RESEARCH ARTICLE

How Does Overeaters Anonymous Help Its Members? A Qualitative Analysis

Shelly Russell-Mayhew[1*,†], Kristin M. von Ranson[2‡] & Philip C. Masson[2§]

[1]Division of Applied Psychology, Faculty of Education, University of Calgary, Canada

[2]Department of Psychology, Faculty of Social Sciences, University of Calgary, Canada

Abstract

Overeaters Anonymous (OA) is a 12-step, self-help group for individuals who perceive themselves to have problems with compulsive overeating. Despite the popularity of OA and the frequent use of addictions-based treatments for eating disorders, little is known about how OA is helpful. The purpose of this qualitative study was to explore members' experiences with and perceptions of OA. We conducted three focus groups with self-selected members of OA ($N = 20$). We present three primary themes that emerged from the analysis of the focus groups' discussions, which emphasize why individuals entered OA, OA's 'tools', and how individuals perceived OA to 'work'. Overall, although participants agreed OA was helpful to them, there was no consensus regarding how OA 'works'.

Keywords

compulsive eating; self-help techniques; self-help groups; support groups; recovery (disorders)

***Correspondence**

Dr. Shelly Russell-Mayhew, EdT 318, Division of Applied Psychology, Faculty of Education, University of Calgary, 2500 University Drive NW, Calgary, Alberta T2N 1N4, Canada. Tel: 403-220-8375; Fax: 403-282-9244.

Email: mkrussel@ucalgary.ca

Published online 13 October 2009 in Wiley InterScience (www.interscience.wiley.com) DOI: 10.1002/erv.966

Considerable knowledge has accumulated in the literature on the treatment of eating disorders and related problems. Unfortunately, treatments often fail to result in complete symptom remission and only help a proportion of individuals (le Grange & Lock, 2005; Thompson-Brenner, Glass, & Westen, 2003). Further, novel theoretical concepts or intervention approaches tend to be slow to enter the repertoire of accepted practice. To advance the field, it may be useful to understand what is appealing about specific intervention approaches, and examine what procedures or techniques clients believe reduce symptoms and distress.

A recent survey indicated that addictions-based treatments, including those administered through Overeaters Anonymous (OA) and other 12-step-based approaches, were used often or always by 26.9% of mental health practitioners who treated people with eating disorders and related problems, and an additional 15.9% often or always referred to addictions-based treatment approaches as a supplement for individuals receiving formal eating disorder treatment (von Ranson & Robinson, 2006). Further, a survey of 177 English-language internet websites for treatment programs emphasizing eating disorders, including programs from United States (87.0%), Canada (5.6%) United Kingdom (5.6%) and South Africa

[†]Assistant Professor.

[‡]Associate Professor.

[§]Graduate Student.

(1.9%), found that 30.5% incorporated addictions-based components into their eating disorder treatment programs (von Ranson & Cassin, 2007). Taken together, research suggests that ~30% of eating disorder treatment programs and clinicians across North America use addictions-based psychotherapies (von Ranson & Cassin, 2007). The frequent use of addictions-based treatments for eating disorders, including OA, suggests it is important to examine these approaches as a first step towards understanding their potential utility.

The gap between research and psychotherapy practice has been well documented and nowhere is this more evident than in the treatment of eating-related problems. Despite extensive research supporting CBT as an effective treatment for bulimia nervosa and binge eating disorder (BED, for a review, see Wilson, Grilo, & Vitousek, 2007), many clinicians use alternative approaches instead, including addictions-based treatments (Haas & Clopton, 2003; Mussell et al., 2000; von Ranson & Cassin, 2007; von Ranson & Robinson, 2006). For mental health professionals and lay people, including families of and people with eating disorders and related problems, it appears to be appealing to conceptualize eating disorders as addictions. The phenomenon of addictions-based treatments for eating-related problems, while controversial (von Ranson & Cassin, 2007), is important to explore because there is no efficacy research on addiction-based treatments for eating disorders. Nevertheless, this approach continues to be used by clinicians and sufferers, possibly with clinical success.

Overeaters anonymous

'Anonymous' or 12-step groups are based on principles and practices originating from Alcoholics Anonymous (AA). These groups consist of individuals with shared experience of addiction whose primary purpose is to abstain from using the identified addictive substance (e.g. certain foods) and to carry a message of recovery to others who suffer (Overeaters Anonymous, 1990). Anonymous groups, which constitute a low-cost self-help treatment option for addictions, are found in communities all over the world, with approximately 6500 OA meetings in 65 countries (Overeaters Anonymous, n.d.). OA provides a 12-step model, a process that involves 12 predetermined 'steps' individuals follow to overcome an addiction, such as making amends and taking a personal inventory (Overeaters Anonymous, 1990), that appears to be relevant for people with disordered eating. People attend OA to obtain support for and help addressing what OA terms 'compulsive overeating'. All OA members use the same framework to recovery from compulsive overeating; no distinction is made in assisting individuals who may have anorexia nervosa, bulimia nervosa, BED, obesity or other eating-related problems.

