Recovery from Binge Eating Disorder

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ABSTRACT

The purpose of this study was to characterize the psychological processes of recovery from binge eating disorder (BED). A model was developed by asking the research question, "What is the experience of recovery for women with BED?" Unstructured interviews were conducted with six women who met the DSM-IV criteria for BED, and who were recovered from binge eating for a minimum of six months. The model consists of the core category, Self-Awakening, and four phases, Self-Reflecting, Assessing Present Life Situation, Healing/Restoring Oneself, and Creating Balance. The main psychological processes of each phase are outlined, and implications for counselling women with BED are discussed.

RÉSUMÉ

Cette étude avait pour objet de découvrir les processus psychologiques en jeu dans la guérison de l'hyperphagie boulimique. Un modèle fut élaboré à partir de la question : « Que vivent les femmes qui guérissent de l'hyperphagie boulimique? » Des entrevues libres ont été menées avec six femmes, qui toutes répondaient aux critères de l'hyperphagie boulimique du DSM-IV et dont la guérison remontait à au moins six mois. Le modèle est constitué d'une catégorie centrale, *L'Éveil à soi*, et de quatre phases : *Réflexion sur soi, Évaluation de la situation de vie actuelle, Auto-Guérison et Établissement d'un équilibre*. Les principaux processus psychologiques en jeu à chaque phase sont décrits, et les effets de ces processus sur le counseling de femmes ayant une hyperphagie boulimique sont discutés.

The prevalence of binge eating disorder (BED) is estimated at anywhere from 1% (Hay, 1998) to 2% (Spitzer et al., 1992) in the general population, to as high as 25% in obese patients seeking weight loss treatment (Hsu et al., 2002; for a thorough review of prevalence rates see Striegel-Moore & Franko, 2003). Many of those with BED are women (Smith, Marcus, & Eldredge, 1994; Spitzer et al., 1992). This disorder is associated with negative consequences such as emotional distress (Spitzer et al., 1992), impairment in work and social functioning (Spitzer et al., 1993), physiological consequences including abdominal pain, headaches, dizziness, fatigue (Leon, Carroll, Chernyk, & Finn, 1985; Lingswiler, Crowther, & Stephens, 1989; Loro & Orleans, 1981), and obesity (Bruce & Agras, 1992; Striegel-Moore et al., 2001).

Binge eating without compensatory behaviours was first studied by Stunkard (1959). In 1994 the classification of BED was finally included in the DSM-IV (see Appendix 1 for the criteria for BED) (American Psychiatric Association, 1994). Although BED is one of the newer issues examined in the field of eating disorders, there appears to be sufficient research evidence to support its use as a diagnosis distinct from anorexia nervosa and bulimia nervosa (Schmidt, 2000; Sullivan, 2001; Vervaet, van Heeringen, & Audenaert, 2004; Wilfley, Wilson, & Agras, 2003). Despite the fact that bingeing is a common feature shared between BED and bulimia nervosa, there are unique features of each that are important for diagnosis and treatment. For example, unlike individuals with bulimia nervosa (purging or nonpurging types), those with BED do not engage in regular inappropriate compensatory behaviours such as self-induced vomiting, misuse of laxatives, fasting, or excessive exercise (American Psychiatric Association). As well, one study found significant differences between people with BED and bulimia, nonpurging type. Those with BED were older, had a longer duration of the disorder, had larger weight cycling, and higher current and previous body mass index (Vervaet et al.).

The purpose of this research project was to investigate the psychological processes of recovery from BED. A model was developed from the participants' responses to the question, "What is the experience of recovery for women with BED?" The participants identified the factors that stimulated and sustained the recovery process. More specifically, the model suggests that recovery is a process of Self-Awakening, whereby the individual resolves the issue of disconnection to self. Counselling implications are based on the suggested stages of recovery and the strategies that emerged from this study.

