling fat" is in itself not a feeling, it can be used to describe meaningful underlying emotions (Merleau-Ponty, 1996).

The awareness of experience is a defining trait of conscious experience, the trait that gives experience a first-person, lived character. It is that lived character of experience that allows a first-person perspective on experience, and that perspective is characteristic of the methodology of phenomenology. As we attempt to interpret the phenomenological description to a greater level we assess the relevance of the context of that experience. In the application of phenomenology, we classify, describe, interpret, and analyze structures of experiences in ways that answer to one's own experience (Smith, 2003).

Phenomenology came into its own with Husserl but phenomenology has been practiced for many centuries. When Hindu and Buddhist philosophers reflected on states of consciousness through meditation, they were practicing phenomenology. When Descartes, Hume, and Kant described states of perception, thought and imagination they were practicing phenomenology. When Brentano classified varieties of mental phenomena he was practicing phenomenology. When William James appraised kinds of mental activity in the stream of consciousness he too was practicing phenomenology. And when analytic philosophers of mind addressed issues of consciousness and intentionality, they have often been practicing phenomenology. Still, the discipline of phenomenology, its roots tracing back through the centuries, came to full flower in Husserl's states of consciousness. (Smith, 2003)

Basic Steps in Phenomenology

The phenomenological approach applies to single case design or to select samples. A variety of methods may be used in phenomenological-based research for collecting data includes semi-structured interviews (as used in this study), conversations and participant observation. The general rule-of-thumb is that of minimum structure and maximum depth. The establishment of a good level of rapport and empathy is critical to gaining data that has depth of information (Lester, 1999). These goals were achieved through initial contact between the researcher and participants to answer questions and give detailed description of the interview process. The participants were given control

over the place and time of the interview to ensure the greatest level of comfort and convenience for the participants. The researcher was familiar with eating disordered individuals and held a deep level of understanding and empathy for participants with this illness. Participants were provided with the opportunity to answer research questions in great detail.

Describing is a key part of the phenomenological orientation. The individual has the opportunity to tell their own story in their own words (Daniels, 2000). The researcher used audio-tapes during the interviews to maintain accuracy of data. The researcher also encouraged complete descriptions of participants' experiences through the use of probing questions such as, "tell me more about that", "what did that mean to you", "how did that make you feel"?

Experiences are the basic data with which phenomenology works. The goal is to make the experiences of another visible and true to the subject's own way of living them. In this approach the researcher needed to continually examine and re-examine their biases and presuppositions. The researcher examined biases and presuppositions before during and after interviews and kept a journal of own impressions, observations and insights during the transcribing process (Daniels, 2000). The researcher noted the states of the participants during the interviews as well as their physical mannerisms, facial expressions, gestures and expression of emotions.

Phenomenological research generates large quantity of interview notes, tape recordings, or other records all of which have to be analysed. Qualitative data does not fall into clear cut categories and therefore needs to be organized in the form of interview transcripts, unstructured notes and/or personal texts. The first stage was to read the data and derive a sense of what was being said, identifying key themes and issues in each text. These concepts could be organized using a mind map or "post-it notes"

(Lester, 1999). A summary of the findings according to themes and topics and key issues discussed by participants are drawn out. The aim was to be faithful to the participants and be aware of one's biases. Deciding what to select, how to order it and express it is critical but the main role in this research is to describe rather than explain. Findings are reported with direct quotes to illustrate points and give deeper understanding to the reader (Lester, 1999). To be open as possible to the participant's story, the researcher needs to suspend any biases, beliefs and judgments (referred to as "bracketing"). The researcher accomplishes this through a process of awareness and self-reflection of preconceptions of biases both at the beginning and during the study (Daniels, 2000).

There are four basic steps in phenomenology:

1. Identifying the phenomenon in which the researcher is interested
2. Gathering descriptive accounts from respondents regarding their experience of the phenomenon
3. Carefully studying the participants responses with the aim of identifying any underlying similarities and patterns
4. Presentation of findings, both to the study respondents (a summary with highlights in ordinary language) and to fellow researchers (formal presentation)

(von Eckartsburg, 1998; Giorgi, 1985; Churchill, Lowery, McNally, & Rao, 1998; Wertz, 1984).

The researcher gathered data during the session through audio-tapes, visual observation and note-taking. The conversations were transcribed and analyzed for themes that emerged during interviews. In accordance with phenomenological enquiry, the researcher endeavoured to suspend biases and assumptions. In order to understand a participant's experience of BED, the researcher attempted to listen to their words with

an open mind, unobstructed by prior assumptions. The intent was to be attentive and empathic, in the spirit of the following quotation from McElroy (1990, p. 209): "Being authentic (or real) in relationship with another is at the heart of collaborative action research and is a matter of ethics."

As described earlier in this chapter, data analysis was done using Van Manen's techniques for analyzing the transcript. The transcripts were read several times keeping in mind what seemed important or revealing about the phenomenon or experience of binge eating disorder (Van Manen, 1990). The researcher then highlighted these statements and marked them in the margins. Phrases, sentences and expressions are highlighted and themes were identified. It is an exercise in thoughtful reflection as the researcher returned to the material again and again to discover new ways of seeing and understanding, writing and journaling throughout the process. Writing and re-writing are necessary aspects of the phenomenological hermeneutic method. As part of the writing and re-writing, quotations from research subjects were used in an attempt to achieve an evocative telling of their experience (Van Manen, 1990). Even though it is human nature to focus on interesting and funny quotes great care was taken to ensure that any quotes used were representative of the observed population (Worthen, Sanders, & Fitzpatrick, 2004). Theories and commonalities were found during the transcription phase as well as data analysis phase. Each answer was compared with all other answers to look for similarities or differences. Whatever the particular phrasing, the common assumption is that the individual descriptive accounts, when carefully studied and considered collectively, "reveal their own thematic meaning/organization if we, as researchers, remain open to their guidance and speaking, their disclosure, when we attend to them" (von Eckartsberg, 1998, p. 29). Several strong themes emerged from the data.

Phenomenology and Eating Disorder Research

Phenomenological-hermeneutics is a tool for the study of personal experience. Questions in phenomenology are *meaning* questions that elicit the essence of the participant's experiences. In this particular study, some of the questions are: What does it feel like to have a binge eating disorder? What does it mean to have this illness? Describe your earliest food-related experience. What did it mean to you? The attempt is made by the researcher to understand how participants construct meaning around the events in their daily lives (Goertz, 1973).

Instruments common to this methodology are in-depth reflective descriptions (using audiotapes), conversations, and written anecdotes of personal experiences, philosophical reflections, poetry or art. Two recent studies examined BED; one study used grounded theory to identify the stages of this illness; another study described the varying experiences of women with BED in counselling.

A recent study (not specifically eating disorders) found Heideggerian hermeneutical phenomenology useful when attempting to understand the world of one who is mentally ill. This interpretative phenomenological study began as a study to understand the meaning of being restrained and later became a glimpse into mental illness. For this study, 10 psychiatric patients were questioned in unstructured interviews. The taped interviews were transcribed and the results analyzed. This study examined two major themes, the question of "Why me?" and the perspective of patients struggling with being restrained (Johnson, 1998). Researchers attempted to understand the meaning of events and interactions of individuals in particular situations. They do not assume to know what things mean to the individuals that were being studied (Douglas, 1976).

As the researcher explored the experiences of women with BED, care was taken to ask the participants to define their own experiences of binge eating behaviour rather than the researchers' definition. BED is often diagnosed later in life than anorexia nervosa (commonly diagnosed in early teens or even younger). In contrast, binge eating disorder is diagnosed in the late teens or early 20s. Knowing the etiology of this illness may help to find a cure and assist in the development of preventative programmes for future generations.

The essence of the phenomenological method according to Herbert Spiegelberg (1965) is to examine experiences of the participants carefully and without theoretical prejudice; to discover the essentials of those experiences; and communicate results to others for verification. The proposed paper explored these concepts in greater detail.

Qualitative research in general is being recognized as a valuable and relevant methodology for research on eating disorders. There are many research designs that exist, as the Foundation for Change Research Department at the Center for Change, a facility dedicated to the research of eating disorders, believes that the most relevant and feasible research to use in clinical settings are experimental and quasi-experimental, correlational, survey, single-N and qualitative ones (Richards, 1997).

According to Dr. Pierre Leichner, Psychiatrist and Director of Eating Disorders Vancouver Children's Hospital (an expert in the field of eating disorders for over 25 years) there need to be more qualitative studies in the field of eating disorders.

There is a growing awareness that disordered eating is a reality that needs to be better understood and addressed. Qualitative research has been increasing in the area of eating disorders and provides valuable insights. These insights have allowed for a re-examination and re-direction of treatment approaches in the area of eating disorders. This is what I believe will eventually lead to improved treatment response and has already shown improved client satisfaction in our program. Qualitative research also provides a sound base for further quantitative approaches.

The field has suffered, in fact, from premature quantitative research in the past. (Leichner, 2003)

Qualitative based research conducted on both the Values group and Cafeteria style vs. Hospital style presentation of meals at Vancouver Children's Hospital proved to be valuable for mental health workers in further understanding this illness (Sandy, Chernecki, & Leichner, 2003).

Researchers have emphasized that professionals who treat bulimia nervosa would benefit from enhanced understanding of the binge-purge processes prominent to the disorder. Although numerous empirical studies have been conducted, researchers have yet to thoroughly understand the nature of binge-purge processes or their role in the development and maintenance of bulimia nervosa pathology.

Using a qualitative research design, Dr. Jeppson psychologist at the Center for Change, an innovative facility for patients with eating disorders conducted a study that undertook a qualitative study of the binge and purge processes in bulimia nervosa. It explored the nature and the functions of the binge and purge process of those who suffer with bulimia nervosa. He conducted semi-structured interviews with eight afflicted women and inquired about their bingeing and purging experiences.

The primary purpose of this study was to gain in-depth insight into how bulimia sufferers perceive and understand their binge and purge behaviours, including the etiological, maintenance, and therapeutic processes associated with these behaviours. It was believed that a qualitative study of participants' descriptions of the nature and functions of their binge-purge processes would enhance clinicians' understanding and empathy by giving these insights from the bulimia sufferer's point of view.

Dr. Jeppson identified four main themes in the interview transcripts. The most prominent was the participant's need for a sense of control over their personal

circumstances that they attempted to achieve by bingeing and purging. Participants often referred to their bulimic behaviour as a coping mechanism. Another theme was the participant's intense desire to be thin and their attempts to improve their self-esteem through dieting. These women regarded thinness as an important criterion for self-worth that was essential to their interpretation of beauty, desirability, personal competence and acceptance. Participants experienced bingeing and purging behaviour as fostering emotional well-being through producing pleasant feelings and preventing unpleasant feelings. Participants also commented on escaping feelings like shame, guilt, anxiety or loneliness through their behaviour (Jeppson, Richards, Hardman, & Granley, 2003).

The researcher commented that:

as practitioners ourselves, we have often found that many research studies provide little or no insight into how we can more effectively assist our clients. Good research could help inform effective psychological practice. We have gained valuable insight into women with eating disorders and how we can more effectively treat them. (Jeppson et al., 2003)

Binge eating disorder is a comparatively new area of study as compared to anorexia nervosa and bulimia nervosa that have been more extensively researched. One newer study characterized the psychological processes of recovery from binge eating disorder. The question asked was "what is the experience of recovery for women with BED?" This qualitative study used semi-structured interviews with 6 women in order to develop a model that outlined the main psychological processes in the phases of recovery. The researchers used an interpretive inquiry approach. Grounded theory was applied and deemed appropriate for use in an area that is being explored for the first time (Glaser & Strauss, 1967). Similar to phenomenology, grounded theory captures the meaning of the participants' experiences in the development of a theory (Krentz, Chew, & Arthur, 2005).

Limitations

Qualitative research is not without its challenges. It is time consuming to collect, transcribe and analyze in-depth data. The major criticism of qualitative research is that it lacks rigor and is therefore open to researcher bias. Even though all research is to some degree guided by one's paradigm and beliefs about the nature of reality and is never totally without bias, researchers need to develop a means for establishing rigor in qualitative methodology. Researchers Lincoln and Guba (1985) and Sandelowski (1986) showed how qualitative research can be made rigorous without sacrificing its relevance in concepts such as *credibility*, *fittingness (transferability)*, *auditability (dependability)*, and *confirmability* (Guba & Lincoln, 1981, 1985).

Credibility in qualitative research is to present "faithful descriptions or interpretations of a human experience that people having that experience would recognize by reading about it" (Davis, 2002, p. 30). Validity of results was ensured by the researcher taking the final interpreted data from the interviews back to the participants in order to confirm its accuracy.

The requirement of fittingness is met when the findings "fit" into contexts other than those that exist within the study situation and when the audience views the findings as meaningful and applicable in terms of their own experience (Davis, 2002). The qualitative researcher can enhance transferability by doing a thorough job of describing the research context and the assumptions that were central to the research. The person who wishes to "transfer" the results to a different context is then responsible for making the judgment of how sensible the transfer is (Trochim, 2002).

Auditability is met when another researcher can clearly follow the "decision trail" used by the investigator. In addition, another researcher could arrive at the same or

comparable but not contradictory conclusions given the researcher's data, perspective and situation (Davis, 2002). Another researcher could relate the findings to their own work with this population. The idea of dependability of findings emphasizes the need for the researcher to account for the ever-changing context within which research occurs. The research is responsible for describing the changes that occur in the setting and how these changes affected the way the researcher approached the study.

Confirmability refers to the degree to which the results could be confirmed or corroborated by others. This is the measure of neutrality in qualitative research (objectivity in quantitative research). Once the criteria of credibility, fittingness and audibility are met, confirmability has been established (Decker, 1997). In order to enhance overall confirmability, the researcher can document the procedures and continue checking and re-checking the data throughout the study. Accurate and thorough descriptions are important in ensuring that another researcher can clearly follow the decision trail.

It is important to use other sources of data such as quotations from field-notes, transcripts of interviews checking to see if data is accurate or needs correction through elaboration, listening to audio-tapes and re-reading transcriptions (Bogdan & Bilken, 1998). The researcher used quotes from field-notes that appeared to capture the essence of participant's descriptions. Transcripts were checked and re-checked for accuracy; researcher listened to audio-tapes several times and transcripts were read and re-read.

The principle of ethical behaviour is an important concept in qualitative research. This is reflected the protection of the identities of participants and the rendering of special attention when sharing sensitive information. Researchers must take care to treat participants with respect and to seek their cooperation. In this study women were

given pseudonyms to protect their identity (Campbell, 1996). During their second interviews, the participants were given the opportunity to read their transcripts and alter anything that they felt compromised their identity. They were also able to clarify what they had meant to say. The terms of the agreement to participate was made clear by the researcher in a two page consent form signed by the participants prior to the commencement of the interviews (Campbell, 1996).

Strengths of Qualitative Research

A major strength of the qualitative approach is the depth to which explorations are conducted and descriptions are written. Extensive descriptions are an important aspect of phenomenology and qualitative research and are an essential part of the research process resulting in sufficient detail for the reader to grasp the complexity of the phenomenon (Myers, 2000). Through the use of small qualitative studies, a deeper understanding of the phenomenon can be achieved and thereby increasing overall awareness and understanding to the community.

Qualitative studies focus more on the processes of how social experience is created and given meaning rather than the outcome. This requires a great deal of dedication, time and commitment on the part of the researcher. It is largely impossible to escape subjective experience for even the most experienced researchers however it is the insights and perceptions of the researcher while in the midst of the research process that directs them through moments of inspiration (Myers, 2000). The goal of the researcher in qualitative design is to better understand human experience and to seek an understanding of the processes by which people construct meaning in their lives (Bogdan & Bilken, 1998).