Although superficially an eating disorder may be experienced or described as similar to an addiction (i.e. both involve loss of control, increased use of substances, guilt), it is unclear to what degree this conceptualization is truly apt. The similarities cited between addictions and eating disorders are often based on people who binge eat, even though binge eating is only one symptom of eating disorders, and some eating disorders do not involve binge eating (Wilson, 2000).

Little research has been conducted on OA in its 45-plus years of existence (Westphal & Smith, 1996). OA is available to anyone regardless of the kind or severity of eating problem they may experience, but no research has addressed how effective OA may be at treating compulsive overeating or other eating problems (Westphal & Smith, 1996). Despite the existence of plentiful OA-sponsored material describing OA and its goals, the content included in OA groups is not tightly regulated or controlled. Thus the emphasis of each group may vary depending on the views of its regular members, including how the OA program is interpreted and implemented, and what aspects are emphasized. Little data exist about OA members' experiences in the program or their views about elements of the program that are helpful.

The use of OA and other 12-step models for the treatment of eating disorders and related problems is controversial (e.g. Davis & Claridge, 1998; Wilson, 2000). Investigating the use of OA for the treatment of disordered eating symptoms neither denies the well-established comorbidity of substance abuse and eating disorders (e.g. von Ranson, Iacono, & McGue, 2002; Wonderlich & Mitchell, 1997; Zeitlin, 1999) nor does it discount possible contributions of other therapeutic approaches from the addiction area (i.e. stages of change model; Prochaska, DiClemente, & Norcross, 1992), but rather explores OA membership as a means of understanding the frequent use of an addictions-based model by people with disordered eating attitudes and behaviours. Advocates claim that OA is 'not universally understood or appreciated' but can provide

the support needed to begin and sustain recovery from disordered eating attitudes and behaviours (Yeary, 1987, p. 303). Critics of addiction-based models of eating disorders have raised concerns about a number of potentially misdirected premises, such as promoting forbidden foods and hypervigilance about food, which they believe may be harmful to a person with an eating disorder or related issue (Bemis, 1985). Exploring OA members' experiences with OA may help better illuminate the appeal of this approach for people with eating disorders and related problems.

Method

We investigated OA members' experiences with and perceptions of OA through three separate focus groups with self-selected members of OA.

Procedure

Focus groups are planned discussions on a specific and defined area of interest (Clark, Marsh, Davis, Igoe, & Stember, 1996) in an environment conducive to honest discussion and disclosure. They are used to capitalize on group interaction and intended to elicit exploratory and descriptive data (Asbury, 1995). Focus groups are especially useful to explore new research areas, to examine complex clinical issues, or when a particular group's perspective is important (Asbury, 1995; Cote-Arsenault & Morrison-Beedy, 1999). The intent of the present focus groups was to learn about OA through the eyes of members. The focus group format was particularly appropriate for our target group as OA meetings are a group experience (Wasson, 2003).

Ethics approval for this study was obtained by a local institutional review board. An OA regional trustee (i.e. an OA member who represents the interests of the group from a specific geographical area at an organizational level), who had agreed to help identify potential participants, provided the phone number and e-mail address of S. R. M. to potential participants. Fliers describing the study were also distributed to OA members by the OA regional trustee. OA members who were potentially interested in participating in this study then contacted S. R. M. to obtain more information. After completing informed consent, participants completed demographic questionnaires immediately prior to the focus group. Participants were not paid for their participation. The focus groups were facilitated by two authors (S. R. M. and K. M. v. R.), both of whom are registered psychologists with experience in treatment settings and one of whom (S. R. M.) has previous experience facilitating focus groups for research purposes. Semi-structured focus group questions guided the discussion and included: (a) How does OA help people?, (b) What are the most important aspects of the OA program?, (c) For whom does OA work?, (d) What is compulsive overeating?, (e) What is abstinence?, (f) What is recovery?, (g) What role does OA play in your life? and (h) What is the most important thing we need to know about your experience with OA? Each focus group was audiotaped and transcribed verbatim, removing any identifying information.

