

The Eating Disorders Recovery Day Program: An examination of the participants and how they have been affected by their eating disorders.

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Executive Summary

Although much has been written about eating disorders, few studies have examined the ways in which sufferers perceive their disorders. This study is based upon the experiences of participants of the Eating Disorders Recovery Day Program, operated by the Society for Assisted Cooperative Recovery from Eating Disorders (SACRED), prior to treatment. The Eating Disorders Recovery Day Program is an intensive, community-based treatment program that operates according to the addictions model of eating disorders. Through group and individual therapy, the reception of meal support, and working the twelve steps of Anorexics and Bulimics Anonymous, participants achieve physical, psychological, emotional, and spiritual healing and begin their process of recovery.

Information for this study was collected from participants' nutritional assessments, intake questionnaires, and discharge summaries. Demographic information includes participants' diagnoses, age and body mass index upon admission, marital status, age that dieting behaviour first occurred, presence or absence of excessive exercise, and purging methods. This study also describes what participants believe they gained or lost because of their disorder, how they felt after engaging in ritual behaviour, and what they experienced if unable to perform these behaviours.

Since January of 2003, 31 women have participated in the Eating Disorders Recovery Day Program. Fifteen women had diagnoses of anorexia nervosa, ten of the binge-eating/purging subtype and five of the restricting type, nine had diagnoses of bulimia nervosa, and seven had diagnoses of eating disorder not otherwise specified (EDNOS). On average, bulimics were the youngest while participants diagnosed with an EDNOS were the oldest. The majority of participants were single. Excessive exercise was utilized by almost two-thirds of participants as a means of weight control. Self-induced vomiting was the most common purging method, followed by fasting and the misuse of laxatives.

Nine perceived benefits were identified based on the participants' responses: structure, guardian, self-esteem, avoidance, difference, mastery, lightness/smallness, care/concern, and eat what/when I want. Fourteen perceived costs were identified: take-over, distancing, physical effects, obsession, emotion, effect on others, occupational/academic effects, economic effects, self-esteem, personality/behaviour, elusiveness, waste, deviance, and hopelessness. As participants' disorders progressed, costs became more apparent and began to outweigh benefits. Benefits and costs were often dichotomous variables, i.e. what was initially a benefit became a cost.

Participants engaged in a number of ritual behaviours, including restricting their food or caloric intake, weighing and measuring their bodies and food, binge-eating, and purging. During performance of these rituals, participants' experiences ranged from euphoria to deep depression. One recurring theme was that restricting food intake signified control and was a source of pride, while binge-eating was a sign of weakness

and a source of shame. If unable to perform ritual behaviours, participants experienced a multitude of emotions, including fear, panic, anxiety, and anger.

This study's findings are consistent with the well-established link between eating disorders and substance abuse (Holderness, Brooks-Gunn & Warren, 1994; Wiederman & Pryor, 1996) and lend support to the addictions model of eating disorders. Every participant identified their lack of control over eating or purging behaviours and over their obsessive thoughts. Lack of control is a hallmark of substance addiction (Smith & Seymour, 2001). Furthermore, many of the thoughts and feelings experienced while performing ritual behaviours or if unable to do so were similar to substance-dependent individuals. Participants also had a high rate of co-morbidity with substance use disorders.

Participants do not neatly fit into the diagnostic categories described by the American Psychiatric Association in their Diagnostic and Statistical Manual of Mental Disorders. Patterns of overlap between categories permit conception of eating disorders as one progressive disease. Further research is needed regarding how individuals with different eating disorder diagnoses are similar, and how well current classification systems capture the reality of eating disorders. Regardless of their diagnoses, it is evident that participants of the Eating Disorders Recovery Day Program have been dramatically affected by their disorder and that they are willing to go to any lengths in order to get well.

Introduction

Eating disorders and the individuals who suffer from them are complex and multifaceted. Eating disorders literature is comprised of a multitude of studies focusing on a variety of topics including binge-eating, correlates of eating disorders, co-morbidities, risk factors, dieting, and cultural influences. However, few studies have investigated how eating disorder sufferers perceive their behaviour or what they believe is gained or lost on account of their illness (Nordbo, Espeset, Gulliksen, & Skarderud, 2006; Serpell & Treasure, 2002).