BED (compulsive overeating) is an area of research that requires qualitative researchers to collect meaningful data for a variety of reasons. There is significant impetus to better understand the meaning behind this disorder (30% of BED afflicted individuals are morbidly obese). Phenomenological methods are particularly effective at focussing on the experiences and perceptions of individuals from their own perspectives. Sometimes these results are found to challenge stereotypical or normative assumptions (Lester, 1999).

Phenomenological methodology tries to understand the meaning of the experiences that are being lived by the participants. Several studies that probe the same phenomenon may discover similar meanings but described them each from a unique perspective. Each study on binge eating disorder leads to new insights and different meanings in understanding this debilitating illness.

Chapter 4.

Results

1. Katherine is 38-year-old single woman. She has had an eating disorder for approximately 20 years suffering extreme weight fluctuations since her teen years. She has no children.
2. Stephanie is a 36-year-old single woman and hopes to marry when she loses weight. She is involved with self-development programs. She is employed in the counselling field. She has been struggling with binge eating disorder since her early teenage years. She has no children.
3. Tatiana is a 46-year-old single parent. She is employed full time and has one adult child who struggles with obesity. She struggled with an eating disorder since her teenage years.
4. Lilah is 44-year-old single mother. She has one teenage child. She is unemployed and struggles with health challenges.
5. Patricia is a 44-year-old married woman and with two young children. She is employed part time and has struggled with weight issues for many years.
6. Amber is a 55-year-old divorced woman. She is employed full time and has one adult child. She has struggled with eating disorders since her early teenage years.
7. Debbie is 41-year-old single woman. She spends much of her time working. She does not have any children. She has had an eating disorder even before she realized it was an eating disorder.
8. Pearl is 37-year-old married woman with adult stepchildren. She is self employed. She has had an eating disorder since 13 years of age.
9. Priscilla is 48-year-old single woman who currently resides with her boyfriend. She has no children and is working full time in the health profession. She has had an eating disorder since her early teen years.

The following results summarize the interviews with each of the women (divided into the respective questions).

Katherine's Story

Katherine's Experience of BED

Katherine presently found herself in a cycle of bingeing behaviour that varied from one month to the next. During the good months she felt more in control of her bingeing while the bad months were filled with obsessive thoughts and behaviour. She noticed her thoughts followed a pattern thinking that could be characterized as "all or nothing" "black or white thinking". Her bingeing behaviour manifested the extreme behaviours of either making poor food choices or starving during the day and bingeing at night. Her thoughts were dominated by food. "What am I going to eat? What I am not going to eat? How much did I eat today?" Katherine found that during periods of fasting she lost a great deal of weight.

She suffered from anemia, hair loss and irregular menstrual cycles. When she was not on a diet she experienced feelings of anxiety and panic for fear of gaining weight. She knew intellectually that the diets did not work but she felt helpless against an eternally optimistic attitude that "maybe this time it will work". Whether she was bingeing or restricting what she ate, her thoughts were continually filled with food. "When I am on the bingeing side, it feels like I am out-of-control." She attempted to regain control through dieting. During these cycles of bingeing and dieting she describes her thoughts as "*stinkin thinking*" because these negative thoughts keep telling her that there was something wrong with her. "When I am really in it, I tend to isolate myself. I will not answer the phone, nor make plans. I just stay by myself the whole weekend."

She experienced spirit, not as a religious experience but rather as part of a holistic perspective.

If you look at a person as a piece of pie and break it into parts, such as emotional, social and physical, then my spiritual piece would not be there at all. The eating disorder feels like there is a whole piece missing or non-existent. I worry about that sometimes and think that I gotta find something but that worry can also be part of my panic.

Katherine was not sure whether finding that piece would make a difference in her life.

Having a binge eating disorder for Katherine meant “wearing my addiction on my body.” Even though her binges occurred in private (a secret behaviour only done at home or never in front of other people) she knew that her excess weight told the world that she was overeating.

It is a private thing, no one knows what I am eating, no one knows how much. It is like having a big secret. However my body shape and size makes it apparent to everyone what I am doing.

There is further shame about the type of food she ate. “There is stuff that I eat that I would never tell anybody.” For years Katherine felt confused as to the reason why she was bingeing and why she did not have enough control and willpower to stop. “I am in a daze when I have eaten a box of donuts and I haven’t even tasted them or felt them going down.” Over the last 20 years, Katherine has experienced extreme weight gain and weight loss. During the times she gained weight her social activities were limited because of a fear. “There are lots of places I don’t want to go because I am too big or I won’t fit in.”

Katherine has lived on the west coast of Canada while her family has been on the east coast. She believed that part of her motivation for moving away from her family was a self-protective one. Katherine found it difficult to explain her disorder to her family because they only understood that she had a weight problem. “It is a private thing, a secretive thing.”

She made the decision to visit her family based on her body size. "This year I didn't go home for Christmas because I knew that I was much bigger than I was the last time I saw them all. Maybe next year I will be thinner." The fear of her family's perceived negative judgment kept her from socializing with them. She admitted that it was her own judgement that was perhaps the harshest of all.

Why Katherine Developed an Eating Disorder?

Katherine described her dieting behaviour at a young age, going to diet groups and planning the grapefruit or cabbage soup diet with her mom. "It was sort of like a bonding thing, my mom never dieted with my brothers." Her father made comments on her body shape or size. "Oh, you gained some weight" or "Your butt is getting big."

After her parents divorced and her brothers were away at university, she lived alone with her mother. When her mother began dating, Katherine felt abandoned and resentful toward the men that her mother brought home. To this day she believed that her binge eating disorder began as an attempt to comfort herself when she was a teenager. "It was more anorexic type behaviour that started at 13 years of age that moved into bingeing at 14 or 15."

She learned to cope with feelings of loneliness and neediness through eating. Food served as a form of comfort, security and safety. Her earliest memories of food began at age 13 when she started dieting and quickly lost approximately 30 pounds in one month. She received a great deal of positive feedback. It was surprising and confusing to her that no one noticed when she ate only one banana a day. "It was really odd that people didn't say "Wow! That is scary!"

What Helped Katherine Alleviate Symptoms of This Illness?

Katherine remembered a time during her early twenties when she felt out-of-control. Katherine's physician referred her to a psychiatrist who experimented with different medications. Prozac appeared to work like a miracle and caused her bingeing behaviour to stop almost entirely. It also helped her experience the feeling of balance.

A weekend workshop at university allowed her to see how bingeing was a form of self-abuse. She discovered that she felt deep emotions and concern about her father's drinking habit that she had not been consciously aware of before. "It was the first time I ever sort of labelled and identified it." She saw a counsellor who specialized in eating disorders/ body image and a nutritionist. Her counsellor challenged her and pushed her to be more consciously aware of her bingeing behaviour. When did it happen? What was she thinking and feeling before the behaviour re-appeared?

Katherine found this type of counselling helpful and supportive. She used to be confused as to what she liked to eat. "I would be standing at the grocery store and thinking, am I dieting or bingeing today? What am I going to buy?" Katherine learned that sometimes it was helpful to just sit down and have a hot meal once a day. She learned to think about what foods gave her energy and what her body needed.

Katherine began to understand the connection between what occurred at her work place and her emotions, that is, loneliness, frustration and vulnerability. The word "connected" was important to her because it was when she felt disconnected from others that she had a difficult time coping with feelings of depression. "When I am connected to my family, when I am connected emotionally to my friends, when I am connected to whatever it is. Those are better times for me." Katherine found art therapy and sport activities to assist in her healing and connecting.

What Katherine Would Like Others to Know About This Illness?

For Katherine one important obstacle was that she felt that she did not fit into the standard eating disorder programs. "Now that I have run the gamete of bulimia, anorexia, compulsive overeating, binge eating, starvation and the whole craziness that has gone on in my head over the years. Where do I fit in? I am not actively bulimic nor am I actively anorexic, so being a compulsive overeater means there is often not a spot for me."

When Katherine was asked during a mental health assessment when she first began treatment for her eating disorder she was puzzled. "It had been 20 years since my eating disorder began. I have been prescribed antidepressants, counselling and had gone to informal support groups. I don't know if I ever had a treatment program."

Katherine wanted other people suffering with this illness to know that it was a serious physical problem that resulted in weight gain. It was also a very deep emotional problem. Katherine considered her eating disorder to be an addiction.

"I had times in my life where I get that food in me and it is almost like a physical reaction. One time I was making cookies and put cookie batter in my mouth and it was (sighing) like I had a hit of a drug." When there was food in her cupboard it was almost like the food is calling to her. "Binge, binge, binge, you need to binge, you need to binge, you need to binge."

Each day Katherine vowed to herself that her bingeing behaviour would get better. Sometimes she would distract herself and call a friend but "*the voice*" was still there. This made her feel like a failure, someone without any willpower or control. It was important to her that people know that this illness it is not about willpower. It was much bigger than that.

Katherine described a situation when a co-worker brought chocolates to the office and encouraged her to have some, maybe just one? "Yeah right! Is there ever a point in my life when I could have just one chocolate? Can an alcoholic have one beer?" Recovery from food addictions is different than recovery from drug addictions. One can physically avoid alcohol and drugs but food is a necessity for survival. She wished that people could appreciate the struggle someone may have with their weight and that it was socially inappropriate to make comments about other people's bodies.

Early on in her illness Katherine explained to her doctor that she could not control what she was eating and that she was experiencing extreme sadness. The physician's comment was that children were starving in other countries and that she should eat less food. "There was no empathy, no support and I remember leaving her office feeling that there must be something wrong with me."

Assistance came from a PhD university student who had herself struggled with bulimia and encouraged Katherine to share her story with others. She discovered that even friends who had what was considered a "beautiful body" struggled with self-esteem. It helped her to realize that she was not alone with this problem. This realization was a powerful healing tool.

Stephanie's Story

Stephanie's Experience of BED

Stephanie experienced the physical aspects of this illness as excess body weight that limited her from doing the things she wanted to do. Her larger body size had practical considerations such as her having difficulty finding clothes that fit because many stores catered to smaller sizes only. Regular exercise was at best limited and

difficult because of the pain in her feet. Her excess weight contributed to her lack of energy and prevented her from going out with friends. Her isolating behaviour increased her feelings of loneliness and perpetuated the pattern of binge eating.

If someone told her that they didn't like her, or an upsetting event happened at work, she experienced emotions that she couldn't handle. This triggered a binge. "I couldn't wait to get food and binge." She believed that her bingeing behaviour prevented her from experiencing her true emotions. The immediate experience of the bingeing created a feeling of comfort and relaxation. These pleasant feelings were replaced with feelings of shame and depression after the binge

Stephanie commented that even though she was cognitively aware that she was going to binge she did not understand why she did it. At times she would plan her binges in advance.

I thought about what I was going to buy for the binge and what my cravings were for the day. I would buy many types of food in preparing myself for the binge. I would go to several different stores so I wouldn't look like a pig to the salesclerks.

At other times Stephanie found that her binges occurred spontaneously. "Sometimes it just happened. I would get home and I would get a strong feeling inside of my stomach. I didn't like that feeling so I would eat." It didn't matter what time of day or night it was, or even if she was in her pyjamas getting ready for bed. She was driven to leave her home in search of food to satisfy her feelings of anxiety. She described her binge eating behaviour as secretive and deceptive, trying to hide her illness from others. She paid for her groceries on separate bills to make it appear that she bought food for another person at work. She also went to fast food restaurants and pretended that she was buying two meals; one for herself and one for someone else.

Stephanie described herself as travelling on a spiritual path of self-growth. She felt that her bingeing behaviour prevented her from continuing further on this path.

"I would give up everything when I felt like a binge. Nothing mattered, my friends, my home or my spiritual life, nothing mattered." Stephanie's family did not notice that she had an eating disorder. They only noticed that she was overweight. They often made the comment that they wished she were thinner because then perhaps she would have a boyfriend and feel happier.

When I visit my family, my mother monitors how much food is on my plate. If I don't get a normal piece of cake, I get a sliver. I feel resentful towards them for not accepting me the way I am (tearfully). They think it is easy to lose weight, to just go on a diet.

Her bingeing behaviour prevents her from meeting new people. "I am afraid of how they will look at me. Some people have a look and they look you over and I get that "eye thing". I just want to run." Stephanie's last serious relationship was over 14 years ago when she was 21 years of age. She described this relationship as not being very healthy. She feared that anyone who got too close will learn her "secret". Her therapist recommended that she live with a roommate (instead of alone).

I used to have a roommate but I had to hide food in my bedroom because if I left it in the kitchen, they might see what I was eating. I won't move or even have a roommate for the fear that I won't be able to 'just be' even in my bingeing". I need to feel comfortable in my bingeing or it would drive me nuts!

Why Stephanie Developed an Eating Disorder?

Stephanie described her childhood as difficult. She felt that she was negatively compared to her sister, a perfect model child, pretty and thin even after giving birth. Her sister did well in school and it seemed that life in general came easier for her. Stephanie often felt left out when her mother and her sister shopped together. Stephanie shopped

at larger clothing stores. Stephanie felt that she wasn't good enough as her mother often compared her to the models in magazines. "I wish you looked like one these of models." She remembered turning to food for comfort. One of her earliest food related memories was receiving sweets as a very young child for "being cute".

As a teenager, Stephanie helped her father in his grocery store business. This gave her easy access to junk foods (i.e., chocolate and chips). Her bingeing behaviour really started to take hold in high school. On her way to school she would stock up on cookies and chips and she would eat them all before she got home. She did not want her family to know how much she was eating or that she was stealing money to get the food. "It was a crazy time, I know the things that I did but emotionally I can't figure out why I did them or what happened that made me want to do that. Something wasn't right."

When she began to fail classes and isolate herself from the outside world her family became concerned. In Grade 10 she emotionally spiralled down to the point where she attempted suicide. She began counselling with her family but that lasted only a short period of time as her father did not believe in counselling for curing one's problems.

"It was taboo to go to counselling." Her family was puzzled as to why she was depressed.

Why you are depressed? You have everything?' It was true that I had everything I wanted materially, my parents got me clothes and toys but emotionally I was just messed up. I couldn't find my way.

Stephanie described her family as having lots of secrets. An atmosphere of open conversation did not exist.

There was a lot of yelling and screaming about what was wrong with me. We never talked about sex and I couldn't tell my mother about the things that happened to me. When I was young, a boy made me do things; I was

confused and felt I was wrong. I didn't have support and I had nowhere to turn so I turned to food. I always felt different from my family members. I knew they loved me but I never felt it.

What Helped Stephanie Alleviate Symptoms of This Illness?

Stephanie felt that the main factor in lessening the symptoms of binge eating disorder was feeling supported by others. She found the strength to overcome her binge eating behaviour when she felt supported, cared for and loved. She would focus on eating smaller portions of food or trying to eat healthier foods. This was temporarily helpful but support from others was the main thing. "I get most of my encouragement from other people, hearing that I can do it, hearing that I am okay even if I don't do it."

Stephanie found that changing her behaviour, for example, not watching television, going out for walks, going to eating disorder support meetings and eating smaller amounts of food was helpful. She felt that being loved and accepted no matter what she looked like or what she did was critically important. "Where I fall short is not loving and caring about myself enough to change."

What Stephanie Would Like Others to Know About This Illness?

Stephanie wanted doctors to become better educated about eating disorders.

"I had gone to doctors all my life and they didn't understand. They gave me pills for depression and said it would help with my eating as well." Stephanie wondered why eating disorders like anorexia and bulimia were more recognized and treated than binge eating disorder. People understood alcoholism but did not understand that overeating was a disorder as well. She wished that people understood that eating disorders are addictions similar to alcoholism. She advised other women suffering with this illness to find any kind of support at all (group support, friend support).