It is recommended that focus group analysis be conducted by multiple coders to 'triangulate' the data and help overcome the intrinsic bias of a single analyser (Butler, Dephelps, & Howell, 1995). Both focus group facilitators/investigators as well as a graduate student who was not present during the focus groups (P. C. M.) composed the analysis team. Focus group analyses included attention to group dynamics, repeating themes and disparate views (Kitzinger, 1995). The method involved comparing successive quotes from focus group transcripts and coming to a consensus about the similarity or differences from previous quotes (Krueger & Casey, 2000) to identify themes that recurred across different focus groups. The nature of coding focus group data is unique because there are two units of analysis: that of the individual members and that of the focus group. Morgan (1997) suggests that analysis must seek a balance that acknowledges both. The individual influences the group and *vice versa*; therefore, both levels of analysis were considered. Analysis centred on the substantive content produced with consideration of the individuals, the group and their interaction (Morgan, 1997).

Results

A total of 20 members of OA, 19 women and 1 man, participated in a focus group. A total of three focus groups were held, with 3–13 participants in each. Each focus group lasted approximately 2 hours. The average age of those ($n = 18$) who completed self-report data was 53.6 years (*SD* 8.1) and 95% identified their ethnicity as White/Caucasian. OA membership was a requirement of study participation but, consistent with the OA program, no external or expert confirmation of

participants' compulsive overeating was obtained. We did not have direct access to meetings so there is no way of knowing how many OA members were approached about this study.

Because of strict notions about protecting anonymity, as a rule the OA organization is reluctant to engage in or allow research of its members. Despite the assistance of a regional trustee in the recruitment of study participants, at the start of the first focus group, at which the regional trustee was not present, we encountered significant skepticism from participants. One participant expressed her concern in this way:

> And the other concern, see we have to look at traditions, and one of the traditions is this is an outside enterprise, and we cannot support any outside enterprise. So this is where there's a little tug here. . . I wanted to take part in this because I want the information to get out there. And how do you get it out there, you know, you have to use some vehicle, that's right. . .But when it's breaking a tradition, this is where there's been a lot of controversy. (Focus Group [FG] 1)

After providing reassurance about our intent to explore what OA members felt was helpful to them about participating in OA, we proceeded with the focus group questions. We have organized the primary themes that emerged from the focus groups into three components, which we have termed problem, structure and attribution. These three primary themes seemed to best describe the underlying structure of what the participants told us. The *problem*, namely compulsive eating, is essentially the 'why' of OA and includes the multiple reasons related to food and eating that members had elected to join the program. The *structure* of the program is essentially the 'what' and includes the nuts and bolts of the OA program or, in the words of participants, OA's 'tools' (FG 1, 2, 3). The *attribution* is the 'how' of the program and includes members' interpretations of the active agents of change offered by OA. Below we describe each theme in turn.

Problem

Although reasons participants gave for becoming an OA member varied greatly, two themes, which we labelled 'end of the line' and 'abnormal relationship with food', defined commonly discussed precursors to joining OA. The 'end of the line' theme connoted a persistent level of desperation and a sense of having tried everything else, particularly 'weigh and pay' (FG 3) programs (i.e. fee-based diet organizations like Weight Watchers, Nutri-System, L.A. Weight Loss) before coming to OA. The 'abnormal relationship with food' theme was the unifying problem that OA members shared in joining OA. These themes are illustrated below with quotes from members of the focus groups.

End of the line

In the words of several participants, OA was 'the last house on the block' (FG 1,3). Many participants described having tried all other available options for help with their eating problem. 'Then I'm thinking, well what else is there? I have been to every program, done everything' (FG 1). There was a sense of desperation in the words of participants, e.g. 'I think I came in too, because it was the last thing. I really thought, 'I'll die or this will work'' (FG 3); 'But I was just so sick from what the food was doing to me I had nowhere else to go. I heard it was the last house on the block. Like I said, I tried everything else' (FG 1).

Abnormal relationship with food

Another commonality that had brought participants to the OA program was their belief that they had an abnormal relationship with food. Participants' discussion of their relationship with food could be described as including an obsession with food, emotional and compulsive overeating and disordered eating symptoms. Emotional and compulsive eating were described in a variety of ways, including 'I just stuffed all my feelings. I didn't actually go through any experiences, I just numbed out with food' (FG 3) and 'Like others are saying, I knew that I wasn't eating because I was hungry, but I couldn't quit eating' (FG 3). Finally,

> 'So a normal eater would overeat. But we cannot stop. You can't believe—I can remember putting food in my mouth and I'm stuffed. And I'm saying, ''What is wrong with you? You crazy idiot, idiot''. I mean, just shovelling in the food in my mouth.' (FG 2).