Eating disorders profoundly affect the lives of those who experience them as well as their families. This study examines how eating disorders were experienced by participants of the Eating Disorders Recovery Day Program, operated by the Society for Assisted Cooperative Recovery from Eating Disorders (SACRED), prior to treatment. Specific areas of investigation include: participants' ability to thrive in relationships, work and school; aspects of their disorder participants believe to be positive and negative; how participants feel after performing their ritual behaviours and if they are unable to perform them; how the participants' conceptions of their disorder evolved over time, and why they chose to come to SACRED for treatment.

SACRED operates out of Edmonton, Alberta, Canada, offering multiple services to those with eating disorders and to their families. The community-based Eating Disorders Recovery Day Program is available for men and women 18 years or older (although select clients 16-17 years old may be accepted) who have been diagnosed with an eating disorder. Potential participants must be voluntarily seeking treatment, medically and psychologically stable, and sober from other addictions for three months prior to admission. The thorough intake process ensures that participants are committed to recovery and willing to go to any lengths in order to get well. Up to six people can participate in the Recovery Day Program at one time. Additionally, SACRED offers meal support, drop-in meal services, and support to participant's family members.

While in treatment at SACRED, participants are not differentiated by their respective diagnoses. Nonetheless, appreciation of diagnostic classification proves valuable when examining parallels between the experiences of participants. Diagnoses

are made by Dr. Joan Johnston, BMed SC MD FCFP, SACRED's Medical Advisor, in adherence to criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR; American Psychiatric Association [APA], 2000). The DSM-IV-TR divides eating disorders into three diagnostic categories: anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified (EDNOS).

Anorexia nervosa, herein referred to as anorexia and abbreviated AN, is characterized by a refusal to maintain a minimally normal body weight, intense fear of gaining weight or becoming fat despite being underweight, significant disturbance in the perception of one's shape or body weight, and amenorrhea in postmenarcheal females. Two subtypes are identified: the restricting subtype (RAN), wherein the individual has not regularly engaged in binge-eating or purging behaviour, and the binge-eating/purging subtype (BPAN), wherein the individual has, in the current episode of anorexia, engaged regularly in binge-eating or purging behaviour (APA, 2000). The APA (2000) estimates the lifetime prevalence of anorexia among females to be 0.5%. A recent literature review found that up to 0.9% of women meet the diagnostic criteria. The highest incidence rates are among females 15-19 years of age (Hoek & van Hoeken, 2003). Anorexia is the third most common chronic medical illness for females of this age group (Garner & Gerborg, 2004). Although the debate continues as to whether true incidence rates (incidence in the community) have increased in the 20th century, there has been a definite increase in registered cases which translates into an increased need for care and treatment (Hoek & van Hoeken, 2003). Hoek and van Hoeken (2003) estimate that only one third of those with anorexia receive mental health care. Furthermore, while overall prevalence and incidence rates are low, they are significantly higher among adolescent girls and young women and for subclinical symptomatology, where one's symptoms don't warrant a diagnosis. Medical care is crucial given that mortality rates, due to medical complications and suicide, for adolescent girls with anorexia are 10-17 times those of age-matched controls (Garner & Gerborg, 2004).

Bulimia nervosa, herein referred to as bulimia and abbreviated BN, is characterized by binge eating and inappropriate compensatory behaviours such as self-induced vomiting; misuse of laxatives, diuretics or other medications; excessive exercise, or fasting. Binge eating and compensatory behaviours must occur at least twice a week for

a three month period for a diagnosis of bulimia to be given. A binge is defined as eating an amount of food that is definitely larger than most individuals would eat under similar circumstances in a discrete period of time, usually less than two hours. The binge episode is accompanied by a sense of lack of control and is followed by the above-stated compensatory behaviours to prevent weight gain. Although bulimic participants at SACRED are not distinguished by subtype, two subtypes are identified in the DSM-IV-TR: the purging subtype, wherein the individual has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas, and the nonpurging subtype, wherein the compensatory behaviours consist of fasting or excessive exercise.. Wherein individuals with anorexia are underweight, those with bulimia are typically within the normal weight range or slightly over- or underweight (APA, 2000). It is estimated that 1-3% of American females meet the criteria for bulimia (APA, 2000; Hoek & van Hoeken, 2003). Females 20-24 years of age have the highest rates of incidence, approximately 80 per 100,000 (Hoek & van Hoeken, 2003; Soundy, Lucas, Suman & Melton, 1995).