Emotional support was critical as was physical support such as a walking partner or sharing healthy recipes. Stephanie suggested getting together for a walk or tea with a group of girlfriends. "When I isolated I start thinking about crazy stuff like suicide." When she picked up the phone, went out and connected with someone she felt better.

Stephanie complained that there were no resources or treatment Centres in her city or province (Vancouver or British Columbia) for binge eating disorder.

There is tons of help for alcoholism and drugs, anorexia and bulimia but you don't see anything for binge eating and overeating that isn't going on a diet. That is sad because we are looked upon as it not being a disorder but as something that you should be able to change, rather than an emotional issue. I am always being told to just stop eating.

Stephanie commented that the understanding of BED needed serious attention for health professionals due to the long-term health implications of diabetes and other illnesses that are exacerbated by excess body weight.

Tatiana's Story

Tatiana's Experience of BED

Tatiana described her experience of binge eating as a love/hate relationship. "I feel comforted, satisfied and nurtured when I have eaten but at the same time I feel self-loathing and hatred because I have eaten. It is a lose-lose situation." Tatiana believed that she used bingeing behaviour as an escape from life, a way to calm herself down or to numb herself out. "I think my biggest problem is that I am lonely and I use food as a security blanket." She identified the feelings that made her binge eat as those of anger, hurt and fear.

Tatiana described her behaviour as a vicious cycle. The more she tried to stop binge eating, the more she binged and thus the more she berated herself. "This behaviour caused me a great deal of self-loathing because I did not have any control over it. It seemed that the more I wanted to stop eating the more I ate." A binge was brought on by variety of situations. "If I was upset about something or had a bad day I would come home and turn on the television and binge."

The consequence of overeating was excessive weight gain. This increase in weight kept her separate from the rest of society and she used it as a reason to not connect with others. "I feel that I am not the same as everybody else out there and I don't have any value or anything to offer other people." Many social activities involving food left Tatiana feeling more and more isolated.

I put up a wall between me and life and it prevented me from having relationships. I don't want to go out there and have people see me eating. It is the whole shame thing.

She felt that this illness was shame based. She felt that other people were watching and judging her and that this validated the shame within her. "You have a right to be ashamed of yourself you know because look at you can't keep control of whatever you are doing to your self."

Now in her forties, Tatiana felt that she doesn't care as much about her binge eating behaviour, partly due to her maturing and also due to feelings of frustration and resignation.

I don't want to fight it and I don't know how to fight. I have tried so many different things in my life to try and fight it and make it go away but most of time it has just made it worse.

Tatiana described her spiritual beliefs as Christian. Her experience of BED was affected by her beliefs that gluttony was one of the seven deadly sins. This compounded her feelings of guilt and self-loathing.

Her family did not have close relationships. She described her mother as someone with a fragile disposition who had spent time hospitalized for nervous disorders. Her father had anger issues and would often exhibit aloof behaviour, that is, withdraw from the family.

She was the only member of her family to reside on the west coast. The rest of her family lived in Ontario. Her parents were married for over four decades and her brother left home for military duty when she was still quite young. Tatiana, a single mother raised her son (now as an adult) on her own. She feared that her own food and body image struggles impacted her son as he began to use food as coping mechanism. He now suffers from obesity. This realization compounded her feeling of guilt. "Not only have I screwed myself up but now I also screwed up my child."

Why Tatiana Developed an Eating Disorder?

When Tatiana was five years of age she was considered to be a normal sized child. At nine years of age she began to gain weight. In her European family environment dinners of rich foods and pastries were customary. Everyone was encouraged to eat and it was considered rude and offensive to turn down food.

By the age of 12 years Tatiana had developed the habit of hiding food in her room. She hid the junk food wrappers in her bedroom closet until it was safe to dispose of them. One afternoon her father had accidentally opened her closet door and found her wrappers of empty chip and chocolate bags. This experience left Tatiana filled with embarrassment and shame. Her father insisted that her mother take her to the doctor

and put her on strong diet pills. It was at this point that Tatiana stopped eating and began over-exercising. This was the beginning of her constant struggle with losing and gaining weight. "Over the years I have probably lost and gained about 700 or 800 pounds."

In her attempts to lose weight Tatiana began dieting and suddenly lost 40 pounds resulting in unpleasant consequences, that is, fainting. The disorder had overwhelmed her and left her feeling confused as to why she could not control her weight.

I used to be a drug addict and I quit doing drugs. I used to smoke cigarettes and I quit smoking cigarettes. I was \$50,000 in debt and I am now self-sufficient. I consider myself a perfectionist and I accomplish whatever I set my mind out to do." Why couldn't she overcome this illness? "It was disappointing for me to walk into my house every night after work. This was not what I wanted my life to be, nor what I ever expected it to be.

This illness prevented her from becoming the person she wanted to be.

Tatiana saw her weight gain as a failure because she could not keep the promise to herself to lose weight no matter how hard she tried.

The one thing that I have failed in time and time again is the weight issue. It was disheartening to realize that I am not worthy to keep my own promises. It has gotten to the point where I just don't care whether I live anymore. I just exist now. Oh well, I have got my cat and he loves me and we will just sit here and I will pacify myself by sticking something into my mouth.

The answer for Tatiana was to accept her disorder and not fight it. Accepting yourself was a form of loving yourself. "You have to learn to love yourself and you can't love yourself when you are constantly putting yourself down."

Tatiana noticed that she became anxious if she did not have her favourite foods accessible to her at all times. She was also very particular about the types of foods she bought and their cost. They had to be high quality items that were reasonably priced.

She understood (through sessions with her psychiatrist) that her earliest connection to food was one of pleasure and the early mother-child bond. These pleasant feelings were accessible to her only through food because her parents had been emotionally distant.

"I have had an addictive personality since I was a child and the addict in me needed to find some place to call home. It went back to where it all started in the food."

Tatiana spoke about her male relationships being destructive to her health. When she lost weight she felt vulnerable to the opposite sex. It had been almost 14 years since she has dated. She described her partners as emotionally unavailable (similar to her father). One man was an alcoholic; another suffered from manic depression. She felt betrayed by their behaviour (cheating or stealing). These betrayals left her mistrustful of her ability to make good choices in men.

What Helped Tatiana Alleviate Symptoms of This Illness?

Tatiana believed that a lifestyle change was necessary to overcome the binge eating disorder and thus lose weight. Ten years ago she chose to have obesity surgery that removed a portion of her bowel and re-routed directly to her stomach (considered a more intensive surgery than stomach-stapling). The results were successful and she lost weight rapidly. The surgery was successful in changing her physical body but the mental and emotional aspects of the illness remained.

When the binge eating behaviour re-surfaced she suffered from the physical consequences of eating the wrong foods. She watched in frustration as her weight increased to as high as before the surgery. "I wish there was a magic answer to put the demon to rest. There was a need for me to self-medicate with food." During the next few years a battlefield of losing and gaining weight ensued as she tried to adjust to the physical limitations of the surgery.

I sort of built bingeing into my life. I knew exactly how far it was to any bathroom and as time went on it became easier for me to be able to hide it until I could get from one place to another. I lost the same 20 to 30 pounds at least seven or eight times. I did more damage to myself as I tried to battle against what my body or mind seemed to want.

Tatiana remembered a time when she did not turn to food for comfort. She had decided to go back to university when her plans fell apart and she was able to cope without bingeing. She attributed this change in her behaviour because of living with a friend. This friend had created a structured environment of healthy foods and exercise.

When I had a friend that I had to be accountable to, I was able to lose 95 pounds, just by being consciously aware of what I was putting in my mouth and exercising every day. I really don't know what was different about that time, maybe there was hope surrounding it.

At that time her binge eating symptoms dissipated, she was hopeful that she could go back to school and do something exciting with her life. Perhaps the positive hopefulness of something wonderful happening in her future motivated her not to binge. She described her inner experience of two people inside of her; one was a logical intelligent person who knew what she was doing and the other was a rebellious child. "You know that I am going to do what I want anyways. You are not going to stop me."

Tatiana had tried various tools to help her recover. She journalled her activities; attended Overeater's Anonymous; attended drug and alcohol counselling. After a period of absence she returned with her son to Overeater's Anonymous.

I saw a lot of the same people there. And they all looked exactly the same way as they looked before. There was no great change. It was like nobody really beats it. That was a big revelation to me! It was not a matter of beating it or making it go away, it was a part of who you were and you had to accept it and try to live in balance with it rather than constantly struggling against it.

What Tatiana Would Like Others to Know About This Illness?

Tatiana wanted other people to know that this illness was something to neither be ashamed of nor hate oneself for. Rather it was a way that someone had chosen to cope with their life.

Don't let the eating disorder define you. When you think about the other things that are out there that you could choose, other than food, it is a kinder and gentler way to placate yourself.

Tatiana believed that it was the very process of fighting against this illness and failing that ensured this illness had more power in one's life. "This illness waits for a foothold to grab you and bring you down." Tatiana believed that in order for individuals to heal they needed to discover the payoff for this illness in their lives. Once the payoff is acknowledged, the binge eating power struggle between right and wrong is replaced with greater understanding and acceptance.

Tatiana believed that professionals need to focus on the brain in search of a cure not stomach-stapling or bowel bypass surgery. When someone powerful like Oprah lost weight many people believed that there was hope for them as well. "Damn girl, you finally figured out what it was and you have come to terms with that demon that has been feeding the dragon." It was disappointing for Tatiana to see that even Oprah with unlimited resources at her disposal gained back the weight. "It was a lose-lose situation. I don't know why she couldn't overcome it."

Tatiana did notice some improvements in her binge eating behaviour over time.

I used to have a big bowl of ice cream followed by chips and then chocolate and I would have to eat and eat and eat until I felt really sick. Sometimes lately I can have a piece of cake and be satisfied. I don't feel I have to eat the whole thing.

She used to believe that if someone loved her enough to help her that she could be successful.

But love fails or fades and you cannot rely on someone else to change you. So I try to be kinder and gentler with myself and acknowledge that this is where I am right now.

She wanted others to understand that even when she lost 95 pounds and able to wear a size 8 dress, she was still unhappy.

When I lost the weight and stood naked in front of mirror I looked at myself and realized that I hated myself just as much as when I was fat. I picked my whole body apart; my breasts are too saggy, my back was still as humped; the fat still hung between my thighs; the bulging stomach; the knock-knees. What was the point? I used to think that if could lose the weight my life would be perfect. It wasn't.

Lilah's Story

Lilah's Experience of BED

Lilah's physical experience of binge eating disorder was high blood pressure, high cholesterol and excess weight. She felt physically uncomfortable. "Either because I was feeling fat or just feeling like I didn't fit in." Psychologically she suffered with low self-esteem and isolated her self from other people. "I have suffered from depression most of my life and I am sure the eating disorder when it is out-of-control contributed to it."

Her cognitive experience of binge eating was to obsess about food. She would pace back and forth between the fridge and cupboard thinking about what to eat. She would often take food to bed. During the day her thoughts were centered on what she would eat when she got home. A bad day meant that she binged excessively. She could

consume an entire can of icing. "I have on occasion binged myself to the point where, (pause) I don't make myself throw up but it is just way too much food."

The closest spiritual experience she remembered was attending Alcoholics Anonymous. She did not believe that she was a religious person. She believed both in science as well as having intuition.

I knew the exact moment when my grandfather died and his uncle died. I seem to know these things, it is kind of creepy. I once dreamt of this whole car accident and it really happened.

Her family did not understand her struggle with food. Her grandmother was a naturally athletic woman, even in her 90's, she wanted to put everyone who needed to lose weight on a diet. Her father and brother also focused on her body and made comments to Lilah. "Oh when you were slim you were hot; all the girls say that if they were as pretty as you they wouldn't be fat." Her sister, a dietician, was also very weight conscious. "My sister tended to throw shame about my weight with comments like I would never let myself get like that." Lilah was secretly happy when her sister went through a period of weight gain.

Lilah described her mother, sister and grandmother as three peas in a pod.

"I just never really fit in". Her sister was the good little daughter and her brother played hockey and took wilderness hikes with their father. "I have the fat gene, perhaps from my grandfather who was a large man. I just don't fit in and I guess I felt that food was my only comfort." One of her earliest food related memories was having a special place during meals to sit beside her father at the dining room table.

My sister sat beside mommy and I got to sit beside Daddy. I liked sitting beside Dad but later on found out that the reason I sat there was because when someone was left handed they were put in a certain spot so you wouldn't bother other people with your elbow when you were cutting food.

Lilah believed that binge eating was a bigger problem in our society than anyone wanted to admit. Lilah felt that although women's liberation had positive impact for women's opportunities in the work force, it also created additional stress for women in the form of higher expectations.

Why Lilah Developed an Eating Disorder?

Lilah believed that her binge eating stemmed from a sense of not fitting-in with both family and friends. Her mother did not role model socialization for her children as she herself did not have friends. Lilah found herself thinking about food when she felt uncomfortable in any social situation. She believed that men did not understand the changes that occurred in a female body as they aged and after they had children.

Lilah chose to have stomach-stapling surgery to assist her in losing weight. She did lose weight. Eventually, as the bingeing behaviour returned, she learned to modify her binges and the physical limitations of the surgery. Later she decided to undergo plastic surgery to improve her body shape in hopes of improving her self-esteem and feeling more confident in her body. She hoped that this would assist her in feeling more comfortable in intimate relationships. She is taking prescribed diet pills to lose the weight required for surgery.

What Helped Lilah Alleviate Symptoms of This Illness?

Lilah noticed a pattern between feeling good and reduced bingeing behaviour. When she felt that she fit in with people, she felt more comfortable and less stressed. When she was not feeling good about herself she focused on food and binge eating that spiralled into depression.

She began exercising regularly with the support of counselling and a binge eating support group. She believed that support groups were helpful in educating people about eating disorders. Binge eating disorders were not about food.

People don't know that it is about how you are feeling inside your head and inside your body and how you are feeling about how you fit into social circles and society in general.

What Lilah Would Like Others to Know About This Illness?

Lilah wanted other women to encourage social service agencies to provide greater support. She felt that this problem would get worse over the next 20 years for both men and women. Professionals needed more education to feel comfortable talking about it. Even her own doctor who felt comfortable enough to put her on the fat flusher pill did not like to discuss her binge eating behaviour. "Women need to be able to go to their doctors and say, Hey, I am sitting in front of my fridge all day long."

She believed that men need to be educated about the women in their lives who have this illness, whether it was their children, wives or sisters. She also believed that greater community awareness would benefit the development of eating disorder programs. This in turn would minimize the feelings of isolation among women with BED.

Patricia's Story

Patricia's Experience of BED

Patricia described her experience of binge eating disorder as a gradual process that began in her late teens. Her bingeing behaviour escalated during a stressful marriage and after the birth of her second son. Her physical experience of excess weight gain created physical limitations. She could not be actively involved in her

children's lives (sports). Her obesity limited her ability to go camping and boating. "It was hard to bend over and do up my shoes, it caused a constant pain and took away the simple joys of life."

Patricia suffers with Type 1 diabetes and sleep apnea. "It scared me because I have no control; a complete numbness like I zone out." She was plagued with negative feelings of self-disgust and failure. "I become disappointed with myself because I should know better and make better choices; sometimes I don't realize that I am bingeing until after the fact."

She described her spiritual experience with binge eating as having broken her spirit. "My spirit was attacked. I struggled every day in how to get it back. I always loved my spirit and my ability to connect with others. I grieved that loss." She learned that feelings of sadness and pain triggered her binge eating disorder behaviour.