In describing participants' problematic relationship with food, distinctions among the kind of eating disorder a participant was experiencing were often not made. For example,

> What I noticed that was really interesting when I was watching the bulimics and the anorexics and the compulsive overeaters and the combination thereof, because reality is a lot of us have done all that stuff through the course of our disease. It's that the route is all the same. To me, it's about control. It just manifests itself in totally different ways. I look at an anorexic and my own judgment of them is that they control what they put in their body. For me, as a compulsive overeater, I have no control of what I put in my own body, so I was running around trying to control everything else. It was very different that way. That's my own experience with it. (FG 1)

Thus, problems that unite OA membership are experiencing an abnormal relationship with food, as well as many failed attempts to find relief from this problem elsewhere.

Structure

The participants assured us that, consistent with official OA literature, the only requirement of membership was a willingness to overcome compulsive overeating (Overeaters Anonymous, 1990). A number of 'tools' specific to OA were consistently reported by our participants as helpful. In addition, a common theme in the focus groups was that understanding their overeating problem as an addiction was fundamental to members' success.

OA tools

We divided the theme of tools into two main categories: explicit and implicit. *Explicit tools* endorsed by OA members and found in OA literature included spirituality, OA wisdom, tailoring, abstinence, the 12-steps, writing, reaching out, daily readings, meetings, anonymity, service and sponsorship. *Implicit tools* included modelling, connection to others, sense of community and honest feedback to self and others.

Explicit tools. There are a number of explicit tools described in the OA-approved literature (Overeaters Anonymous, n.d.) that members we interviewed said were helpful. An overview of these tools, which were discussed in all three focus groups, is described by the following exchange among participants in FG 1.

> Participant: '. . .[W]e have the tools and program. There's eight tools. And there's no importance to each one, but ''Plan of Eating'' seems to be a good one. You should have some direction. And we have ''making phone calls for support,'' or emails. Writing. Some people who journal, that helps. Especially with unloading some of the resentments. Telephone—'
>
> Multiple participants: '[A]ttending meetings, sponsorship, service and anonymity'.
>
> Participant: 'Those are the tools that we have and talk about all the time to help you with your program. That's the action part of it'.

The spiritual nature of the program was experienced as different from any other available program.

> In recovery, you have the physical, emotional and the spiritual. And they're like three boats going down a stream all tied together. You're never gonna have them all the same level, but this program, for the spiritual and emotional, it has really changed me. . . it's about the food but it isn't. (FG 2).

Participants emphasized that if there was one tool that was most helpful, it was the spiritual nature of OA. 'So what is it that's turning things around for me? I guess I have to think that it's a power greater than myself. It's something in the universe I can't explain, but when I ask for help, I get balanced again' (FG 2). The spiritual nature of OA was discussed often in all three focus groups.

Implicit tools. Whereas the explicit tools are all described in the OA literature, there seemed to be a number of other, less obvious tools that were consistently used as well. For example, participants often referred to *purposefully modelling* what others did, '. . .and we say, ''I want what she has, and I'm willing to do that, so show me how you did it''' (FG 3) and *learning new ways of thinking* from others, 'And what I heard when I first came to meetings too, was people talking about problems that they had in their life, and then they would say whatever happened, ''but I didn't eat over it''. For me, that was huge because that was the only response I knew to anything' (FG 3). *Honest feedback* from others was another implicit tool used by members. 'When I came into the program, I blamed my mother. That's why I ate the way I did. Then somebody pointed out she hadn't fed me for years [laughter]' (FG 3). Finally, *the power of belonging* was experienced as a

powerful tool. 'And just knowing you are with people who are like you, just makes all the difference in the world' (FG 1).

> So, because this is such a disease of isolation, I don't think anyone else has my problem, until I sit down in a group of women like this and am brave enough to start sharing, 'You. . .eat twenty-two cookies in a half hour too?'. . .You know, like I thought I was the only one. So to sit down and be able to finally relate to what someone else is saying is the first step, for me. (FG 1).

Addiction model of compulsive overeating

Conceptualizing and labelling compulsive eating as an addiction seemed to be fundamental to participants' discussion. Not surprisingly, given OA's origin as a 12-step approach to addiction modelled directly after AA, it was clear from the language participants used and the interaction among members in the focus groups that an addiction model was foundational. 'Our drug of choice is food' (FG 1& 2). This was demonstrated in a number of ways including a sense that members of OA were 'different' from other people in how their bodies processed certain foods. 'I found there was a name for what was wrong with me. It was a name, it was a disease, it was called compulsive overeating. It was an addiction. It was a big breakthrough' (FG 3). 'I truly believe it's an obsession of the mind, plus we have something in our body—they call it an allergy' (FG 2). 'I never realized that there was a body problem. I never realized the reason I would eat so much was because there was something different in my body. That was kind of good news, to know it's not just because you're crazy' (FG 2). The 'addiction' label seemed to make sense to many OA members as it allowed them to explain experiences that they had struggled with or had not been able to make sense of before conceptualizing it in this manner.