A diagnosis of EDNOS is given to an individual who does not meet all the criteria of anorexia or bulimia, presents with a combination of the two, repeatedly chews and spits out large amounts of food, or presents with binge eating disorder (BED). Binge eating disorder is characterized by recurrent binge eating not followed by compensatory behaviours to prevent weight gain (APA, 2000). Diagnoses of EDNOS account for three-quarters of eating disorder diagnoses (Machado, Machado, Goncalves, & Hoek, 2007). Prevalence estimates for BED alone range from 1-4.5% (Hay, 1998; Striegel-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000).

The National Institute of Mental Health (NIMH) has acknowledged that there is a lack of consensus regarding the best eating disorder treatment (Agras, Brandt, Bulik, Dolan-Sewell, Fairburn, Halmi, et al., 2004). Behavioural therapy (BT), cognitive-behavioural therapy (CBT), cognitive-analytic therapy (CAT), psychopharmacological treatment, family-focused treatment (FFT), psychodynamic therapy, hypnosis, interpersonal therapy (IPT), addiction-based therapy, nutrition counseling and meal support, eye-movement desensitization and reprocessing (EMDR), and dialectical behaviour therapy (DBT) are some of the treatment approaches available for eating-disordered patients (Bulik, Berkman, Brownley, Sedway & Lohr, 2007; Treasure &

Schmidt, 2005; von Ranson & Robinson, 2006). The ways in which eating disorders are described and the reasons why they are believed to have developed and are maintained determine the method of treatment deemed appropriate by a given clinician or treatment center. As there are multiple theories regarding eating disorders' conception, etiology and reinforcement, it is not surprising that treatment programs and centers operate according to different treatment philosophies. Many clinicians do not use only one therapy or will use different therapies for patients of different diagnoses. A recent study of therapeutic approaches used by Calgary-area therapists revealed the most common approach, used by half the respondents, to be an eclectic one (von Ranson & Robinson, 2006). In that study, the majority (59.6%) of clinicians used cognitive-behavioural therapy as their primary approach or in addition to other therapies. A number of cognitive-behavioural models have been applied to the development, maintenance and treatment of eating disorders. Supporters assert the interrelations between behaviour, emotions and cognitions. A person's thoughts influence his or her emotions, which affect his or her behaviour (Shafran & de Silva, 2005). For example, an anorexic may think that she will get fat if she eats something, causing her to be fearful of eating and, consequently, refrain from this behavior. The goal of treatment is to help the patient identify the cognitions that underlie problem behaviours or negative emotions, test the validity of these thoughts and feelings, and replace them with more accurate ones (Shafran & de Silva, 2005).

SACRED operates under the conviction that eating disorders are addictions. Traditionally, the term addiction was reserved for reference to drugs or alcohol and considered to be a physical dependence characterized by drug tolerance and physical withdrawal symptoms. The primary goal of treatment was detoxification (Smith & Seymour, 2001). In mainstream society, addiction still predominantly refers to substances, although both physical and psychological dependence are recognized (Merriam-Webster, 2005).

The addictions model of eating disorders defines addictions, and therefore eating disorders, as chronic and progressive diseases. This definition is in line with that given by the Canadian Society of Addiction Medicine ([CSAM], 1999). This Society defines an addiction as a primary, chronic disease characterized by impaired control over the use

of a psychoactive substance and/or behaviour. Eating disorders, along with workaholism, compulsive gambling, sex addiction, and compulsive shopping, are process addictions, wherein it is the behaviour that is addictive. SACRED's philosophy is that eating disorders are addictive because of the element of control. People with anorexia, bulimia and EDNOS are addicted to the control that they perceive they have over food, weight, and eating, exercise or purging behaviour.

Treatment at SACRED is based upon a twelve-step model of addiction. Participants work the steps and attend meetings of Anorexics and Bulimics Anonymous (ABA). They also attend open meetings of the Alcoholics Anonymous (AA) fellowship, upon which the ABA fellowship and steps are based. Participants must admit their powerlessness over their insane eating practices and turn to a Higher Power to be restored to sanity and rid themselves of the obsessions of their minds (ABA, 2002). This Higher Power is of the individual's choosing, as ABA and SACRED are not religious organizations or affiliated with any religion. Program counsellors strive to promote and assist in the spiritual, emotional and physical healing of participants. With the intense support of these counsellors, all of whom are in recovery from addiction, participants take responsibility for their own recovery.