Patricia was one of five children and the only one in the family who suffered with a binge eating disorder. She did not feel attractive and compared herself with her sisters who were thin. She made excuses not to attend family functions and was often told to go on a diet. "When it came to my family, I often felt alone, abandoned and not good enough. I felt that I did not fit into my family dynamics." She felt more support from her friends. She believed that her friends judged her heart first and then her physical body.

Her parents lived in the Depression Era when food was regarded both as a source of celebration and something to be hoarded or not wasted. Food was to be valued and appreciated but not necessarily enjoyed.

If there was something you didn't like to eat you would sit at the table between 10 minutes to 4 hours after the rest of the family had finished. I spent many a night sitting for 4 hours. It was a real battle of the wills. It was really more about power than waste.

Difficult emotions around family events triggered a binge afterwards. "I will do anything to avoid an outing where the whole family is there because it is too much, that is why Christmas always makes me a nervous wreck."

Why Patricia Developed BED

Patricia felt neglected at a young age. She believed that her illness started because of a lack of outward expression of love from her family. She could not recall her mother and father showing her love and affection either verbally or physically. She believed that her early experiences with food were associated with her inability as a child to get the care and nurturing that she needed. Through counselling and education she understood that eating disorders were based on emotions. "An eating disorder is the result of someone who is broken; emotionally, physically, spiritually and mentally."

Patricia was sexually abused from the age of 13 to 16 years of age. Her Catholic upbringing increased her feelings of shame and guilt around her abuse. In her early twenties she entered into a relationship that resulted in a miscarriage and a betrayal of her love. She believed that had she worked harder to appear more attractive she would be more worthy of being loved.

She married out of a fear that this would be her "last chance". In her decision to marry she dismissed values that were important to her. "The physical touch, the closeness, the communication of sharing feelings, hopes and desires." Patricia believed these things were meant for skinny, smart and beautiful people. "I realized that all these things I dismissed and pretended that I could survive without were things I needed."

Her earliest food related memories were of being told to eat everything on her plate during family meals. She was a chubby child who enjoyed food but did not recall feeling obsessed with it. Her parents had a traditional marriage for 45 years. Her mother

stayed home with the children and her father worked to put food on the table. She remembered longing for certain foods that were considered a treat (i.e., coke and food that were only served at certain times of the year).

When she was 13 she developed diabetes. Patricia remembered waking up Easter morning to find chocolate for all her siblings but not for her. It saddened her that her mother never took a personal interest in her special needs (even though the Diabetes Association sold chocolate Easter eggs (without sugar but more expensive). "When I didn't get any chocolates I felt like I wasn't worth it. As a mother myself I would re-mortgage my home to get those eggs for my children."

As a married woman and mother she chose to stay home and care for her children. She began to feel overwhelmed and unappreciated. "I heard comments such as how stupid I was or can't I even make something simple like dinner." She felt inadequate as a wife and mother. She served her family healthy meals and bought junk food for herself. "It was all about this incredible need to fulfill something within."

Patricia believed that women were by nature more sensitive, nurturing and caring compared to men. It was female hormones and bodily changes that brought women's emotions to the forefront of her experience. Patricia questioned the way people sought love and acceptance. "How do we achieve this acceptance? Is it by weighing 125 pounds and looking good in a bikini?" This struggle to find love and acceptance left Patricia hiding behind her eating disorder. "I fear that if people knew who I really was they would reject me and be repulsed. With an eating disorder I wear a mask everyday."

What Helped Patricia Alleviate Symptoms of This Illness?

Patricia's symptoms diminished when she was employed outside of the home. She believed it was because she contributed to society and felt appreciated by her co-

workers and employer. When she saw a difference she made in her children's lives she felt valuable and worthy. Through counselling and eating disorder support groups she found a basis for understanding that she was worthy of being loved and that her healing was a lifelong journey. She felt lucky to have found an eating disorder support group.

It is one of the hardest things I have done in my life, but there is the connection with people who relate to each other through stories of their successes and failures. It is this connection that draws me back. I am very lucky to have it. I would not want to be without it.

What Patricia Would Like Others to Know About This Illness?

Patricia would like other women to know that this illness has nothing to do with food and everything to do with what is happening inside of them. She wanted people to know that those who suffer with BED are still human beings with feelings and that they are worthy of respect. She asked people to be kind to this vulnerable population so as not to break and destroy their spirit.

She wished that there was greater understanding and education in this area of study. Patricia cautioned professionals not to treat the binge eating disorder problem lightly. "Oh just lose weight and you will be fine."

It was a long struggle to find effective counselling. Patricia believed that healing a broken spirit came from the love, compassion and caring of others.

There is not enough said about binge eating disorder; not enough support and not enough compassion. That is what people need the most in order to get their life back.

Patricia dreamed of her recovery.

When I can be free to be me and I don't feel judged and I can give of myself without having to hide. When there is not a part of me to abuse and punish me and there is no longer a feeling of anger.

Amber's Story

Amber's Experience of BED

Amber described her experience of binge eating disorder as having caused her physical discomfort and pain. She walked with a cane as she suffered pain in both her back and legs. Amber has diabetes, arthritis, heart irregularities and is at high risk for stroke and cancer. "Sugars and sweets are bad for me yet I am unable to stop eating them. I know I am putting my life at risk." She takes nine medications per day. She has trouble sleeping and sometimes sleeps sitting upright. "Everything keeps coming up into my throat." Her future health is precarious. "I need a hiatus hernia surgery; gallstones surgery; artificial hip and knee surgery." All of these surgeries had been put on hold until she loses weight. At 300 pounds she is at high risk for complications. "That just fed into my feelings of worthlessness."

Her binge eating behaviour increased feelings of guilt and hopelessness and ultimately depression. She dreamt of how much healthier and happier she would feel if she were thinner. These thoughts were inspiring and motivating but only temporarily. Emotionally charged situations, feelings of anger or not standing up for herself resulted in a loss of her motivation. This triggered the cycle of binge eating behaviour. This behaviour was followed by feelings of shame and self-abuse that spiralled into further depression.

In the beginning, Amber experienced her binges as a blackout. She had no recognition or memory of the reasons why the binges occurred. After time she developed some insight and understanding that feelings of anxiety, loneliness, sadness

and boredom triggered her binges. She described her binge eating behaviour as gorging food all at once and at other times as eating slowly but unable to stop.

She found her behaviour of eating in bed and in front of the television were a pattern that both comforted her and depressed her.

Sometimes it felt satisfying and other times I felt sick. I put myself down for not having the discipline to stop but nothing had worked. My weight has remained consistent at 300 pounds for the last 10 years.

From her perspective the root of her problem was that she did not have a sense of herself.

Amber believed more women suffer from eating disorders than men because women are treated differently. "Girls in my family were treated as a second class persons compared to males in my family." The girls were valued for cooking, cleaning and having children.

It was impressed upon me that sending a girl to university was a waste of time. Women were raised in the capacity of a caregiver, looking after children, husbands and parents. There was very little time to look after your self.

She believes that women turn to food for comfort because they have greater physical access to food. They are often the cooks in the family, (males may gravitate more towards alcohol). "It was a drug of choice."

Why Amber Developed an Eating Disorder?

Amber felt that since she was a young child her opinions and wishes were not valued or respected by her parents. She was a chubby girl (10 pounds overweight) being constantly teased by her siblings and other children at school. Her binge eating behaviour began in her late teens. At 13 years of age she was molested. She believed

that this lead to her emotional issues around sexuality. "Secrets have always been a big part of my life."

She spoke with sadness and anger about her abortions.

I don't ever think that it is an easy choice. There are far too many people with regrets around it. If I had been a much stronger person, a more powerful person, a more together person, I certainly would not have done it a second time. It was my mother's wrath that I couldn't contend with, that I couldn't handle. I spent my whole life trying to get her approval.

At 18 years of age she married and became pregnant with her first child. Her husband rejected her sexually when she gained weight. During her second pregnancy, six months after the birth of her first child, her weight increased to 200 pounds. She constantly worried about money and not having enough food. After her second child was born she started part time work at McDonald's restaurant. She was told by her employer to lose weight or she would be fired. She joined a diet program, TOPS and lost 55 pounds in six months. She eventually left her husband and kept the weight off for 2 years.

She later married her second husband. "I knew that I shouldn't have married him and didn't know how to get out of it? All I kept thinking was what would my mother think?" This man was abusive to both herself and her sons. She gained over 100 pounds.

She believed that he sabotaged her attempts to lose weight fearing that she would leave him if she were thin. She left this marriage fearing for her safety and that of her children.

After her second marriage ended she lost weight and began dating again. She made decisions that later she regretted. "I was not emotionally set up for the bad choices that I made." She didn't like the way men treated her and felt that it was during this time

that she started bingeing again. "I built a wall around me so thick and deep that nobody would be attracted to me. I didn't have to worry about men raping me or sleeping with me and dumping me. But in the process I made myself sick and put my life in danger."

What Helped Amber Alleviate Symptoms of This Illness?

Amber felt that binge eating support groups helped her develop a deeper understand about BED. It gave her the opportunity to speak with other women who had a similar illness. "When I heard their stories, I knew exactly what they were talking about and my heart breaks for them." She received counselling through UBC psychology program that was helpful. She found one therapeutic technique that was particularly useful (projecting an imaginary person into the empty chair). "That exercise was the hardest thing I had ever done. It was so powerful." She developed a better understanding of her relationship with her mother. Her family was ineffective in expressing thoughts and emotions. "We just don't know how to communicate very well. I knew my mom loved me but she didn't know how to say it or show it."

She sought healing both in a spiritual church and through sessions with spiritual mediums who spoke to her about her children. "All this baggage and it all led back to food, the food is the comfort, the friend, the lover you don't have. It is your worst enemy."

She had one experience recently when she did not binge.

That was the one and only time in my life that I can remember actually clicking in enough with the intellectual, emotional and mental to realize that this was not going to solve the problem, it was amazing.

What Amber Would Like Others to Know About This Illness?

Amber wished other women could find a binge eating support group like she had. She felt that the general public needed to be educated about compulsive overeating. It

was not the same as anorexia or bulimia. There were more similarities between these illnesses than differences. "There are so many people in the medical community that don't get eating disorders."

She believed there was more compassion from the general public towards people who were underweight than those who are obese. "A huge part of me hangs onto the eating disorder. It is almost like I am more afraid to be thin than I am to be fat." Her greatest concern was for the children in our communities who struggled with weight issues.

As a child I was 10 or 15 pounds overweight, but there are children today who are 60 pounds overweight. What is that doing to them physically, emotionally and mentally?

Debbie's Story

Debbie's Experience of BED

At first Debbie did not realize that she had an eating disorder, she only knew that she really enjoyed food. She believed that weight issues were purely "mind over matter", a matter of willpower. "I am just lazy, that is why I am not having any success and why I can't stop eating." When Debbie turned 30 years of age she realized that she had an addiction to food. Her doctors only repeated the prevalent message, go on a diet, eat less and exercise. She felt that no one understood her. She tried to explain her binge eating in relation to other addictions. "If I was addicted to anything other than food, like alcohol, drugs, smoking, sex or pornography, then I would get help." Debbie felt frustrated when she tried to explain this illness to others. "If I had anorexia or bulimia there would be a line up of people there to help and support me. It was very frustrating

and it made me mad." Debbie habitually kept little food in her home as it was easier for her to not eat rather than eat properly.

Her experiences with binge eating varied from extreme dieting to bingeing. At 24 years of age she stopped eating food for 3 months (except for clear broth). She lost over 100 pounds. This was not a healthy way to live and she eventually gained back all the weight and more. When a friend suffered a heart attack she was motivated to join a gym. Once again she lost close to 100 pounds. The reaction of other people to her weight loss made her feel uncomfortable. "The more attention people paid to me, the less successful I was and I gained back most of the weight." She asked the gym staff (who celebrated their client's weight loss by putting their names on the wall) to remove her name from the wall. It created unwanted attention on her weight losses and gains. "This is a disorder. It is not a matter of dieting. I can't stop eating and when I do I am in a panic mode." She eventually gained back most of the weight she lost but still managed to continue exercising. She attributed her persistence in exercising with her current physical wellness (low cholesterol and no diabetes).

She was motivated and inspired to lose weight when she remembered fitting into smaller sized clothes, but these memories were not enough to keep her motivated. She understood that not all individuals with binge eating disorder were overweight.

I have been over eating as long as I can remember. I was always a chubby kid. I am disheartened because I don't really understand why I have this illness? Maybe I am not good enough?

As previously mentioned, Debbie experienced relatively good physical health (normal cholesterol and blood pressure level). Her negative experiences of binge eating disorder were weight related and evident in social situations.

I had people yell at me from passing cars, I had things thrown at me, I have been spit on, sworn at, given rude hand gestures and had people in the grocery store gasp at me like I was a monster.

This disorder was a double-edged sword. It offered her protection from social situations and relationships yet it also caused her pain and physical ailments. "Food is a comfort to me, it is a friend, some people curl up with a favourite "blankie" but I curl up with a bucket of KFC."

Debbie described a usual day as waking up in the morning and making the decision that she would not eat anything that day. It felt good to hear her stomach rumbling. After work, alone in her car, she began to feel out-of-control. She planned her route home. "I tell myself that this is the last time I will do this, this is my last meal, my last binge. I will actually plan it." Her plan consisted of a trip to MacDonald's for fries, burgers from Burger King, onion rings from the Dairy Queen etc. including all the various foods she liked best. At times she pretended that the food she bought was for her friends as well. Every day she tricked herself into thinking that this would be the last day, the last binge. But it wasn't.

During her binge she identified a variety of emotions that included anger, discouragement, aggravation, embarrassed, shame, disgusted, confused and disappointment. During the times she felt in control of her binge eating behaviour she experienced happiness. "I am 10-feet off the ground because I am in control."

Debbie described herself as a good person who cared about others, worked hard, contributed to society and always followed the rules. "I have never even so much as gotten a parking ticket. I am a goody two shoes, so why am I burdened with this stupid disease?" Debbie believed that this illness was a public disease because it couldn't be kept a secret. "It is inhibiting because it affects the way I look."

Her behaviour became more isolative. "I don't participate and I don't go out in public, no walks because I know unpleasant things are going to happen." She wondered whether her brother, family and friends were ashamed of her. She believed that men also suffered from binge eating disorder but the public was more forgiving of overweight men than women.

She had some *real* friends who did not appear to notice whenever she lost or gained weight. Even though she felt comfortable eating in front of them, she would never buy "binge foods" in front of them. "I would never order the family size bucket of KFC in front of a friend."

Why Debbie Developed an Eating Disorder?

Debbie was raised in a family where she described her father as strict and "dinner-time was punctual". Her mother was an excellent cook and large meals were customary. Everyone was expected to eat everything on their plate and not "waste food". Meal-time with the family was usually tense and uncomfortable. Usually there was a fight either because someone had not finished their food or a plate was thrown across the room in anger. Meal-time was the only time her family spent together. "I remember sitting there and thinking, Okay, just get this over with, eat your food, behave and just get out of there."

Every Sunday after dinner her father took her and her mother to MacDonald's for more food. Debbie often wondered why her male cousin and brother were never expected to go, and if they did they were given a choice as to whether to eat or not. In order to please her father Debbie would do as he wished.

I remember my dad asking me what I wanted and I said nothing; I felt that had to have something so I ordered a coke; that was not good enough for my dad so I ordered a milkshake; at least I didn't have to eat a burger.