RESEARCH ON BINGE EATING DISORDER

Due to its relatively new status as a diagnostic category, the research on recovery from BED is limited. To date only two studies have focused on the natural course of BED without treatment (Cachelin et al., 1999; Fairburn, Cooper, Doll, Norman, & O'Connor, 2000). A number of studies on treatment outcome have focused on the outcome of cognitive behaviour therapy (CBT) or compared CBT with other treatments such as interpersonal psychotherapy or behavioural weight control (for a review see Dingemans, Bruna, & van Furth, 2002). The research has not yet focused on the subjective experiences of recovery from BED, nor has it addressed the contributing factors of recovery.

The literature suggests that eating disorders, particularly binge eating (Heffernan, 1994; Katzman & Wolchik, 1984; Telch, 1997), can be a coping strategy. Therefore, it is important to examine how BED is replaced with healthier strategies for coping. Counsellors can use this information to facilitate the recovery process of clients by discussing what others have found helpful and how the strategies were implemented.

THE CURRENT STUDY

In order to obtain a rich understanding of recovery, grounded theory (Glaser & Strauss, 1967) was selected as the research method for the current study. As an interpretive inquiry approach, the grounded theory method is appropriate for use in an area that is being explored for the first time (Glaser & Strauss, 1966). In addition, grounded theory captures the meaning of the participants' experiences in the development of a theory.

Participants

When using this method, sampling decisions are guided by the emergence of the grounded theory (Glaser & Strauss, 1967). Theoretical sampling, the selection strategy used in grounded theory, is accomplished by moving from one participant to the next while developing categories and building theory (Corbin, 1986). The researcher simultaneously collects, codes, and analyzes the data, and the emerging hypotheses guide further sampling directions (Chenitz & Swanson, 1986). For this study, participants were initially selected if they were able to contribute to an understanding of recovery from BED. After the first four participants were selected and interviewed, a working model of recovery was developed. In order to provide more variation to the model, the next participants chosen had to be different from the previous participants in some way, for example, have recovered for a longer period of time, or have struggled with binge eating for a longer period of time. The strategy dictates that sampling continue to occur until theoretical saturation has been reached; that is, no new or relevant data emerge regarding a category, category development is dense, and the relationships between categories are well established and validated (Glaser & Strauss, 1967). In this study, selection continued until saturation was reached with a total of six participants.

Participants were female over the age of 18 who met the DSM-IV (American Psychiatric Association, 1994) criteria for BED at some point in their lives, and who were recovered for a minimum of six months. Participants were recruited through word of mouth, community-based posters, and contact with Overeaters Anonymous (OA). A total of nine women expressed interest in the study. The final sample included six women who ranged in age from 26 to 46, were white, middle class, and university or college educated. Four of the six women attended counselling. The age of onset of binge eating ranged from 5 years old to 22 years old, and the length of years in recovery ranged from 1 year to 12 years. Recovery was defined as the absence of the criteria required for the diagnosis of BED, and the subjective opinion that one no longer suffers from BED.

Interview Process

The majority of participants were interviewed twice for an average of 80 minutes. The first interview was unstructured, thereby allowing the participants to describe the experiences of recovery in their own words (Swanson, 1986). To

begin with, participants were asked the question, "How were you able to recover from binge eating disorder?" A transcript of the interview was given to the participant to review for correction or clarification.

The second interview was more structured and narrow in focus in order to address missing information (Swanson, 1986). After the interviewing process and subsequent data analysis, a copy of the emerging model was sent to each participant for feedback. This step helped to ensure the trustworthiness of the developing model. The feedback was received by phone and e-mail, and the feedback was then used to make any necessary corrections to the transcripts, categories, and model.

Data Analysis

The procedures for the grounded theory method as outlined by Strauss and Corbin (1990) were followed. Based on the first author's experience working with women recovering from eating disorders, the transcripts were analyzed closely in order to name and categorize the phenomena. Questions such as "What do I see going on here?", "What are people doing?", and "What is happening?" were asked as part of the analysis (Charmaz, 1983). The constant comparative method was used throughout data collection and analysis. Comparisons were made between the interviews to check for similarities and differences (Chenitz & Swanson, 1986). The data were also examined again and again to provide a check on their trustworthiness (Hutchinson, 1986).