Often comparisons were made with alcoholics or AA members to demonstrate the power of their addiction to overeating. 'I knew when I came in that I ate, not because I was hungry. I didn't know what it was; I didn't know why, but I knew I ate like they drank. They didn't drink because they're thirsty, and I didn't ever eat because I was hungry. I never felt hunger. I just ate'. (FG 3) The comparison with other additions, like alcohol, seemed to offer legitimacy to the difficulty and the struggle they experienced. 'I was in OA for a better part of 5 years, 6 years, and I was still having problems. And she said to me, ''When are you going to quit pissing around with the food? When are you going to start treating this disease as seriously as a recovering alcoholic or drug addict treats theirs?'' (FG 1)

Use of words associated with addictions, such as 'physically addicted', 'hangover', 'withdrawal', 'craving', 'cycle', 'drug of choice' and 'abstinence' were commonplace in the focus groups. For example, 'I like to say I can eat anything I want except for these two things, which are flour and sugar. Carbohydrates, essentially. . . .[M]y body was physically addicted to those substances. . .. (FG 1).'

> Now how does an addict let go of sugar and desserts? I loved it more than I loved anything in the world. I know that sounds bizarre, but I loved it more than sex, I loved it more than my daughter, I loved it more than anything. I was addicted. . .But only OA identified the addiction of certain substances that were addictive, just like alcoholics are. Other weight loss programs aren't talking about addictions and compulsions with certain foods. (FG 1)

Understanding the food problem as an addiction seemed important for members as it offered a way of conceptualizing their problem in a way that reflected their lived experiences.

Attribution

Many participants seemed to attribute the emphasis placed on emotional and spiritual aspects of recovery as a reason that OA is effective.

'You come for the vanity and stay for the sanity' (FG 1)

This emphasis is best exemplified by a participant's words: 'Mind you, we do have a saying, ''You come for the vanity and you stay for the sanity.'' People think they will lose the weight, so you come because you want to look good, but then you start . . . getting the sanity side of it. And that's why people stay' (FG 1). 'I think a lot of us go—I mean, I did—and talk to a lot of people that went because they had a food problem and stayed because they had massive life problems [laughter]' (FG 3).

> And recovery's different for me at different times. My first five years was crawling out of the sugar. I mean, that was an amazing thing. And the next five

> years was getting out of my relationship, getting out of jobs that weren't right. . . And then it came to be, I mean, I had everything I wanted. And then it wasn't right yet. And I was like, 'Oh man'. And then I had to do more things. For me, it was about getting spiritually aligned, and coming to the point now where it's like the only question is, is this God's will for me? (FG 3)

In addition to valuing the emphasis placed on emotional and spiritual aspects of recovery, we observed that most participants initially entered the program only focussing on losing weight, but shifted to attending to emotional and spiritual issues over time.

> And that's how I started to get the concept of having a higher power, is that something did for me what I couldn't do for myself. That is the whole thing. I can't do this for myself, something else has to help me. So, you talk a little bit about the food, but really the root of the program is spiritual. (FG 1)

The process of moving from a focus on the physical to an 'awakening' of spirituality was described as unique to OA.

Contradictions

We noted that contradictory statements and evidence also emerged from the focus groups. For example, despite discussion related to the 'vanity/sanity' theme, weight status seemed to remain a crucial component of success for participants. 'For gratitude meetings, people will say, ''I have given away a hundred pounds.'' They call it qualifying because if somebody new came in and saw this thin person sitting there. They get it a lot, these thin people, like, ''Why are you here'' (FG 2)? 'Well, I almost didn't come [tonight] because I didn't think I had any worthwhile. . .because I've been in the program 21 years and I'm just now starting to lose weight' (FG 2). 'And everyone in this room knows that when I say I gained thirty pounds and I never ate over it, we know what a miracle that is' (FG 3). So although it was emphasized that the journey to recovery involved a spiritual shift from 'vanity' to 'sanity', weight status remained an important construct to many participants.

When analyzing the transcripts we noted several participants had many highly distorted cognitions around food and eating that demonstrated an unhealthy relationship with food. This caused particular concern because these distorted cognitions were not challenged by other members during the focus groups, and therefore seemed to be accepted if not explicitly, at least implicitly, by the other focus group members. In addition, there seemed to be an underlying sense of self-blame in individuals. If an individual was not 'getting better' or losing weight, it was attributed to not 'working the program' hard enough or well enough. We were concerned about this observation, especially because these individuals may already feel ashamed of their weight. Our own process as analysers was challenging at times because our perceptions of healthy eating or a normal relationship with food seemed to differ from what the focus group was discussing.