Debbie often went home feeling sick to her stomach. She never understood why only she and her mother had to eat so much. Some family members believed her father wanted to control her mother and keep his little girl at home forever. "My father was trying to plump us up."

There was not a specific emotion that triggered a binge. "If I am angry because I had a hard day, I deserve a treat that turned into a binge. If this was the best day of my life; I am planning a binge." It appeared that any intense emotion, whether it was good or bad triggered a binge. Perhaps it was the intensity of the emotion that triggered the binge rather than the type of emotion.

What Helped Debbie Alleviate Symptoms of This Illness?

Debbie did not binge during a time that her mother was away taking care of her brother and her father moved out of the family home to live with his girlfriend. For the next few years she was involved in her job working up to "16- to 18-hour days". It was a revelation for Debbie during the interview to realize that her bingeing pattern started again when she returned to a 40-hour week. "This is a conundrum, because then what do you do? Is it better to work yourself to death or eat yourself to death?" Debbie believed that in order to minimize bingeing episodes she needed to keep busy.

If I can keep myself occupied until about 8 pm, then I pass that critical zone. I have had days where I had intentionally gone to the wool shop. What I really want to do is go home and relax but I couldn't because relaxing for me would end up in a binge. I couldn't go home.

What Debbie Would Like Others to Know About This Illness?

Debbie wanted the general public to be aware and educated about BED. It is a legitimate disorder just like anorexia or bulimia and just as dangerous. She felt that the media needed to take this disorder seriously.

I have seen lots of shows on obesity, how our nation is getting fat; our children are getting fat; but the media portrays this as laziness not as an eating disorder. This has to change.

She believed that physicians today, as compassionate as they are, they don't fully understand BED.

It really needs to be stressed that people are not bingeing on purpose. It is an addiction that is just as hard to break, as cigarettes or alcohol, even harder because you can't avoid food.

In her search for treatment, she found recovery Centres for anorexics or bulimics but nothing for binge eaters. The closest program to assisting BED sufferers was "Overeaters Anonymous" although their focus was on dieting. "It shouldn't be this hard to find help for a legitimate problem, a disease, people just don't get it; they just don't get it."

Debbie believed that other women with this disorder need to talk about it even if others don't understand.

Find someone you trust, a friend, or relative or doctor even a stranger. Just talk about it. Recognize that you are not the only one out there that is doing it; when you tell someone about it, it legitimizes it. It was when you began talking about it that you understand that it was not about you rather it was the disease.

She believed that women with BED spent most of their life thinking that they over-ate and did not suspect an eating disorder. Debbie realized that she was not a lazy stupid person and that this illness was bigger than her.

To recognize the difference between, "I like to eat" and "I can't stop eating". I still don't know the answers but I understand now that I can't stop. Understanding that it was an addiction was the biggest help to me.

Pearl's Story

Pearl's Experience of BED

Pearl believed that her eating disorder was a coping mechanism. She believed that compared to other addictions (sex, alcohol or drugs) an eating disorder was one of the better ones. She recalled experiencing her first symptom of this disorder when she was 13 years of age. Her weight fluctuated continuously between approximately five different sizes of clothes. When she gained weight, her back would begin to hurt. This left her feeling frustrated and tired.

When anyone commented that she lost weight, Pearl would just roll her eyes. She knew better than anyone that she would gain it all back. Pearl's attitude was that hard work equalled success. She kept dieting hoping for results even though she understood how harmful dieting was to her body. She restricted her food through dieting followed by a period of binge eating and weight gain. This pattern repeated itself over and over again.

If I am going to do it (binge) most of the time then I am going to put the trough in front of me, light a candle and enjoy the crap out of it because if I am going to do it anyway I might as well enjoy it and live like a king.

She hoped that thinking in this way might help her to accept her behaviour. Pearl's psychological experience of binge eating was a continuous thought process of food and eating. "You can't stop eating when you are full and walk away. You can't rest

and relax because you are always thinking about what you are going to eat next?" When she gained weight, she was embarrassed.

What I was doing didn't seem like normal people who go out on the weekends and enjoy a dinner, and not worry that in two weeks they would have to get their jeans out that are three sizes bigger.

Emotionally, it sapped her confidence and self-respect as she felt that no matter how hard she tried attending therapy, eating disorder support groups and even adult-child groups she could not overcome it. "I felt like I was getting kicked in the head and my confidence went down the tube, I felt like such a failure." Now in her thirties, her motivation to lose weight is not so much to look thinner as it is to feel healthier.

Pearl was confused as to the reason why the desire to binge-eat overpowered her and why she felt so powerless against it. "Why couldn't I pick up a jigsaw puzzle or rent a movie? Why did I go back to this as an escape?" Part of her coping mechanism after binge eating was to forgive her self quickly in order to minimize the damage to her self-esteem.

She compared her thinking pattern when she binged to her thought processes when she quit smoking cigarettes. Six years after she quit, she fantasized about smoking for more than six months. Similarity, when she tried to stop bingeing, she fantasized about eating tons and tons of food.

Just sitting around and ordering three large pizzas with Greek salad, eating, drinking wine, then feeling the numbness and not having to stop. Just saturate yourself and feel full, and fantastic, not having to stop eating; that is the best thing in the world! There is something about it that is so bad but I yearn for it; it is like crawling back to the womb to complete oblivion, like drugs or alcohol, complete happiness. I don't know why I want to escape to this.

Pearl considered the idea of her binge eating experience spiritually similar to yoga or joining the swim club that helped in her recovery. She was not raised with any

particular religious beliefs nor did she attend church as a child. She believed that this might have given her a better sense of belonging and of other people.

She had never wanted to have children and did not understand others who questioned her as to why she didn't want to be a mother. She is currently married with adult stepchildren. "I have learned that his kids will always be number one. I have to put myself first because I know that he will put his kids first, even though he can't admit it."

Pearl grew up with a single alcoholic mother. Without close family bonds and no sense of belonging she always felt that something in her life was missing. She left her mother's home at the age of 13 to become a ward of the court. Pearl was almost adopted by a family (her chance to belong) but at the last minute her mother changed her mind and would not sign the adoption papers. "So that is a big regret in my life. That I didn't get that chance."

She spent some summers living with her grandparents but always felt like someone on the outside. She met her father for the first time when she was eight years of age and lived with him for a short while. During that time her mother told her stories that created doubt in Pearl's mind about her father's love for her and his dedication to making a place in his life for her. She now believed that her mother intentionally tainted any positive relationship she could have had with him.

It was at the age of 13 that she developed a binge eating disorder. She felt distrustful towards everybody. "How do you separate an eating disorder from your whole past and your life?" She described herself as angry and bitter and believed it was because she was never able to develop a sense of belonging that made her feel like she fit in.

She believed that more women suffer with eating disorders than men. "Men have been given all the power in the world (or taken it) because they are raised as providers.

Pearl's attitude was that women were given the message to "spread your legs for a man one day, get pregnant, have his children and don't talk too much." Women who felt powerless resorted to getting what they wanted through their bodies not their minds. Even highly educated women were still existing and fighting in a world where they struggled to be successful.

The hardest challenge for Pearl was to stand on her own two feet and work for herself. In spite of her difficult childhood she succeeded in creating a successful business. It was important that she retain financial independence. In the future she looked forward to doing something in her life that made a valuable contribution toward helping people.

I think that is missing for a lot of people. There has to be a connection to society, not just being the rib of some guy. I grew up in East Van, the daughter of a poor single mother. I have to fight even though now I live a middle class lifestyle. My husband and his kids don't have a clue how spoiled rotten they are.

Why Pearl Developed an Eating Disorder?

As a young girl Pearl remembered keeping food containers by the side of her bed. One of her earliest food related memories was of being told to go to bed on her mother's birthday without any cake. The following morning Pearl hoped that she could share a piece of birthday cake. She was upset to discover that her mother and cousin had been drinking and had a food fight leaving cigarette butts and beer in the cake. "They never thought to save a piece of cake for me."

At the age of 12, Pearl's mother sent her to bed and proceeded to eat all the treats she had bought for herself. Pearl recalled this memory tearfully.

She never gave me anything before I went to bed, I wasn't even bad or anything, she couldn't even wait until I was asleep, she would always tell

me "don't touch", always leave the last of it for her, even if it was rotting, she was totally selfish.

Concerned neighbours recently contacted Pearl and conveyed to her that they wished they could have done more to protect her when she was young. They were afraid to contact the authorities for fear that Pearl would end up in the welfare system. Instead they offered Pearl their home when she needed a place to stay.

Pearl remembered having recurring nightmares of people chasing her in a house she lived in with her mother. The room felt like it was getting smaller and smaller filling up with spider webs. She couldn't get out. She went to peek out the keyhole (for an old fashioned "skeleton key") and saw an eye staring back at her. It wasn't until after she left home that she realized that the eye staring back at her was her mother's. "I was so terrified in this room full of spiders getting smaller and smaller and she wouldn't let me out. I was terrified of her."

She moved every few months from the time she was 13 to 19 years of age.

If you ever had a feeling of terror; this was it. It was terrible as I kept moving trying to get away from it. That just made the problem worse because that promoted instability. I became tougher and tougher; harder and harder.

What Helped Pearl Alleviate Symptoms of This Illness?

Pearl found that joining a swim club and yoga classes helped create a balance in her life and a positive connection to others. Exercise also helped her feel better about herself after binge eating. Pearl enjoyed to work long hours. "Idle time scares me to death, finding that sense of what you really want to do next."

For most people, time off from work was relaxing and something to look forward to, but for Pearl it was a day of hell. "If you don't have anything planned, you pull up at

the 7-11 and fill your boots, restaurant to restaurant, and you try to pass out in between and hold your breathe for a while." Saturdays were the scariest because she snacked on everything. "It just grabs hold of your mind and won't let go, like a leech that sucked the life out of you." Pearl found a combination of anti-depressants, exercise and therapy helped. "It was the first time in my life that somebody asked me how I felt."

What Pearl Would Like Others to Know About This Illness?

Pearl's advice to other women with BED was to look after themselves as human beings first. Pearl believed that women were caught up in having to look a certain way, being married and having children.

I don't know if women know that they don't have to do that. Put yourself first. You don't have to look pretty. You don't have to be skinny and you don't have to do all that crap. You don't have to wear stiletto heels so your ass looks good and men can jump you. My biggest message is that you don't have to do that.

Pearl believed that women were raised not to compete with men.

Oh here honey, here is your little book, your little bible, you just be pretty, wear high heels, be skinny. God forbid you get a brain and come compete with me and be successful.

Pearl advised women not to be impatient in therapy. "I used to think I haven't learned anything from this therapist so I am outta here." She learned that progress took time.

Part of therapy is to stay with one person in order to experience feeling a connection with another person. No matter what you do or say they still accept you and talk to you. That shows you that through all the good and bad times you are worthy and valuable.

She commented on the importance of developing and keeping a strong social network. "The longer you spend with people the more you see that they are flawed and

the more able you are to accept your own flaws; and that everybody is flawed and you are in this murky soup together forever.”

Pearl does not believe that binge eating is any different from smoking dope, drinking coffee or carrying water bottles. “It is a nervous reaction to life that you can at times displace onto something healthier but sometimes you can’t.” She believed that the reason people don’t have eating disorders or other addiction was because someone paid enough attention to them to develop a healthy outlet for their stress. “When you are left alone to cope as a child you can never get enough, you are never full.” For example, when the therapist told Pearl not to come to therapy, she felt good. She needed to learn what it meant to feel complete. “Then I could walk away from therapy and get on with my life.”

Pearl believed that all human beings feel hurt and struggle in life. There is really nothing wrong with you other than that somebody treated you like there was something wrong with you. Even by their actions of not paying attention to you as a child sent you the message that something is wrong with you. “I am not going to pay attention to you, you are not worth it. It is this feeling that you are trying to fix with this disorder.”

Priscilla’s Story

Priscilla’s Experience of BED

Priscilla experience of binge eating disorder was that of sheer destruction.

Destruction to the point of isolation; it just destroyed me to the point that I isolated. It destroyed my self-esteem; I felt worthless, that life is not worth living. I spent a lot of time thinking about suicide.

Physically the binge eating behaviour kept her energy levels low. At times she felt so full from binge eating that she did not want to get out of bed. "I wanted to stuff my feelings. I often didn't know what they were but I knew that something bothered me."

Sometimes she planned her binges and other times they occurred spontaneously. Initially the binge eating experience was comforting. But afterwards her emotions turned to frustration, guilt and shame.

Just when I thought I had it under control, that I would never binge again, I felt hopeless. I was never going to change. This was never going to stop. I was a terrible person. I didn't deserve to exist.

Priscilla's parents raised her to believe that when she did something wrong she had to be punished. Even though both her parents were deceased their voices still existed inside her head. She believed that her bingeing behaviour was a way that she punished herself. Spiritually she experienced her bingeing behaviour as being cut off from her *higher power*. She believed that she had done something wrong and that she was not deserving of support. "Without my higher power support there is really nothing."

This illness isolated her from her family, friends and community. When her brother came to visit she felt uncomfortable because she gained weight. She was afraid that he would tell her older sister. "I don't want him to tell her that I have put on weight and I don't want her to send me fat clothes. I feel disgraced."

She isolated herself physically from intimate relationships. "I don't want to have sex with my boyfriend because I don't feel good about my body and if we do then I want all the lights off. I am constantly apologizing." She realized that even when her weight was very low she was still not happy it was still not good enough. But still she could cope better when she was thinner. "I am more outgoing and I did not isolate myself."

She felt that her co-workers and friends judged her by her weight. "When I felt really good and was getting into shape people gave me positive feedback." She stopped going to the gym for fear that people would see that she had gained weight. She stopped attending eating disorder support groups because she felt ashamed.

There were fewer clothes that fit me. I didn't want to buy new clothes because I would have to admit that I got fatter and that my disease had gotten worse. I was not able to control it anymore.

Priscilla took time off work to get back into shape. When she did not succeed at losing the weight she expected, it became difficult for her to return to work.

She believed that more women than men had this illness because advertisers used women's bodies to sell products.

You have never seen an overweight woman selling a car. Perhaps women are more susceptible to buying that stuff. Both men and women buy into women being thinner.

Why Priscilla Developed an Eating Disorder?

Priscilla's father was an alcoholic and her mother had emotional difficulties coping in her own life. In elementary school her older sister and brother called her names like *fatty* and *pot-belly*. She never learned to accept her body. "It made me mad but then I started to believe it. I felt uncomfortable that I didn't belong anywhere."

She described her sister as the smart one in the family. Priscilla was told that she was "behind the door when the brains were handed out". She lived in her sister's shadow both at school and at home. She felt self conscious of being laughed at or fearful of getting hit if she made a mistake.

She did not have many friends and learned to turn to food when she felt uncomfortable. "I found food comforting and the only thing that could relieve the pain."

Food also comforted her during family conflicts. When her father was physically abusive to her mother, Priscilla turned to food for comfort. "I felt guilty that I could enjoy eating food while my mother was being beaten up and my world was torn apart."

Priscilla felt that socializing with people was difficult. She described herself as an extremely shy child afraid of authority figures. At 14 years of age she began dieting. She took an overdose of pills. "I felt fat. I tried to explain to people why I took the pills but I gave up trying to explain because nobody was listening." Her family physician lectured her about over-eating and told her not to do it. She was sent to different psychiatrists over the years. "I would get the weight off somehow but it always came back. I thought that I finally got a handle on it then I realized that I didn't. Each time it got more and more devastating."

Priscilla believed that her parents were not capable of loving her. Her father was emotionally sick from his alcoholism and her mother was preoccupied with caretaking their father.