The data consisted of basic units of analysis that were carefully broken down into concepts (Strauss & Corbin, 1990). These concepts were then grouped into substantive codes, which reflected the substance of the participants' descriptions (Glaser & Strauss, 1967). The codes were then categorized and conceptualized. Pertinent reflections about the research process were recorded in the form of memos (Stern, 1980). Memo writing was the method used to record ideas generated about the data, which aided in the model's development (Chenitz & Swanson, 1986). Ideas and hypotheses about the categories were generated and then tested with the data. Contradictory data that did not fit with what had already been found was kept to add to the richness of the model as it progressed (Hutchinson, 1986). Relationships between the categories continued to be developed until a pattern among relationships emerged. Analysis focused on the interrelationships between categories, and a model about the relationships was produced (Chenitz & Swanson). The second author provided an audit of the emerging categories and model.

A MODEL OF RECOVERY FROM BINGE EATING DISORDER

The model of recovery from BED included a core category, "Self-Awakening," and four suggested phases, "Self-Reflecting," "Assessing Present Life Situation," "Healing/Restoring Oneself," and "Creating Balance." Each of the four phases was analyzed within the paradigm model, which provided a framework

for drawing connections and denoting relationships between the categories (Strauss & Corbin, 1990). The data analysis addressed context, intervening conditions that facilitated or constrained strategies in a specific context, strategies carried out under a specific set of perceived conditions, and consequences of strategies (see Table 1).

Self-Awakening as a Core Category

The core category that links together the categories and their properties was Self-Awakening. Self-Awakening is the process that the women went through to resolve the disconnection between themselves and the world. This activity occurred over the course of four phases. Movement from one phase to the next was dependent on the presence of Self-Awakening. For instance, before the participants moved from Phase II to Phase III, they had an "awakening" to the realization that there was a problem with binge eating. With the new revelation, greater

Table 1
Grounded Theory of Recovery from Binge Eating Disorder

Core Category	Phases of Recovery	Paradigm Model and Categories	
Self-Awakening	Phase I: Self-Reflection	Context:	Life changes/transitions
			Disapproval from others
		Conditions:	Distress
		Strategies:	Attempting to recover
		Consequences:	Contemplation
			Desperation
	Phase II: Assessing Present Life Situation	Context:	Dissatisfaction
		Conditions:	Wanting something better for self
		Strategies:	Seeking information
		Consequences:	Gaining awareness
	Phase III: Healing/ Restoring Oneself	Context:	Learning
		Conditions:	Striving for personal happiness
			Accepting ambiguity
			Attending to emotions
		Strategies:	Changing relationship to body
			Changing relationship to food
			Breaking isolation
			Creating alternatives
		Consequences:	Self-assertion
	Phase IV: Creating Balance	Context:	Making room for life
		Conditions:	Fostering self-renewal
		Strategies:	Practicing prevention
			Maintaining changes
		Consequences:	Experiencing self-acceptance
			Overcoming obsession

freedom was encountered in terms of learning what might be helpful in the recovery from binge eating.

The "awakening" was integral to the ongoing movement toward recovery. While the participants were in the midst of binge eating, there was a lack of self-awareness. They avoided troublesome experiences and emotions by "numbing." As some participants stated, there was a disconnection from the body and also from emotions.

Through the process of recovery, the women "awakened" to what was actually taking place in their lives. They noticed emotions, desires, and hopes in life. Furthermore, the women gained awareness about what contributed to binge eating, the detrimental effect of low self-esteem and negative body image, and what minimized relapses. The women found safety and support in opening up to others. The process of recovery also involved trying new strategies to recover and learn from their experience. Self-Awakening enabled the women to reconnect with themselves and with the outside world.

Phase I: Self-Reflecting

During this suggested stage of recovery, the participants' engagement in self-reflection set the stage for the possibility of recovery to follow. Two main contexts affected the women's lives: life changes/transitions and disapproval from others. The participants experienced one or more forms of life change or transition such as moving, the death of a loved one, the end of a relationship, starting a new job or school, and having a birthday. One woman talked about the impact of having a new job:

> I had just started working in a business I really enjoyed … and life was just wonderful, and I was eating my face off … and that's when I really … had to look at my real recovery, and for me it really took off at that point.