Discussion

The purpose of this study was to better understand OA members' experiences, as 12-step programs are often used as an adjunct to traditional interventions, are supported anecdotally if not empirically, and have broad support in clinical practice. Despite the popularity of OA, little is known about how, why, or for whom OA 'works' (Ronel & Libman, 2003). The perspectives and experiences of OA members in this study provided insight into the use of one addiction-based model for treating disordered eating attitudes and behaviours. Results from this study suggest that conceptualizing the eating problem as an addiction had value for OA members, as did the practical tools and spiritual nature of the group. The themes described in this study may be useful as background knowledge to eating disorder clinicians, some of whose clients may participate in OA. For example, it may be useful to be aware of conflicts between basic tenets of cognitive behavioural therapy for binge eating—i.e. moderation in eating all foods—and the abstinence model supported by OA. Despite these conflicts, individuals may still derive benefits from OA participation, including social support.

Certain themes uncovered in this research, including those concerning OA tools and the spiritual nature of OA, replicate findings of previous research studies. For example, Wasson and Jackson (2004) conducted focus groups to understand how women with bulimia used OA in their recovery and found that meetings, spirituality, support from a sponsor, writing and food plans were the key elements identified by participants as facilitative. The role of social support in the success of

12-step programs across numerous samples has also been supported in the literature (e.g. Aase, Jason, & Robinson, 2008; Groh, Jason, & Keys, 2008).

By attending open OA meetings over 2 years, listening to recorded testimonials from OA retreats, reading OA approved literature, and interviewing OA members, Martin (2002) identified a number of themes at an organizational analysis level that echo the themes we identified through our focus groups. Martin (2002) states that 'organizational vocabularies allow participants to name and constitute their experiences' (p. 158). OA uses the language of 'disease' and 'addiction' to describe compulsive overeating in their basic text (Overeaters Anonymous, 1990) as well as brochures (Overeaters Anonymous, 1987, 1989) and monthly journal (*Lifeline*). In the present study, this vocabulary of addiction seemed to help participants finally understand what had been happening to them.

Additionally, Martin (2002) identified a theme, 'transforming the meaning of participation: from dieting to recovery' (p. 187). This transformation involved initially joining OA to change physical appearance or as a weight loss alternative, and then a broadening of motivation to concerns about overall health and wellness. This theme is comparable to the theme identified in the present study as 'vanity to sanity'. Indeed, OA literature itself (OA, 1992; as cited in Martin, 2002) suggested that 80–90% of all OA members attend an initial meeting believing the program to be an alternative weight-loss program rather than a program for compulsive overeaters. Ronel and Libman (2003) identified similar themes in a phenomenological study of 88 OA members in Israel. These authors found that members were drawn to the tangible tools of the program initially and as they progressed in the program a more spiritual foundation became the focus.

The present findings replicate other findings of Ronel and Libman's (2003) as well. Some OA members from our sample avoided certain foods, often white flour and sugar, because they saw themselves as 'allergic' or 'addicted' to them. However, participants made clear that OA members were free to define 'abstinence' however they found most useful, not necessarily as refraining from eating white flour and sugar, or even abstaining from any other foods. Similarly, in Ronel and Libman's sample many women described certain foods as 'poisonous' (p. 161). Terms such as 'allergic' and 'poisonous' were commonly used by OA participants, and were consistent with the interpretation of their compulsive overeating as an addiction.

The present 'end of the line' theme is also mirrored in Ronel and Libman's work, as most of the Israeli sample described themselves as coming to OA only after a range of potential solutions, like surgery, drastic diets and therapy, had failed. The 'end of the line' theme observed in this and other qualitative studies demonstrates that many OA members seek out weight loss programs initially but feel that these programs are not able to meet their needs (Ronel & Libman, 2003).

Interestingly, one study found 30% of people attending hospital-affiliated weight loss programs had BED, whereas only 2% of a community sample met criteria for this disorder (Spitzer et al., 1992). It is not known whether OA has more similarities with a hospital-affiliated weight loss program or a community sample; however, we speculate that OA may appeal to people with BED and obesity because there is a lack of viable treatment options for both conditions, particularly options that address the complex nature of their relationship with food.

In summary, a number of themes are emerging across qualitative studies that describe OA members' experiences of the program.