They loved us in their sick ways, I think they were there for my sister but after that they weren't able to be there for the rest of the children." At 17 years of age she left home. "If I had stayed with my parents I would have killed myself.

What Helped Priscilla Alleviate Symptoms of This Illness?

When Priscilla was in good physical shape the bingeing symptoms subsided. She began jogging. "It was a way of forgiveness and gave me a second chance. It felt good." She jogged until she damaged her feet and was not able to run anymore. She had taken a variety of prescribed drugs; antidepressants, tranquilizers, lithium and diet pills. She went to counselling for interpersonal relationships, self-esteem and anger

management. She did not find any of these solutions particularly helpful. She only knew that she wanted to lose weight. Nothing else made sense to her.

What Priscilla Would Like Others to Know About This Illness?

Priscilla wanted other women with this illness to know that it was okay to love them selves. "Thinking that the only way to be okay is to be thin is not true." She wanted women to know that they looked good no matter what they weighed and not to focus on their bodies. "They think that they will only be okay when they are thinner, but it will never thin enough." She felt that fashion magazines had a damaging message for both men and women. The more people were aware of eating disorders the less they were going to buy into dieting gimmicks. "Instead of discovering new diets, people should write articles about how beautiful people are at any size, weight or shape."

Priscilla was disappointed in the Oprah magazine. "If Oprah really wanted to help people, why are weight issues and diet tips still talked about in her magazines? It just doesn't jive." Perhaps in the future fashion magazines will have a similar fate to cigarettes packages that carry a warning:

WARNING: *Reading this magazine may increase the risk to the consumer of lower self-esteem and increased dissatisfaction of body image.*

Chapter 5.

Discussion

This chapter outlines and discusses some re-occurring themes observed by the author. A number of distinct themes emerged from the data analysis of the transcripts (as described in the Methodology). Briefly, these themes were; emotional connection to food, loss of control, feelings of “not being good enough”, isolative behaviour and secrets, cognitive obsessions, poor body image/weight issues and a sense of not belonging/not “fitting-in”. These themes were selected because they seemed to capture the essence of the women’s experiences of BED.

Themes

Food and Emotions Connection

All the women experienced strong emotions with BED. In fact emotions were often cited as a trigger for these women to binge. The type and intensity of these emotions varied among the women. “Binge eating prevented me from experiencing my true emotions.” Katherine experienced an inability to access her true emotions cycling between binge eating and dieting. For Stephanie, BED was a dichotomy. She experienced feelings of comfort and safety during the binge, which then turned into shame and depression after the binge.

Tatiana experienced a love-hate relationship with BED. She felt comforted and nurtured by the food yet vaguely aware of the inevitable feelings of self-hatred and shame once the binge was over. Food served to calm her down and numb out her

feelings. It was a security blanket that kept her safe when her emotions of loneliness, anger, hurt and fear overpowered her.

Both Patricia and Lilah identified feeling of sadness and depression. They judged themselves negatively as did all the women after they binged. Amber's bingeing episodes amplified her emotions of guilt, hopelessness and depression. She identified feelings of anger and emotionally charged situations where she did not stand up for herself (felt powerless) that triggered her binge eating behaviour. After a binge she felt shamed and depressed.

Debbie found that when she experienced feelings of boredom she filled it with bingeing. It was like filling a void. She felt deeply hurt by the negative reactions of people to her weight. "I have had people yell and spit at me. I have been swore at and gasped at as if I was a monster." This same illness that caused her so much unpleasantness and turmoil also offered protection. "Food is a comfort to me. Some people curl up with their favourite blankie and I curl up with a bucket of KFC."

Debbie felt that any one of her emotions could trigger a binge; anger, discouragement, aggravation, embarrassment, shame, disgust, confusion and disappointment. The binge was a way to reward and console herself. When something wonderful happened, she experienced a strong positive emotion and planned a binge to celebrate. She felt that she deserved it! When she experienced a strong negative emotion she also planned a binge to make her feel better. For Debbie it was the intensity of her emotion that was a defining factor for triggering a binge and not necessarily the type of emotion.

Pearl described her BED as a "coping mechanism that no one would ever want to have." It provided her with comfort and support. For Priscilla it was a force of destruction that spiralled into hopelessness and despair. "It destroyed my self-esteem. I

felt worthless and that life was not worth living. I spent a lot of time thinking about suicide." She too felt comforted during the binge and later felt frustrated, guilty and shamed. The thoughts of never being able to overcome this illness filled her with despair.

There were a variety of emotions that these women experienced with BED before during and after the binges. BED functioned as a coping mechanism (a way to shut off their emotions) and it provided a disconnection from their emotional pain.

Loss of Control

According to the Eating Disorder Research Center of British Columbia (2002), eating disorders are a maladaptive coping strategy at gaining control over one's life. Feelings of being *out-of-control* were described as characteristic of eating disordered individuals. It is not the amount of food consumed that defines a binge eating disorder rather it was the overwhelming feelings of a loss of control that the individual experiences when they binged (Nash, 1999).

The participants in this study experienced feeling of loss of control during binges. Katherine described this experience. "When I am on the bingeing side it felt like I was out-of-control. I am in a daze, when I have eaten a box of donuts and I haven't even tasted them or felt them going down."

Tatiana described her weight loss and gain as a vicious cycle that spun out-of-control. The more she tried to stop eating, the more she ate. For Debbie, her lack of ability to stop bingeing was discouraging. She criticized herself as someone who was "lazy with no will power." Pearl did not understand why she felt powerless against her desires to binge eat. When Priscilla lost control and binged she felt hopeless that this illness would never stop. "I felt like a terrible person. I didn't deserve to exist."

The women's loss of control supported their sense of powerlessness and their inability to change their dieting and bingeing behaviour (Johnston, 1996).

Not Good Enough

The concept of "not being good enough" or not measuring up against some empirical ideology is evident in all of the women's stories. Debbie felt disheartened that she had this illness for as long as she could remember. "Maybe I am not good enough." Several of the women felt that their parents compared them negatively to their siblings. They were criticized and judged for their eating habits or excess weight.

This concept of "not being good enough" is supported by other eating disorder research. Dr. Hardman and Dr. Berrett of the Centre of Change found that women with eating disorders believe that others view them as "flawed, unworthy and unacceptable" (Hardman & Berrett, 1999). Comparative comments about other siblings were evident among some of the women. Katherine's family were always making negative comments about her weight and eating behaviour. Priscilla's sibling teased her about her weight since she was a child. The importance of body image and weight reduction was stressed in order that a woman achieve one's goal of being worthy of love, success and desirability.

Traumatic experiences early in life such as having alcoholic parents, divorce, sexual and emotional or physical abuse resulted in low self-esteem for many women. Three out of the nine women spoke about experiencing some form of sexual abuse. All women had negative feelings about their bodies. In most cases this was reinforced by the other members of their family.

The results of this study are supported by the literature which suggests that half of all dieting girls were encouraged to do so by their mothers. Some of the women

bonded with their mothers through dieting. The fathers and brothers were also found to encourage dieting through comments and attitudes about the girls' appearance (Sandbek, 1993). Women learn to get attention and ultimately power through their bodies and physical attractiveness. It is the way that many women learned to make a statement about their identity and personal dreams (Brumberg, 1988; Hesse-Biber, 1998).

Isolative Behaviour and Secrets

Eating disorders are characterized by secretive and isolative behaviour. The cycle of binge eating began with overwhelming feelings that were often unconscious. In order to cope with these feelings the individual seeks comfort in food and binges. This bingeing behaviour provided short-term comfort, safety and a numbing of their feelings. After the binge the individual was flooded with remorse and feelings of being "a failure". They also experience physical discomfort or pain. Their negative thoughts slid further into depression and feelings of hopelessness that resulted in isolative behaviour. The binge cycle began all over again.

All the women shared common behaviours of isolation, secrecy, preoccupation with food, extreme dieting and bingeing. Their behaviours were described as secretive, lying about what they ate or pretending to buy food for other people (that they ate themselves). These behaviours left the women feeling isolated from others around them.

When Katherine found herself in a cycle of bingeing she would isolate herself. Stephanie planned her binges. "I would buy many types of food in preparing myself for the binge. I would go to several different stores." Stephanie's behaviour was secretive and deceptive in an attempt to hide her illness from the outside world. She paid for her

groceries on separate bills pretending to buy food for more than just one person out of a fear of embarrassment.

Tatiana's inability to stop her bingeing behaviour left her feeling frustrated and hopeless. It was the only promise that she made to herself that she continually failed to keep. Patricia prepared and served healthy meals to her family. After her children went to bed, she went out and secretly bought food for her self and binged.

All of the women experienced extreme weight fluctuations as a result of dieting and bingeing behaviour. Pearl's frustration with this cycle of bingeing and dieting finally left her resigned. "If I am going to do it anyway I am going to put the trough in front of me, light a candle and enjoy the crap out of it."

All the women shared experiences of isolation, secrecy and depression. The reason the women perceived that they isolated themselves varied. Priscilla isolated herself when she gained weight. This isolative behaviour led her to deeper states of depression and self-abuse. Katherine did not wish to be with others for fear they might discover her secret. She avoided family visits fearing negative judgment towards her. Her excess weight kept her isolated from social activities as she felt that she was too big to fit in.

Stephanie isolative behaviour increased her experience of loneliness and perpetuated the binge eating pattern. She feared getting close to anyone as they might discover her secret. It was better to live alone than live with someone else for fear that she would not be able to feel comfortable in her bingeing.

Tatiana's eating disorder put a wall between her and her life and kept her from intimate relationships. Lilah believed that her feelings of low self-esteem and lack of socialization as a young child left her feeling isolated from other people. As Debbie's behaviour became more isolative, she had less ability to communicate with others.

Priscilla stopped socializing at her gym, her workplace and even her eating disorder support groups for fear that people would see that she gained weight and the resulting shame. "I got fatter and my disease had gotten worse."

For most of the women, weight gain was devastating and often determined the extent of their isolative behaviour. This isolation contributed to feelings of loneliness, disconnection, depression and suicidal ideation.

Cognitive Obsessions

BED was found to consume the women's thoughts with food or dieting. To eat or not to eat...that was the one question on their minds. Eating disorders are a "leveller of experience reducing life to a small caloric awareness and focus on food" (Leichner & Manley, 2002). This obsession with food focused attention on one aspect of an individual's life and at the same time took the focus off aspects that were painful, difficult or felt out-of-control.

Katherine described her obsessive thoughts as "black and white thinking". This "all or nothing" attitude is characteristic of eating disordered individuals when after eating one cookie the thinking process is "well now I've blown it I may as well eat the whole bag".

Pierre Claude, author and founder of the Montreux Clinic says that the work of the "negative mind" or voices that women listen to inside of themselves contribute to low self-esteem and their lack of self acceptance (Claude-Pierre, 1997). Katherine felt confused about what she should eat or how much she should eat. Her negative thoughts constantly told her that there was something wrong with her. Stephanie knew beforehand that she was going to binge but could not stop herself. Most of the women

would either plan their binges in advance or experience them happening spontaneously like an uncontrollable urge.

Tatiana promised herself over and over again that she would lose weight. "It was disheartening to realize that I am not worthy to keep my own promises." Lilah thoughts were obsessively centered on what she could eat when she arrived home. Both Patricia and Amber experienced an unconscious "zoning out" or "black out". They had no memory of the reasons why they binged; only that they did. This state of dissociation prevented these individuals from experiencing pain (Nash, 1999).

Debbie believed that dieting was simply mind over matter. She played a game with herself in which she told her self that this was "her last binge". She would then proceed to visit all of her favourite fast food restaurants and eat all the foods that she liked the best. Every time she said this was her last binge, it wasn't.

Pearl felt that she couldn't relax because she was always thinking about what she was going to eat next. When she was able to stop the bingeing behaviour she fantasized about eating copious amounts of food. "There is something about it that is so bad, but I yearn for it. It is like crawling back into the womb to complete oblivion, like drugs or alcohol, complete happiness."

All the women spoke about uncontrolled urges and obsessive thoughts that haunted them until they had to succumb to it and binge. Katherine captured these thoughts in the following, "Binge, binge, binge, you have to binge, you have to binge, you have to binge."

Poor Body Image/Weight Issues

The physical experience of binge eating disorder left the women with a variety of ailments. Some of these ailments were the result of quickly eating high caloric foods

over a short period of time, feeling of fullness and indigestion. Other ailments were the accumulation of many years of bingeing (lack of proper nutrients) and severe weight fluctuations.

Katherine suffered with anemia, hair loss and irregular menstrual cycles. Stephanie experienced pain in her feet. She felt that her excess body weight limited her from everyday activities. Lilah's physical experience of BED left her with high blood pressure, high cholesterol and excess weight. She constantly felt physically uncomfortable in her own skin.

Patricia suffered with Type 1 diabetes and sleep apnea. She experienced difficulty in executing basic physical movements such as tying her shoelaces or playing with her children. Sometimes Amber slept sitting upright to keep food from coming up in her throat. For the past several years she had suffered with diabetes, arthritis and heart irregularities. Her upcoming required surgeries (hiatus hernia, gallstones, artificial hip and knee) have been put on hold until she lost enough weight to reduce the risk of complications.

Priscilla's BED kept her energy levels low. Sometimes she felt so full from bingeing that she could not get out of bed. Three of the nine women exercised on a regular basis. Two out of nine women had stomach surgery that resulted in weight loss. Over time both women gained back most of their weight.

Regardless of how much or how little weight was lost or gained, body image carried a great deal of importance in these women's everyday life experience. It was not uncommon for BED individuals to be both overweight and at the same time constantly dieting to gain control over their food intake (Nash, 1999). It is not surprising that being overweight is so feared and hated by these women.

A study by the Rudd Center for Food Policy and Obesity at Yale, U.S.A. conducted an online survey about obesity. Of the 4,000 people from the general population that responded, half said that they would give up a year of their life rather than be fat. 15-30% felt that they would give up their marriage or the possibility of having a family rather than be fat. They would rather be depressed or become an alcoholic than be obese. Approximately 5% would even lose a limb or their eyesight rather than be overweight (Schwartz, Vartanian, Brownell, & Nosek, 2006). How does an individual suffering from BED who is also overweight (some individuals with BED are average weight) heal in a fat phobic society where the size of one's body is so harshly judged?

The non-acceptance of their larger size by society, family, friends and even the women themselves, triggered feelings of shame and rejection. The women isolated from family, friends and society. "I don't want to go out and have people see me eating. It is the whole shame thing." The excess weight for these women was a constant source of discomfort everywhere. They felt judged and persecuted because of it.

It was surprising to the author that even the women who were not physically overweight were psychologically wounded and experienced similar shame and self-disgust as much as those who were visibly obese. They exhibited the same self-reproach and harsh judgements towards their bodies. When was thin, thin enough? Tatiana spoke of a time when she lost weight.

I stood naked in front of mirror and I looked at myself. I realized that I hated myself just as much as when I was fat. I picked my whole body apart. My breasts were too saggy. My back was still as humped. The fat still hung between my thighs; the bulging stomach; the knock-knees. What was the point?

Not Belonging or Not Fitting-in

The author found it interesting to hear the words “I didn’t fit in or I didn’t belong” evoked by so many of the women. These women felt judged by their families and communities. This sense of “*not belonging*” was a catalyst for the BED.

There were a number of different ways in which the women felt that they did not *belong to* or *fit in*. Stephanie felt that she did *not belong* with most women because she had difficulty fitting into clothes at most retail outlets. She felt different from the other members of her family and did not feel their love for her. “I knew they loved me but I never felt it.”