Disapproving messages from others were related to the amount of food consumed or body size. The women received these messages directly and indirectly in the form of jokes or by others maintaining physical distance. One woman spoke of being at family gatherings in which her weight was the target of jokes.

The intervening condition was distress, which included experiences of fear, negative feelings about self, a low point, isolation, physical discomfort, obsession with weight and food, loss of control, lack of acceptance by others, and self-punishment. As one participant described:

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

At this suggested stage the women were attempting to recover with the strategies of seeking help and focusing on weight loss. They sought help in the form of counselling, health care professionals, diet clinics, and Overeaters Anonymous. However, the strategies were short-lived at this stage of recovery. These resources and strategies were reconsidered at a later point in the recovery process.

Some participants focused on the strategy of weight loss due to being obsessed with weight and food. Food choices were re-examined and weight control was practiced. The participants described their experiences as follows:

> I just felt like I was on a compulsive diet, where I sat there and counted everything I ate. Even the smallest carrot stick, I counted as 5 calories.…I remember one time I weighed myself up to 12 times a day or more just to really punish myself and to sink in my head "You're getting fat."

As a result of this phase, the women began to contemplate, and feelings of desperation emerged. The "contemplating" category highlights a growing awareness of the lack of personal change. The women were not recovering despite many attempts to stop bingeing. They began to question why bingeing continued and what contributed to the problem. The following comment reflects this process of questioning: "It's like a gradual process … it's not like one day you wake up and … ask yourself 'Why?' and that's the end of it. You still binge, but you're starting to ask yourself 'Why am I doing this?'"

Another consequence in Phase I was desperation. The women made many attempts to recover and felt they did not know what else to do, which prompted the search for new avenues of recovery. The following comment reflects the desperation one participant felt:

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

Phase II: Assessing Present Life Situation

In the second phase, the participants began to assess present life circumstances in terms of hopes and aspirations. The context was dissatisfaction. One woman spoke of her personal dissatisfaction: "I didn't want to do it anymore, I was sick and tired of doing what I was doing. And that's what made me say, 'What am I willing to do to recover?'"

Along with the dissatisfaction was a desire for something better. Disenchanted with the unhealthy patterns of life, the women started to think about desires for a different life. Desired changes were expressed in many areas such as binge eating behaviours, friendships, and feelings about food and body size. In addition, the women expressed the goal of finding happiness. These new desires were noted in the following comments:

> I was on this big quest for "How do I be happy? How can I be happy with who I am? And how can I be happy in my life?" … it's like I'm wasting my time doing this. I'm not doing anything … I don't have a good job, I don't have an education … it was like let's take this brainpower and do something else.

The strategy used in this suggested stage was information seeking. The most common strategy was to read books about binge eating, nutrition, codependent relationships, and self-esteem. Others sought information by attending workshops related to binge eating, body image, and self-esteem.

The consequence of the events of this phase was that the participants started to gain awareness. Women acknowledged that there was a problem and that help was needed. Personal issues related to self-esteem, family of origin, or other distressing events were identified. Some women also developed an awareness of engaging in self-punishing behaviours. Examples of the growing awareness were reflected in the following comments:

> So I knew that I didn't like the fact that I was eating lots … to the point where I was sick. So I think I realized it was a problem. [I thought] maybe it's true what I've been reading, that it actually is quicker to deal with the problem rather than cover it up by something else.

Phase III: Healing/Restoring Oneself

The third phase involved considerable action taken by the women to facilitate recovery. The most visible signs of change occurred during this phase. It was also during this phase that the momentum of recovery increased.

The context of this phase was learning from sources such as the women's internal realizations, books, courses, self-help groups, counsellors, and role models. They acquired important knowledge from others who had experienced binge eating. From these external sources of information, the women learned about cultural influences on body size and about the binge-diet cycle. The women also learned from making shifts in previously held beliefs. First, thinness was no longer equated with happiness. Second, taking control of one's life and managing food became possibilities. Third, they were not alone in the experiences with binge eating. The following comments illustrated the acquired learning:

> Being … physically skinny doesn't necessarily make me happy, it comes from within. … [realizing I wasn't alone] made it seem like it wasn't such a huge … problem … maybe I'm not so abnormal, maybe I can change this, maybe there is hope for me.