Seeking clarity where it may not exist: The mystery of the program that 'Works if You Work It'

A paradox exists for members of OA: the solution to their perceived addiction cannot be absolute. Indeed, humans must eat to survive. As such, typically specific foods are avoided in specific way, making recovery from compulsive eating in a 12-step approach much more complicated than total abstinence from addictive substances like alcohol or illicit drugs (Ronel & Libman, 2003). While many OA members acknowledged that abstinence as defined in OA is more complex than in AA or other Anonymous groups, a coherent solution did not emerge in the focus group discussions.

Participants in the present study likely represent a dedicated, select group of individuals for whom OA is a great source of strength and support. Better understanding the social support aspects of this support group as well as the spiritual nature of their self-described recovery might be useful topics for quantitative investigation. Some of the tools that OA members

described, especially the explicit tools, are already used in some forms of therapy (i.e. food plans, seeking social support, journaling, *etc.*). At a minimum, OA offers a larger social support network of individuals with similar problems. The OA members we interviewed suggested they found comfort in gathering with a group of individuals who, like themselves, were seeking to stop compulsive overeating.

We must seek to better understand apparently contradictory stances that members seem to juggle so successfully. For example, members discussed weight loss as a measure of success, yet also stated that a critical, transformative experience of the program was its emphasis on spirituality. Similarly, some participants described adhering to quite strict and inflexible patterns of eating, e.g. a food plan that allowed three predetermined, precisely defined meals a day—no more and no less—while pronouncing that their relationship with food was finally healthy. Further probing into what we outsiders perceived as contradictions resulted in discussions of the 'tailoring' of the program and how 'different things work for different people' (FG 1) and the admonition to 'take what you want and leave the rest' (FG 1). It could well be that it is the ambiguity of OA's dicta, including its very definition of success, that allows members to find success. Members may identify with aspects of the program that fit their world view and then associate any success they have with the whole program.

The OA fellowship is difficult to research because of its structure. It is difficult to gain access to members because of an OA tradition that indicates that OA neither solicits nor accepts any position on outside issues (Overeater's Anonymous, n.d.). It would be helpful to conduct a randomized controlled trial to obtain a more objective measure of the efficacy of OA in reducing compulsive overeating and other eating disorder symptoms, as well as weight loss. However, given the anonymous nature of the fellowship, this type of research may prove difficult if not impossible to conduct. Tracking individuals throughout their OA tenure would be important, as participants often spoke about a high attrition rate and there may be important differences between temporary and long-time members of OA. Investigating who continues in the program, who drops out, and why would give us a broader view of the potentially active components of OA and also potentially help identify the people for whom OA is most appropriate and most likely to help.

OA members for whom the program is effective (such as our self-selected sample) tend to remain in OA over time and are passionate, dedicated and loyal to the OA fellowship. While some of the themes we identified are confirmatory, such as themes regarding the addiction model and spirituality of the program, other themes are unique to this study and need more investigation. The themes 'vanity to sanity' and 'end of the line' require further support, and the ambiguous or paradoxical nature of success in OA would be an interesting focus for future research. Perhaps one of our participants sums up best the need for further study of OA, for whom it works, how, and why:

> Then you think, 'Well, how did that work? I don't even know who I'm praying to, or what. I'm not even sure how strong'. All I know is they talk about it in the program. Ask God for help. And so I'll do it, and in a couple hours, maybe even the next day, I'm restored to sanity again. Then you think, 'Wow, this is working, and I'm not even sure how, or why'. That's been my experiences, when I follow the program. So that is a mystery, you know? (FG 1)

References

Aase, D. M., Jason, L. A., & Robinson, W. L. (2008). 12-step participation among dually-diagnosed individuals: A review of individual and contextual factors. *Clinical Psychology Review*, *28*, 1235–1248.

Asbury, J. (1995). Overview of focus group research. *Qualitative Health Research*, *5*, 414–420.

Bemis, K. M. (1985). ''Abstinence'' and ''nonabstinence'' models for the treatment of bulimia. *International Journal of Eating Disorders*, *4*, 407–437.

Butler, L. M., Dephelps, C., & Howell, R. E. (1995). Focus groups: A tool for understanding community perceptions and experiences. [Electronic version]. Retrieved 8 January 2007 from http://cru.cahe.wsu.edu/CEPublications/wrep0128/wrep0128.html

Clark, L., Marsh, G. W., Davis, M., Igoe, J., & Stember, M. (1996). Adolescent health promotion in a low-income, urban environment. *Family Community Heath*, *19*, 1–13.

Cote-Arsenault, D., & Morrison-Beedy, D. (1999). Practical advice for planning and conducting focus groups. *Nursing Research*, *48*, 280–283.

Davis, C., & Claridge, G. (1998). The eating disorders as addiction: A psychobiological perspective. *Addictive Behaviors*, *23*, 463–475.