Katherine did not feel that she belonged in her family when she was overweight or when she felt out-of-control about her weight. Lilah described her sister, mother and grandmother as three peas in a pod. “I just never really fit in. I have the fat gene. Food was my only comfort.” Binge eating for Lilah was about how well she did or did not fit into society.

Patricia was the only one in her family with BED and the only one who was overweight. She felt alone, abandoned and not good enough in her family’s eyes. “I felt that I did not fit into my family dynamics.”

Pearl always felt that something was missing in her life. She felt that she did not fit in. When Priscilla was in elementary school her older sister and brother called her names like “*Fatty*” and “*Pot-Belly*”. “It made me mad but then I started to believe it. I felt uncomfortable that I didn’t belong anywhere.”

The strong sense of belonging and fitting-in with ones’ family or “tribe” played an important role in identifying family values and rituals.

Spirituality and BED

According to Deborah Kesten, a nutritionist and lecturer (who wrote about the connection between spirituality, food and health), the complete picture of the causes for eating disorders lies in the “culturally nurtured spiritual starvation” that is endemic to so many women’s lives today (Kesten, 1997). For most of the women, the BED was viewed as an impediment to experiencing their spirit on a deeper and fuller level. The importance of spirituality varied for each of the women in the study.

Katherine described her spirit as a holistic experience and felt that “her spiritual piece was missing”. For Stephanie her spiritual path of self growth was interrupted by her eating disorder. “I would give up everything when I felt like a binge, my friends, home or spiritual life, nothing mattered.” Tatiana’s feeling of guilt and self-loathing were compounded by her Christian beliefs that gluttony was one of the seven deadly sins. Patricia felt that her spirit was attacked and broken by her BED. Amber sought spiritual healing from both her church and spiritual mediums. “All this baggage and it all led back to the food. The food was the comfort, the friend, the lover and the enemy.”

Pearl’s spiritual experience consisted of yoga and swimming, activities that helped her feel better physically and more connected with herself and others. Priscilla’s BED left her feeling cut her off from her higher power. This left her feeling that she did not deserve support. “Without my higher power supporting me there was really nothing.”

Eating disorders may represent a search for meaning, a desire for recognition and perfection and a hunger for a deeper and larger sense of themselves (Leichner, Brown, Atkinson, Henderson, & Jacek, 2001). For a woman to recover from disordered eating she needs to recognize that the food she requires is not material food. Her true needs and innermost desires are hidden behind those urges that are symbolic of those

real needs and desires (Johnston, 1996; Lelwica, 1996; Ginsburg & Taylor, 2002; Normandi & Roarke, 1998). Eating disorders may be the beginning of a woman's search for a meaningful existence and larger purpose in her life. "It is only with the heart that one can see rightly; what is essential is invisible to the eye" (De Saint-Exupery, 1943).

Eating Disorder as an Addiction

Many of the women referred to their experience of BED as an addiction. Anita Johnston (1996), an eating disorder specialist and author, refers to eating disorders as a *process addiction*. The woman with disordered eating is addicted to her eating behaviour, and not to food itself. Katherine described her experiences of BED. "I had times in my life when I put food in my mouth it was like I had a hit of a drug." The food in her cupboard would call to her much like the experience of alcoholics towards alcohol. "Binge, binge, binge, you need to binge, you need to binge, you need to binge." Sometimes during these moments, Katherine was successful at distracting herself, that is, calling a friend, but the compelling voice and desires remained. "Was there ever a point in my life when I could have just one chocolate? Could an alcoholic have just one beer?"

Many of the women wished that people could understand that eating disorders were addictions that dieting could not cure. Tatiana overcame both her drug addiction and her alcohol addiction but she could not overcome her addiction to binge eating. "The addict in me needed to find a place to call home and it went back to where it all started: with food."

Binge eating disorder shares similarities with alcohol and/or drug addictions. One similarity is that the abused substance was used as a way to cope with stress and

regulate emotions. Another similarity between BED and other addictions is that the person continues the addictive behaviour even though they are aware of the negative harmful effect in their life and on their health (Nash, 1999).

The addiction model of binge eating is not without controversy. Addictive models of eating disorders ignore that dietary restraints and “all or nothing thinking” is harmful for individuals with eating disorders. With restrictive diets, counting calories and food plans there is too much emphasis on the food itself and not enough on the addictive process, the disordered eating behaviour (Johnston, 1996; Nash, 1999). Dieting is a precursor to developing eating disorders (Bruce & Wilfrey, 1996) and the “all or nothing” thinking characteristic of BED often precipitates a binge (Nash, 1999).

Is it possible to re-train an individual's behaviour with food and eating without having to encourage dieting? One area of research was developed by Dr. Jean Kristeller, who has had success with BED patients through her program “mindfulness meditation for eating”. This exercise taught BED individuals how to be more aware of their eating process. This awareness also increased the participant's sense of control over eating and decreased bingeing episodes. Recovery required the subject to learn to eat a full range of foods (Katzman & Pinhas, 2005). The addiction model can be helpful in coping with BED by providing support groups. It also supported the idea that food and eating were a coping mechanism for other problems.

Family Relationships

The “blame and shame” mentality towards families was no longer considered popular as a factor in the development of eating disorders (Kirkpatrick & Caldwell, 2001). There is no evidence to suggest that any specific style of parenting or characteristic of

parent caused an eating disorder (Katzman & Pinhas, 2005). However, the power of the family should not be underestimated in providing immunity or susceptibility towards this illness (Nash, 1999). Adverse experiences within the family, especially those that contribute to the onset of extreme dieting may serve to catalyze and/or perpetuate this illness (Walsh & Devlin, 1995).

The family is the beginning of a child's emerging self-image (Friedberg & Lyndden, 1996). The best approach to building positive self-esteem in a child is to incorporate healthy eating, active living, size acceptance and role modelling by the parents and family members (Katzman & Pinhas, 2005).

In this study, all the women expressed difficulty in relationships with their families during their childhoods and also as adult women. As a teenager, Katherine dieted with her mother. "It was sort of like a bonding thing, my mom never dieted with my brothers." It was considered acceptable, in the family, that her father comment on the shape and size of her body. "Oh you gained weight and your butt is getting bigger". Now as an adult her decisions to visit her family depended on how much weight she had lost or gained. "This year I didn't go home for Christmas because I was much bigger than last year."

Stephanie felt left out of the mother-daughter bonding experiences (e.g., shopping). Her mother shared this with her sister who was described as thin, pretty, perfect and smart. She resented their constant attention to her portion sizes of food. "My mother monitors how much food is on my plate. I don't get a normal piece of cake, I get a sliver. I feel resentful towards them for not accepting me the way I am." Her family commented on how much happier she would be if she lost weight and had a boyfriend.

As a child Tatiana was discovered hiding and hoarding food and was thus sent to the family doctor. The doctor's focus of recovery was on weight loss not on the emotional component as to why she was eating. She described the significant

relationships in her life as destructive to her health. When she lost weight she felt vulnerable to the opposite sex.

As a child, Patricia experienced a power struggle with her family at meal times. "It was a real battle of the wills." She spent long periods of time sitting at the dinner table until she finished all her food, even foods that she disliked. Difficult uncomfortable emotions during family events often triggered a binge. As an adult, Patricia did not believe that she was worthy of a relationship that included closeness, communication, sharing one's feelings, hopes and desires. She perceived that this was meant for *skinny, smart, beautiful people only*.

As a child Amber never experienced being told or shown how much she was loved. She now protected herself from relationships through her weight.

I built a wall around me so thick and deep that nobody would be attracted to me and I didn't have to worry about being raped or men dumping me. The consequence was that I put my health in danger.

Lilah's family was judgmental about weight issues, often commenting about how good she looked when she was slim and how pretty she would be if she wasn't "fat".

Debbie believed that her father used food to control her and her mother. She thought that being overweight meant being safe. Pearl's had a difficult relationship with her mother who was addicted to alcohol. She was often neglected and abused as a child. Priscilla avoided physical intimacy because she did not feel comfortable with her body.

BED affected all of the women's relationships with their family, friends, co-workers and spouses. It seemed that the women did not believe that their families and spouses could really accept them for how they were. Most of the women's families were not aware that they had an eating disorder; they noticed only that they gained weight.

Earliest Memories of Food

It appeared that each of the women's recollection of food related events were extremely emotionally difficult, even visibly so. Katherine remembered losing weight quickly (30 lbs in one month). Her rapid weight loss received a great deal of positive attention, even when she used drastic measures for losing weight. In hindsight, she was curious as to why no one in her family noticed that her only meal of the day was just one banana.

Stephanie remembered being rewarded with sweets and candy as a young child for "being cute". Lilah got to sit next to her father during meals, giving her a special feeling of being "Daddy's little girl". Later she found out that she was seated there so as not to elbow others when cutting her food (left handed people needed to be more accommodating). She was disappointed that something so special to her did not have the same meaning for her father.

At 13 years of age Patricia remembered being left out of the family Easter egg hunt with her siblings. There was chocolate for everyone but not for her as she was a diabetic. She felt her mother did not care enough about her to get some sugar free chocolates and include her in the family celebrations.

It became evident during the interview that food was an important symbol of love, acceptance and nurturing from a parent to a child. When food was withheld or rationed, it sent the message to the child that they were not worthy or deserving of this special love and attention.

Pearl had remained quite composed and relaxed during the interview but began to cry while remembering times when her mother would intentionally not share treats and birthday cake with her. This sentiment was shared by many of the women who shed

tears at the remembrance their mother's lack of affection during meals or on special occasions. They felt unimportant and worthless when their family members did not pay attention to their needs or judged them negatively.

Why These Women Developed an Eating Disorder?

Anita Johnston (1996) called the preoccupation with food and body image in eating disorders "the red herring". This suggested that BED was a symptom of a problem and not the actual problem. The red herring that everyone focused on was an attempt at a solution that kept the women in the dark about what was really happening in their lives and how they truly felt.

Most of the women became aware at an early age that their behaviour around eating was abnormal. The teen years appear to have been a particularly vulnerable time for women to develop extreme dieting behaviours and body dissatisfaction. Most of the women expressed shame about their bodies and attempted to soothe these feelings of emptiness and pain with food.

One woman believed it was her lack of socialization skills as a child that contributed to her sense of isolation. This prompted her to seek comfort with food whenever she felt unsafe or threatened. Several of the women believed now that their family loved and cared for them but they did not experience this as love at the time. It was never communicated to them in a way that it had a positive and meaningful impact on their futures.

Katherine believed that she developed an eating disorder as an attempt to comfort herself with food when she was a teenager. "It was more anorexic behaviour

that started at 13 years of age that moved into bingeing at 14 or 15." She learned to cope with feelings of loneliness and neediness through eating.

Stephanie also developed her eating disorder in her teenage years. She remembered how strongly she resented being negatively compared to her sister. She described her family as having lots of secrets and an inability to communicate openly or effectively. "I was confused. I didn't have support and had nowhere to turn so I turned to food."

Tatiana began gaining weight at age nine. By the age of 12 she had developed the habit of hiding food from her family. When she was "outed" by her father, (eating foods that she wasn't supposed to eat) she felt ashamed and embarrassed. She believed (from therapy) that her early connection to food was one of pleasure, the mother/child bond. She learned to access these pleasant emotions through food.

For Lilah, the eating disorder began as a way to cope with discomfort in social situations. She believed that her eating disorder developed as a result of not being socialized as a young child.

Patricia believed that her illness started because she lacked outward expressions of love and support from her family. She could not recall a time when her mother or father displayed verbal or physical affection. She turned to food to replace the emotional nurturing she did not receive and longed for as a child. "An eating disorder is the result of someone who is broken, emotionally, physically, spiritually and mentally."

Amber's BED started in her late teens. She believed that she developed this disorder because she did not have a strong sense of self. She felt disrespected and not valued as a child. Pearl developed an eating disorder when she was 13 years of age. She remembered keeping food containers by the side of her bed. She believed that she developed this disorder because of a lack of attention from her mother.

Priscilla turned to food at a young age driven by her desire for comfort and as a way to stop the emotional pain. Like many of the women in this study she believed that her parents had difficulty loving her. Several of the women believed that their disorder began in their early teens. One woman did not realize that what she suffered from was an eating disorder until she was 30-years-old.

Coping Mechanism

All of the women used food as a way to cope with life. As mentioned previously, eating disorders were considered a maladaptive coping mechanism. After Katherine's parents divorced, she used food to cope with her feelings of loneliness and neediness.

Stephanie used food to create a feeling of comfort and relaxation. It was the way that she learned to cope with difficult emotions. Tatiana also used binge eating as a way of coping with daily upset and feelings of loneliness. "If I had a bad day at work, I would come home, turn on the television and binge." Amber also used food as a comfort when she arrived home from work. At times she would take her meal to bed with her. "Food is the comfort, the friend, the lover you don't have. It is also your worst enemy."

Lilah's thoughts of food comforted her in stressful social situations. Pearl was aware that food was a poor coping mechanism but felt it was better than other coping strategies she could have developed like sex, drugs or alcohol (her mother's choice).

What Helped Alleviate Symptoms?

Medication/Counselling/Connection/Movement

All of the women had lived with BED for many years, even decades. Their ways of coping and struggling to recover were as varied and unique as each of the women.

Katherine found Prozac helpful even though it provided only short-term relief. It helped her experience a feeling of balance. A counsellor helped her identify and connect with her emotions and connect these emotions with her BED behaviours. She learned to simplify her food concerns. "Just sit down once per day and have a hot meal." For Katherine, connecting with other people was critical in order for her to feel supported. "I am connected to my family, my friends those are better times for me." She also found art therapy and sport activities both healing and connecting.

Stephanie believed that support from others helped her cope with this illness. "Just hearing that I can do it and that I am okay even if I don't succeed." She changed some of her behaviours such as not eating when watching television, going out for walks, and attending eating disorder support groups. It was when she was connected to other people that she felt the most positive. "When I isolate myself I start thinking about crazy stuff like suicide."

Tatiana initially opted for surgery to help her lose weight. Unfortunately, the mental and emotional aspects of the illness remained. Tatiana believed that accepting this disorder emotionally and psychologically was a way to stop the anguish and constant struggle. It was a way to break through the wall and connect with other people. "I have to learn to love myself and I can't love myself when I am putting myself down."

Lilah found regular exercise, support groups and individual counselling helpful. Through counselling and eating disorder support groups Patricia began to understand that she was worthy of being loved. She felt that the eating disorder made her lose the ability to connect with others. It was healing for her to admit and acknowledge that she had a problem. After she joined a binge eating support group she enjoyed connecting with people and hearing their stories of success and failure.

Amber was helped by educating herself and gaining a deeper understanding of why she binged. BED support groups gave her the opportunity to speak with other women and listen to their stories. The empty chair technique (projecting an imaginary person into the chair in front of you) was especially helpful. This exercise helped her improve her relationship with her mother. This same technique can be useful when projecting the BED into the empty chair. Separating the individual from the eating disorder is an important step in the recovery process (Nash, 1999).

Debbie found that working helped keep her busy. She realized that she binged less when she lived on her own and worked 16 to 18 hours per day. Her strategy was to keep busy until eight o'clock in the evening. "What I really wanted to do was to go home and relax but I can't because relaxing for me would end up in a binge".

Pearl also enjoyed long hours at work. "Idle time scared me to death." Pearl found that joining a swim club and yoga class helped create a balance in her life and a positive connection to others. Priscilla turned to jogging and exercise. It gave her a way to forgive herself for binge eating behaviour.

BED Served a Purpose

Tatiana believed that each woman needed to discover the payoff that the BED had in their life. The physical, emotional, spiritual pain of an eating disorder may force each woman to pay closer attention to what is happening inside of her (Nash, 1999; Ginsburg & Taylor, 2002). Perhaps in understanding this better they could cease their constant struggle within themselves.