Three intervening conditions occurred in phase three: striving for personal happiness, accepting ambiguity, and recognizing emotion. At this stage, the participants felt that striving for personal happiness meant doing something to accomplish the goal of happiness. This included addressing personal issues and nurturing self-acceptance. An example of nurturing self-acceptance was captured in the following comment: "The desire to accept myself as I was. To recognize that there was a genetic link to my body type and to accept it. There was a big push to just accept myself as I was."

Accepting ambiguity captured the participants' entry into "unknown territory" as a part of the recovery process. Because past attempts at recovery were unsuccessful, they had a need to find alternatives. Risks had to be taken, as it was not known what would happen as a result of new recovery attempts. Accepting ambiguity included taking risks and trying new ideas. It was necessary to give up control over certain aspects of life such as eating habits, food, emotions, and weight. As one participant stated: "[T]here were control issues as well, letting go of control of other things, other people. That was freeing also. To give up control over worrying about things I had no control over."

Attending to emotions, particularly difficult emotions such as anger and sadness, is the third intervening condition in this phase of recovery. The participants spoke of starting to recognize and pay attention to emotions, whereas they had made attempts in the past to "bury" or "numb out" emotions with food. The women became aware of emotions, accepted those emotions, connected the binge eating with emotions, allowed the experience of emotions, and reflected on emotions. One participant described how experiencing her emotions helped her recovery:

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

There were four strategies in the third phase: changing relationship to body, changing relationship to food, breaking isolation, and creating alternatives. Changing relationship to body refers to the new relationship that the women developed with their bodies in order to feel better about and more connected with their bodies. Participants discussed the negativity toward and disconnection from their bodies while binge eating. The implementation of new strategies enabled the women to experience greater comfort and connection with their bodies. The reduction of weight monitoring strategies helped to diminish the focus on weight loss. In addition, the attention given to internal body cues or signals such as hunger reflected the growing trust in listening to their bodies. As a result, the strategies of overexercising, dieting, or fasting lessened considerably. One participant described the changes she made: "I had to … [decide] to take better care of my body, not by dieting, not by fasting, not by exercising … to realize that all that wasn't necessarily good for my body either."

Changing their relationship to food was another strategy used to recover from binge eating. This was a result of the participants' willingness to take risks in different ways. The women experimented with food. The previously held rules about food consumption were eliminated or modified. A concerted effort was made to examine what was being eaten and how food was being used. The variation of approaches to food were reflected in a number of ways: inclusion of forbidden foods, ceasing all diets, eating when hungry, eating until full, not eating when emotional, eating healthier food, enjoying food, planning meals/structuring meal times, and abstaining from binge foods. Furthermore, there were deliberate attempts to remain aware of what, how much, and how fast food was being consumed. The following comments illustrated some of these approaches: "just not eating on the run, but trying to … have a meal planned … rather than just sort of stuffing my face as I ran out the door." "just three meals a day, and I didn't restrict on any specific foods … because as soon as I would try to cut something out I would obsess about it."

The third strategy is breaking isolation. Up to this point the women experienced isolation, but during this phase ways were found to overcome it. By opening up to others in a more personal way, reconnecting with previous sources of support, and accepting the support of others, participants lessened their isola-

tion. Clearly, it was very important for the women to move from isolation to making meaningful connections. An example of this strategy included the following comment:

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

Creating alternatives is the final strategy used in the third phase. The women assumed more responsibility for healing. Instead of automatically turning to binge eating when the urge to eat arose, they chose healthier alternatives. Several women spoke of writing in a journal or engaging in exercise to minimize stress. Taking a hot bath, talking to a confidant, and attending counselling or Overeaters Anonymous were also used as strategies. In addition, the women became aware of emotional needs. Instead of trying to meet these needs with food, they sought alternatives. One participant who felt lonely or upset made the choice to seek out someone to spend time with or to call up a friend.