Groh, D., Jason, L. A., & Keys, C. (2008). Social network variables in Alcoholics Anonymous: A literature review. *Clinical Psychology Review*, *28*, 430–450.

Haas, H. L., & Clopton, J. R. (2003). Comparing clinical and research treatments for eating disorders. *International Journal of Eating Disorders*, *33*, 412–420.

Kitzinger, J. (1995). Introducing focus groups. [Electronic version]. *British Medical Journal*, *311*, 299–302.

Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks: Sage.

le Grange, D., & Lock, J. (2005). The dearth of psychological treatment studies for anorexia nervosa. *International Journal of Eating Disorders*, *37*, 79–97.

Martin, D. D. (2002). From appearance tales to oppression tales: Frame alignment and organizational identity. *Journal of Contemporary Ethnography*, *31*, 158–206.

Morgan, D. L. (1997). *Focus groups as qualitative research* (2nd ed.), Vol. 16 Qualitative Research Methods Series. Newbury Park, CA: Sage Publications.

Mussell, M. P., Crosby, R. D., Crow, S. J., Knopke, A. J., Peterson, C. B., Wonderlich, S. A., et al. (2000). Utilization of empirically supported psychotherapy treatments for individuals with eating disorders: A survey of psychologists. *International Journal of Eating Disorders*, *27*, 230–237.

Overeaters Anonymous. (1987). *To the newcomer: You're not alone anymore*. Torrance, CA: Overeaters Anonymous, Inc.

Overeaters Anonymous. (1989). *A commitment to abstinence: A decision, one day at a time*. Torrance, CA: Overeaters Anonymous, Inc.

Overeaters Anonymous. (1990). *The twelve steps of overeaters anonymous*. Torrance, CA: Overeaters Anonymous, Inc.

Overeaters Anonymous: 12-step recovery program from compulsive eating. (n.d.) Retrieved 29 December 2008, from http://www.oa.org/index.htm.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, *47*, 1102–1114.

Ronel, N., & Libman, G. (2003). Eating disorder and recovery: Lessons from overeaters anonymous. *Clinical Social Work Journal*, *31*, 155–171.

Spitzer, R. L., Devlin, M. J., Walsh, B. T., Hasin, D., Wing, R., Marcus, M., et al. (1992). Binge eating disorder: A multisite field trial of the diagnostic criteria. *International Journal of Eating Disorders*, *11*, 191–203.

Thompson-Brenner, H., Glass, S., & Western, D. (2003). A multidimensional meta-analysis of psychotherapy for bulimia nervosa. *Clinical Psychology: Science and Practice*, *10*, 269–287.

von Ranson, K. M., & Cassin, S. E. (2007). Eating disorders and addiction: Theory and evidence. In J. S. Rubin (Ed.), *Eating disorders and weight loss research* (pp. 1–37). Hauppauge, NY: Nova Science Publishers.

von Ranson, K. M., Iacono, W. G., & McGue, M. (2002). Disordered eating and substance use in an epidemiological sample: I. Associations within individuals. *International Journal of Eating Disorders*, *31*, 389–403.

von Ranson, K. M., & Robinson, K. E. (2006). Who is providing what type of psychotherapy to eating disorder clients?: A survey. *International Journal of Eating Disorders*, *39*, 27–43.

Wasson, D. H. (2003). A qualitative investigation into the relapse experiences of women with bulimia nervosa. *Eating Disorders 11*, 73–88.

Wasson, D. H., & Jackson, M. (2004). An analysis of the role of Overeaters Anonymous in women's recovery from bulimia nervosa. *Eating Disorders*, *12*, 337–356.

Westphal, V. K., & Smith, J. E. (1996). Overeaters Anonymous: Who goes and who succeeds? *Eating Disorders*, *4*, 160–170.

Wilson, G. T. (2000). Eating disorders and addiction. In W. S. C. Poston, & C. K. Haddock (Eds.), *Food as a drug* (pp. 87–101). Binghamton, NY: Haworth Press.

Wilson, G., Grilo, C. M., & Vitousek, K. M. (2007). Psychological treatment of eating disorders. *American Psychologist*, *62*, 199–216.

Wonderlich, S. A., & Mitchell, J. E. (1997). Eating disorders and comorbitity: Empirical, conceptual, and clinical implications. *Psychopharmacology Bulletin*, *33*, 381–390.

Yeary, J. (1987). The use of overeaters anonymous in the treatment of eating disorders. *Journal of Psychoactive Drugs*, *19*, 303–309.

Zeitlin, H. (1999). Psychiatric comorbidity with substance misuse in children and teenagers. *Drug and Alcohol Dependence*, *55*, 225–234.