Obsessions with the body, dieting and over exercising are considered normal behaviour (Hesse-Biber, 1998; Bergeron & Senn, 1998). Feminists hold the perspective

that all women have disordered eating to some degree (Brown & Jasper, 1993). It was also a way of rebelling against the societal expectations placed on women's sexuality. "Both over-eating and non-eating are a protest against the way in which women are regarded in our society as objects of adornment" (Orbach, 1993, p. 63). What are the ways that a woman can say that she has had enough of the pressure and expectations to be perfect, thin and pretty?

An anorexic person may remain thin as a resistance to growing up and becoming a woman (Katzman & Pinhas, 2005). Perhaps women with BED focus on body, size, weight and shape that prevents them from dealing with issues that once resolved would move them forward in their lives. Amber was reluctant to let go of her eating disorder. She believed that it served a purpose in her life, "I am more afraid to be thin than fat." It was protection from relationships and aspects of life that are difficult and messy. For many of the women BED was a cocoon that shielded them from difficult and painful emotions both inside and outside of themselves.

For eating disordered individuals food is a way to express thoughts and feelings that they find difficult to communicate. The child who lives with a diet-conscious parent or family may gain weight as if to say, "You can't make me be just like you. I am my own person." Or she may stop eating altogether to "really show them" who is in charge of her life (Johnston, 1996).

Debbie described herself as someone who cared about other people, worked hard and always followed the rules. "I never got a parking ticket in my life. Why do I have to have this illness?"

Perhaps the purpose of an eating disorder is to understand the deeper meaning of a woman's compulsive hunger when she eats voraciously. In order to recover she may need to redefine her hunger and develop a deeper awareness of what she is really

hungry for, so that she can begin to seek the appropriate emotional nourishment (Johnston, 1996; Lelwica, 1996; Normandi & Roarke, 1998).

What These Women Wanted Others to Know About This Illness?

The women were very pleased and enthusiastic to talk about what they believed others needed to understand about BED. They all felt that BED was not understood by the general public or their family physicians. They felt frustrated in their struggles to find adequate facilities or resources in B.C.

Message to Other Women

Katherine wanted women to know that although this illness may manifest as serious physical problems that are rooted as a much deeper emotional problem. Treatment should focus more on the emotional aspects of BED rather than the physical (e.g., diets). Women with BED need to realize that they are not alone with this illness and that even the most physically beautiful people with thin bodies can struggle with self-esteem and body image issues.

Stephanie wanted women to seek support in a group or in an activity as simple as walking with a friend or meeting some girlfriends for tea. Tatiana wanted women to know that they should not be ashamed of this illness nor hate themselves for it.

It was the way that they had chosen to cope in their life. Having an eating disorder is actually a kinder and gentler way to placate your self compared to all the other things out there, drugs and alcohol.

Lilah wanted other women to encourage social agencies to provide greater facilities and programs for support. Amber wished that other women could more easily access a BED support group. Debbie felt that women needed to talk to someone even if

the other person did not understand. It would help them legitimize the disorder and understand that it was the disease, not them. This illness was bigger than the person; it was an addiction.

Pearl wanted women to know that they did not need to be skinny or look pretty to feel good about themselves. "You don't have to wear stilettos heels so your ass looks good and men can jump you." She believed that therapy was useful in developing a relationship with someone who could connect with you.

The longer you spend with people, the more you see that they too are flawed and the more you can accept your own flaws and realize that everybody is flawed and that we are all together in this flawed murky soup together forever.

Priscilla wanted other women to know that it was okay to love themselves. She felt that fashion magazines had a damaging message for both men and women.

Message to Other People

Katherine wanted other people to know that this illness is not about willpower or control and that it was much bigger than that. She wished that people could appreciate the struggle that someone might have with their weight and that it was socially inappropriate to make comments about other people's bodies. It is important to provide support and specific information designed for BED. She often felt left out of many already existing programs that focus on anorexia or bulimia disorder. "Where do I fit in if I am not anorexic or bulimic?"

Stephanie wished people understood that eating disorders were addictions similar to alcoholism. Tatiana shared that even when she lost weight and wore a size 8 dress, she still felt unhappy. "I used to think that if I could lose weight my life would be perfect. It wasn't."

Patricia wanted other people to be kinder to this population that is so vulnerable to having their spirit broken. Amber believed that the general public needed more education about BED. Eating disorders such as anorexia, bulimia and binge eating were really more similar than different.

Debbie wanted the general public to know that binge eating disorder was both a legitimate eating disorder just like anorexia and bulimia and an addiction, just like alcohol, drugs, smoking sex or pornography. Priscilla commented that both men and women "*bought into*" women being thinner. It was important to be a critical consumer. "You never see an overweight woman selling a car."

Pearl believed that binge eating was the same as smoking dope, drinking coffee or even the habit of carrying water bottles. "It was a nervous reaction to life that you can at times displace onto something healthier but sometimes you can't." She believed that people who had eating disorders were not given attention as children to help them develop healthy outlets for stress.

When a child is left alone to cope, you never feel full nor do you feel that you can ever get enough. When someone doesn't pay attention to you as a child it sends you the message that something is wrong with you. This is the feeling that you are trying to fix with an eating disorder.

Message to Professionals

Katherine wished that doctors would look for the possibility of eating disorders in their patients and not recommend dieting as a solution. Stephanie wanted doctors to be better educated about eating disorders. She complained about the lack of resources and treatment Centres for binge eating disorder. "There is tons of help for other addictions and other eating disorders but there isn't anything for BED that does not involve going on a diet." Stephanie believed serious attention from health professionals was needed to

cope with long-term health implications of diabetes and other illnesses exacerbated by excessive body weight and extreme fluctuations in weight. Often when a person loses weight, they are viewed by professionals as being healthy.

Amber would like to see greater attention being paid to overweight children. They are in danger of future health and emotional problems. BED is viewed as a behavioural issue, something that the person can change rather than an emotional issue. Often people with BED are told to "just stop eating".

Tatiana felt that professionals need to focus on brain processes not stomach-stapling or bypass surgery. These surgeries are highly complicated and not necessarily helpful in the long-term. Lilah felt that professionals needed to be educated about BED in order to feel comfortable speaking about it with their patients. Patricia cautioned professionals not to treat binge eating disorder with suggestions for another diet but to look more deeply at the emotional issues and make appropriate recommendations.

Debbie believed that if she was an anorexic or bulimic or had any other addiction, she could get support, but for binge eating disorder there was nothing. Debbie felt that although physicians today were compassionate, they did not fully understand BED. Eating disorders were an addiction that was just as hard to break as alcohol and even harder because you can't avoid food. Furthermore, suggestion of dieting was not helpful as dieting behaviour was a strong precipitate to BED (Johnston, 1996; Nash, 1999).

Counselling Interventions for BED

The following list is a summary of suggestions for the treatment of BED currently used by mental health professionals as well as suggestions by the author and women in this study.

- A multidimensional approach is best suited
- Anti-depressants
- Group therapy
- Support groups
- Psycho-educational sessions
- Nutritional counselling
- Cognitive behavioural therapy (CBT): suggesting that the client keep a diary of their thoughts/feelings in situations before, during and after the binge episode to gain insight into behaviour (i.e., triggers)
- Progressive muscle relaxation
- Teach techniques for relaxing the body (i.e., box breathing)
- Psychodynamic techniques: a technique that connects the body and mind
- Help them to understand that all feeling states are temporary
- Notice the negative self talk = change to positive
- Practice nurturing and self care including the senses (i.e., aromatherapy)
- Greater focus on the *functionality* of the body rather than the *appearance* (exercise in gratitude for the use of their arms/legs/hands)
- Interpersonal therapy: focuses on the connection between interactions between people and the development of symptoms (useful for depressions)
- Mindfulness meditation gives a greater sense of awareness/increased acceptance of oneself, self-regulation and stress management
- Client-centered therapy
- Important to "just be present" and connect with the client
- Separate the person from the bed (empty chair technique)
- No dieting recommended
- Communicate healthy boundaries
- Mouth-stomach hunger (notice the difference between them)
- Legalize all foods (there are no good or bad foods)
- Stages of change (Prochaska & DiClemente, 1982)
- Explore what the payoff is for the disorder? Be curious (no judgement)
- It is not uncommon for an individual with an eating disorder to experience ambivalence (exercise in writing a letter to the eating disorder as a friend and as a foe)
- Yoga and breathing assists in the acceptance and positive feelings toward the body
- Forgiveness
- Being in nature, spending time with horses/animals
- "You have to start eating if you want to stop bingeing"
- "Recognize relapse as part of recovery"
- "Eating disorders are not about food" (look deeper for emotional hunger)

Limitations

The limitation of this research was that all the participants were female, Caucasian and living in Lower Mainland, British Columbia area. It would be interesting to expand the research population to include Afro-American, Latino and Asian populations. Cultures that have a very thin body ideal and are in the process of changing the female role are vulnerable to eating disorders. There seemed to be a troubling relationship between being exposed to Western society and developing eating disorders, among females in particular (Katzman & Pinhas, 2005; Lee, 1996). The study of eating disorders in minority populations is still in its infancy (Fitzgibbon & Stolley, 2000).

Recommendations

Binge eating disorder is a relatively newly diagnosed mental illness. The women in this study felt frustrated that there were not adequate resources available to them. More support, education and programmes are needed to better serve the needs of this eating disorder population in B.C and the rest of the country. Health professionals need more education about BED in order to cease the automatic recommendation of weight loss diets or surgery as a solution to obesity. Therapists that specialize in BED are a great asset and can be added to any recovery program (just as have eating disorder specialists for anorexia and bulimia nervosa is beneficial).

A focus on the preventative programs that promote healthy body image and empower organizations to utilize the internet, influence policies and establish support groups for developing healthy body image. A preventative model implemented to educate and promote nutrition exercise and body acceptance at an early age needs to be a priority at educational and recreational facilities.

These educational programs implemented at the primary grades would include a curriculum on balanced nutrition, exercise and body acceptance; the focus being on health and fun activities *not* on weight loss, shape or size. It is important that even at these early grades critical thinking about ads and media are encouraged. It is important for young girls to understand that dieting is not a normal or healthy part of the female experience. It is often a slippery slope to disordered eating and poor body image.

Parents and educators need to pay attention to children and young teens who are coping through food. An eating disorder can feel as devastating as a drug or alcohol addiction. Dieting is not the answer.

As a society of parents, teachers and professionals, we need to come to terms with our own body image issues before we can model a healthy body image to our children. Reflecting on and examining our own biases and judgements about food, weight shape or size would be useful in order that we do not perpetuate harmful normative assumptions and stereotypical attitudes and images. Teaching our children that kindness towards other human beings no matter what their weight shape or size is far more important than physical appearance.

This research also suggests that it is important that children felt like they belong. Many of the women in this study felt that they did not belong in society nor in their own family. Carol Myss, author and spiritual healer recommends rituals that bring families together, not as a religious ceremony but rather as a spiritual bonding of the child to their tribe, thereby instilling a sense of belonging.

A holistic approach that deals with the mind, body and spirit implemented in the counselling of individuals with binge eating disorder shows promise in recognizing that every facet of a person is affected by this illness and consequently needs to be addressed in order for healing to occur. This type of program would be beneficial as

some of the women in this study felt that the BED affected their ability to access what they thought of as their spirit or “higher power”. Many clinicians have discussed the importance of spirit as a basis for discovering a more meaningful and purposeful existence, “eating disorders may represent a search for meaning, a desire for recognition and a perfection and a hunger for a deeper larger sense of themselves” (Leichner et al., 2001).

This research found that for many of the women in this study the symptoms of BED began in their young teen years and even earlier as children, while current research suggests that this illness is diagnosed in the late teen years or early twenties. BED needs to be considered as a potential disorder for both children and young teens. Although BED can be a problem at any age, many people do not seek help for BED until they are in their thirties, forties and fifties after years of struggling on their own with this illness (Nash, 1999).

Future Research

A potential for future research could be to study individuals with BED that are not obese as most research has been conducted on obese individuals with BED. Perhaps the categories for eating disorders should be re-evaluated, redefined and broadened so that more people may be included in programs and find support from these resources. This is also a way of recognizing and validating the experience that these individual's are living.

The study of eating disorders in males is another potential area of research as the occurrence of BED in males is higher as compared to other eating disorders such as anorexia or bulimia nervosa.

A further direction of research would be to examine the impact of family environment on BED. The importance of family is underplayed in many eating disorder books yet all the women claimed that the role of family was significant in their BED. Focus on research that includes prevention and the role of the family as significant in the early child's experience can play a role in developing greater immunity against eating disorders.

In all these very courageous women's stories of struggle, there was a light of hopefulness and strength that shone through their eyes... One day they would overcome this illness.

At the heart of every eating disorder whether it is compulsive eating, bulimia or anorexia, there is a cry from the deepest part of the soul that must be heard. It is a cry to awaken, to embrace our whole selves, to see past the limitations that we have put on ourselves, through defining our bodies or eating habits as good or bad. It is a way to deepen the understanding of who we really are. It is a call from the part of us that holds our desires and passions to grow heal and fulfill our dreams. (Normandi & Roark, 1998, p. 18)

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Appendix "A".

Criteria for Binge Eating Disorder

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - 1. Eating in a discrete period of time (e.g., within any 2-hour period) an amount that is definitely larger than most people would eat in a similar period of time under similar circumstances
 - 2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)
- B. The binge eating episodes are associated with three (or more) of the following:
 - 1. eating much more rapidly than normal
 - 2. eating until feeling uncomfortably full
 - 3. eating large amounts of food when not feeling physically hungry
 - 4. eating alone because of being embarrassed by how much one is eating
 - 5. feeling disgusted with oneself, depressed or extreme guilt after overeating
- C. Marked distress regarding binge eating is present
- D. The binge eating occurs, on average, at least 2 days a week for 6 months
- E. The binge eating is not associated with the regular use of inappropriate compensatory behaviour (e.g., purging, fasting, excessive exercise: and does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa) (American Psychiatrist Association, 1994, p.731).

Appendix "B".

Themes

Body Image and Weight Issues

- anemia
- diabetes
- excess weight
- fear and hate of being overweight
- feeling full
- hair loss
- high blood pressure
- high cholesterol
- indigestion
- irregular cycles
- not felt acceptable to family and friends when overweight
- obesity
- severe weight fluctuations from constant dieting
- sleep apnea
- stomach surgeries
- surgery complications
- women of average weight still obsessed with dieting behaviour

Emotional Connection to Food

- anger
- binge
- celebration
- depression
- disgust
- excitement
- fear
- guilt
- hate
- hurt
- loneliness
- love
- offered feelings of comfort and safety
- powerlessness
- sadness
- security blanket
- shame
- support
- weight-ism

Loss of Control

- being in a daze
- constantly dieting to gain control
- hopeless
- numbness
- powerless
- vicious cycle of dieting and bingeing

Not Belonging/Not Fitting-in

- abandoned
- a catalyst for BED
- fat gene feeling
- larger in size
- no sense of tribe
- not fit into family
- not good enough in family eyes
- shopping for clothes difficult

Not Good Enough

- not measuring-up
- flawed
- unworthy
- negative view of body
- unacceptable
- family stress
- abused
- body appearance

Cognitive Obsessions

- all or nothing
- leveller of experience
- negative mind
- obsessive thoughts
- preoccupation with thoughts and behaviour around food
- thinking black or white thoughts
- zoning out

Isolative Behaviour and Secrets

- disconnection
- hiding
- ideation
- loneliness
- lying
- remorse
- suicidal
- unconscious feelings