One of the consequences of this phase was the increased ability to be assertive. Self-assertion was manifested in two ways: eliminating negative relationships and standing up for oneself. Several participants ended relationships that were unhealthy or detrimental. Others spoke of leaving abusive relationships, severing ties with family members, and ending friendships. Standing up for self was another strategy. For example, one woman noted that she began to defend the values she believed in. Another woman talked about her choice to relinquish a passive role in her relationship.

Phase IV: Creating Balance

The fourth phase, Creating Balance, is the final phase of recovery. The women began to enjoy life more and experience greater stability. Creating Balance is demarcated by the women's pursuit of hopes and desires and the maintenance of the changes made.

The context of the fourth phase is making room for life. The women were no longer focused on the problem of binge eating. Instead, they devoted time to meaningful experiences. Making room for life included: working toward personal goals, thinking about the future, becoming involved with life, becoming less self-absorbed, connecting with others, and helping others. Emphasis was placed on being productive, pursuing new activities, and reclaiming goals. The participants met new people and formed new friendships. Some of the women sought out opportunities to do volunteer work or help those in need. The desire to contribute to the lives of others is reflected in one participant's comments on her changed aspirations: "Now … I contribute myself to the world … I'm not always hung up on thinking about me."

Fostering self-renewal is the intervening condition of the fourth phase. The participants engaged in experiences that promoted personal growth or self-renewal. These endeavours paved the way for self-care. Self-care had been hin-

dered in the past because the women had not been aware of their needs and were engaged in self-punishment. Given these hindrances, they were not ready to nurture themselves. The experiences associated with fostering self-renewal included: spirituality, quality time alone, enjoyable activities, self-knowledge, self-acceptance, and self-compassion. Fostering self-renewal is illustrated in the following comment: "And [one way to] get rid of these negative messages, is to go … and do something really nurturing, to do something in opposition to those messages."

The strategies that emerged in this phase of recovery are assumed under the category "practicing prevention/maintaining changes." In order to maintain the changes, the participants engaged in strategies that prevented relapses, including proactive and reactive strategies. The proactive strategies were used in preparation for vulnerable times when the urge to binge arose. These strategies included self-monitoring, changing self-talk, and identifying vulnerabilities. The reactive strategies were used in direct response to the urge to binge. The reactive strategies identified by the participants included doing something else or choosing not to binge. Some strategies were considered both proactive and reactive. These strategies were identified as remembering the past and addressing underlying issues. Some women remembered the past in order to be mindful of what their lives were like before recovery. For instance, one participant said, "I guess it helps to have my memories of the bad times to … not go back there again. Not to forget … I wasn't happy there, and that it's not fun to feel out of control." Addressing underlying issues meant identifying what might have triggered the urge to binge or addressing these factors before the urge in order to circumvent binge eating.

There are two consequences associated with this final phase: experiencing self-acceptance and overcoming obsession. The experiences of recovery fostered self-acceptance. The participants began to gain a positive self-concept as negative thinking and self-punishment were minimized. Self-acceptance was reflected in improved self-esteem, increased comfort with body size, permission to incorporate positive messages, enhanced belief in abilities, and the acceptance of struggles throughout the recovery process. One participant captured these changes in the following comment: "Giving yourself permission to have those slip ups … to the point where you almost accept it, and all of a sudden it becomes a lot easier to deal with…because you can't recover from something if you're always punishing yourself."

The second consequence in Phase IV is overcoming obsession with weight and food. The women were no longer preoccupied with food, weight gain, or weight loss. As important sources of life meaning emerged, food and weight no longer held the same importance as in the past.

DISCUSSION

The findings in this study suggest several considerations for counsellors working with clients who have BED. These include issues to be aware of and to address

in therapy when working with this population, and ideas about what people who have had eating disorders have found helpful in their recoveries.

Readiness for Change

Research suggests that only a small percentage of women who binge eat seek treatment specifically for eating issues (Thompson, 1994; Whitaker et al., 1990). Most of the participants in this study who attended counselling sought assistance to discuss other concerns and not to intentionally address eating issues. Counsellors need to inquire about the client's coping strategies as a means of identifying the possibility of BED.

Counsellors who work with clients with BED need to be cognizant of the individual's stage of recovery and the attempts that have been made to recover. By keeping in mind the suggested stages of recovery, therapy can be tailored to address the client's level of readiness for change (Levy, 1997). The models of change that can be used for this purpose include the present study's model of recovery, the transtheoretical model (a five-stage model that represents the various constellations of intentions and behaviours that individuals pass through as they move from having a problem to doing something about it; see Prochaska & Norcross, 1999), or Virginia Satir's model of change (a six-stage model that also outlines the process of a person moving from having a problem to making a change; see Gross, 1994). For example, the findings of this study suggest that a client in Phase II of recovery is likely to be seeking information. Therapists in turn, could provide assistance in the form of book recommendations or educational workshops.

Counsellors can also be guided by what the client found helpful and unhelpful during past attempts at recovery. DiClemente et al. (1991) suggest that relapses and repeated attempts enable the individual to learn from past mistakes and try new strategies for recovery.

Contextual Influences on BED

The findings of this study indicate that recovery from binge eating involves more than changing eating patterns. Several contextual issues may need to be addressed or considered in addition to focusing on changing the behaviour of binge eating. A feminist approach helps us to understand these issues as they relate to eating disorders. This perspective explores why more women than men are vulnerable to eating disorders, and makes a connection between women's relationship to their bodies and the conditions of their lives (Brown, 1993). Thompson (1994) describes eating disorders as "survival strategies—sensible acts of self-preservation—in response to myriad injustices including racism, sexism, homophobia, classism, the stress of acculturation, and emotional, physical, and sexual abuse" (pp. 1–2).

Based on a study of women who recovered from bulimia nervosa, Peters and Fallon (1994) argue that recovery is a multi-dimensional process involving a progression of changes in relationship to self, body, family, and culture. Counsellors

need to consider the individual's context or environment. The conditions that have shaped an individual's experience with weight and eating are important factors (Brown, 1993).

The participants in this study discussed the influence of external messages on weight and binge eating. In addition, various forms of abuse and family problems often served as the contexts in which binge eating began. Participants who had attended counselling spoke of the benefits of addressing the family context and/or the cultural context in terms of the embedded food and weight messages. The opportunity to discuss these personal conditions contributed to overall recovery. Peters and Fallon (1994) also found that an essential component of treatment was the ability to talk about physical, sexual, and emotional abuse to those who listened and honoured their pain. As identified in this study, there were other concerns that were necessary to explore in therapy. These included body image, self-esteem, depression, and emotions.

Body image and self-esteem. The findings in this study point to the participants' struggle with body image. Prior to recovery, their struggle to be thin was accompanied by negative thoughts about the body. This type of body dissatisfaction (Barry, Grilo, & Masheb, 2003; Goodrick et al., 1999; Hsu et al., 2002; Romano & Quinn, 1995) and drive for thinness is frequent among women with BED (Goodrick et al.). Rorty, Yager, and Rossotto (1993) found that women who had recovered from bulimia nervosa identified negative body image and the fear of becoming fat as the most difficult issues to change in the recovery process. Similarly, the participants in this study noted that addressing negative body image was a difficult and ongoing challenge. Recovery involved learning to accept the body and to overcome weight and shape obsession.

One study found that women who recovered from anorexia nervosa regarded the goal of positive experiences of one's self and body as the most important focus for therapy, while eating and weight were considered the least important therapeutic goals (Noordenbos, 1989). Although similar information has not been gathered from women's recovery from BED, the participants in this study emphasized the importance of working on the issue of body image over eating behaviours. Due to the fact that body image is a struggle for women with BED, therapy is an appropriate arena to address this issue.

Linked with poor body image is the issue of self-esteem. Women with BED often have low self-esteem (Crow, Agras, Halmi, Mitchell, & Kraemer, 2002; de Zwann et al., 1994; Goodrick et al., 1999). The participants in this study identified a connection between poor self-esteem and binge eating. Through the process of recovery, the women's self-esteem improved. The association between recovery and self-esteem has been found in other research. Troop, Schmidt, Turnbull, and Treasure (2000) noted that increases in self-esteem were associated with recovery from bulimia nervosa. Furthermore, those who changed little in self-esteem levels also maintained bulimic symptoms.

Stanton, Rebert, and Zinn (1986) discovered that the desire to improve self-esteem was the most influential factor in initiating change in women with bulimia

nervosa. Rossotto, Rorty-Greenfield, and Yager (1996) suggest that in order for women to recover from bulimia nervosa, women must acknowledge the harmful impact of low self-worth and begin to accept themselves despite the struggle with the eating problem. Ronel and Libman's (2003) study also suggests that self-acceptance is an important foundation of developing self-esteem during recovery. Given the associations between BED, self-esteem, and recovery, it may be helpful for therapists to assess the self-esteem of clients with BED, and incorporate relevant strategies to enhance low self-worth.

Exploring Emotional Costs of BED

Research supports the connection between recovery and exploring emotions. Thompson (1994) suggests that recovery depends on a woman learning that she has the right to feel, and learning how feelings affect actions, including eating patterns. The participants in her study identified how painful emotions fueled eating problems, and described the need to understand emotions rather than eat to cope with emotions.

One particularly relevant emotion for individuals with BED is depression (de Zwann, Nutzinger, & Schonbeck, 1992; Kuehnel & Wadden, 1994; Marcus et al., 1990; Mussell et al., 1995; Specker, de Zwann, Raymond, & Mitchell, 1994; Spitzer et al., 1993; Yanovski, Nelson, Dubbert, & Spitzer, 1993). The participants in the present study identified many signs of depression, such as suicidal ideation, lack of energy, feelings of worthlessness, and sleep disturbances. Counsellors need to assess for symptoms of depression, and consider counselling to address affect regulation as needed, while exploring the contextual influences on depression.

The participants in this study emphasized the importance of exploring emotions in the recovery process, as binge eating was often used as a means of escaping emotions. The recovery process involved an exploration and acceptance of the emotions that may be associated with binge eating.

Developing a social network (Ronel & Libman, 2003) and seeking emotional support (Pettersen & Rosenvinge, 2002) contribute to the recovery process. Women who recovered from anorexia nervosa identified that relationships played a major role in their recoveries (Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). Yager, Rorty, and Rossotto (1995) found that women who recovered from bulimia nervosa show a greater tendency to seek out emotional support and express emotions compared to nonrecovered women.

Counsellors need to keep in mind that clients with BED may not be aware of the connection between emotions and the use of food. It may be necessary for counsellors to educate clients about the role of emotions in maintaining eating issues. Clients could benefit from assistance in identifying and exploring emotions, and developing an adequate support system.

SUMMARY AND CONCLUSION

This study provides a theoretical model as a framework for understanding the recovery experiences of women who once had BED. Different strategies and factors that facilitate and aid recovery during each phase of the process are presented, as well as ideas and suggestions for clinicians. The major strength of this study is the fact that it is the first known study to examine recovery from BED from the perspective of the participants.

Although measures were employed to ensure the trustworthiness of this study, some considerations must be taken when examining the results of this study. The transferability of this study may be limited due to the small number of participants and degree of homogeneity of women who participated in this study. Although the researcher made attempts to obtain variation, all of the women were white, middle class, and college or university educated. As a descriptive, qualitative study, the results are not generalizable to others with BED. However, the description of the stages of recovery for these six women may provide other researchers with direction in designing studies with larger samples. An additional limitation of this study is the issue of memory. The participants were asked to recall and discuss their experiences of recovery. For some participants, the events were many years ago. Checks on credibility enabled the data to be repeatedly compared and contrasted. Furthermore, the constant comparative method was used to show that different participants were saying the same thing.

The limited research on recovery from BED needs to be expanded. For example, future research could address recovery with a broader population, recovery with and without treatment, and predictors of outcome in BED. Additional research studies are also needed to confirm the suggested stages in the process of recovery.

Recovery from BED appears to be a long, difficult, and ultimately rewarding process. The findings suggest that it is possible for women to recover and have a healthy relationship with food, themselves, and others. Counsellors can promote the recovery process for clients by offering knowledge about eating disorders and how eating disorders affect women's lives, and effective strategies for recovery.

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Appendix 1
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 very guilty 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 Psychiatric Association, 1994, p. 731.)

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