Procedure

The information in this report was primarily collected from each participant's nutritional assessment, intake questionnaire and discharge summary. Nutritional assessments and discharge summaries are completed by Dr. Johnston, while the participants themselves complete the intake questionnaires. Compilation of these documents is believed to provide a detailed account of the effects of eating disorders on the lives of participants and their families.

Data collected to describe the participants includes DSM-IV-TR Axis I diagnoses, age and body mass index (BMI) upon admission, marital status, age that dieting behaviour first occurred, presence or absence of excessive exercise, and methods used by participants to purge. Diagnostic information was collected from discharge summaries of former participants and from Dr. Johnston for those participants currently attending the Recovery Day Program. Marital status, age and BMI upon admission, and age that

dieting began were collected from nutritional assessments. Information pertaining to participant's exercise rituals and purging behaviours were collected from both the nutritional assessments and intake questionnaires. All participants consented in writing to the use of their demographic information and questionnaire responses for research purposes. All necessary measures have been taken to protect the identities of participants and respect the sensitive nature of this information.

The advantages and disadvantages that participants believed their disease conferred to them were identified via text analysis. This author, drawing on existing coding schemes and in consultation with the Executive Director, compiled a list of common themes that participants expressed in their intake questionnaires (Nordbo et al., 2006; Serpell, Treasure, Teasdale, & Sullivan, 1999; Serpell & Treasure, 2002).

Thoughts and feelings after the performance of ritual behaviours, including restricting, binge-eating, purging, and exercising, and when denied this performance were collected from the intake questionnaires. There are questions that directly ask the participant to recall and relay these experiences.

This author consulted the Executive Director and/or SACRED program counsellors for clarification or elaboration of information from all sources and entered the data into EXCEL spreadsheets. Calculations were performed using EXCEL functions.

Data presentation is facilitated by the use of the following acronyms: anorexia (AN), anorexia with a restricting subtype (RAN), anorexia with a binge-eating/purging subtype (BPAN), bulimia (BN), eating disorder not otherwise specified (EDNOS), and binge eating disorder (BED).

Results

Participants

Since January 2003, thirty-one women participated in SACRED's Eating Disorders Recovery Day Program. Fifteen participants had diagnoses of anorexia (BPAN=10, RAN=5), nine had diagnoses of bulimia (BN), and seven had diagnoses of EDNOS (BED=4, without BED=3).

Twenty-four participants had at least one Axis I diagnosis in addition to their eating disorder diagnosis. These participants suffered primarily from substance abuse or dependence or from depression. Substance abuse generally involves pathological use of a substance resulting in potentially hazardous behaviour, or continued use despite persistent social, psychological, occupational or health problems. Substance dependence involves a marked physiological need for increasing amounts of the substance to achieve the desired effects (tolerance). A drug-dependent person will experience withdrawal symptoms, including sweating, tremors, and anxiety, when unable to access the drug (Butcher, Mineka & Hooley, 2004). Twenty participants had diagnoses of substance abuse or dependence, eight of whom had more than one substance-related diagnosis. Specifically, 7 had a diagnosis of past alcohol abuse, 6 of alcohol abuse in remission, 6 of alcohol dependence, 1 of past sedative abuse, 1 of past cannabis abuse, 1 of opiate dependence, 1 of cocaine dependence, 2 of amphetamine dependence (1 of which was past dependence), 3 of polysubstance dependence, and 1 of drug-induced psychosis. While participants from every eating disorder diagnostic category had substance-related diagnoses, restricting anorexics and those diagnosed with BED did not abuse a substance other than alcohol. Two of the five restricting anorexics and three of the four participants diagnosed with BED had alcohol abuse or dependence diagnoses. Six of the ten binge-eating/purging anorexics had substance-related diagnoses. All of these participants had abused or depended on alcohol and two also had developed dependence on other drugs. Seven of the nine participants diagnosed with bulimia had substance-related diagnoses. Each had a diagnosis of alcohol abuse or dependence and five have diagnoses of abuse of or dependence on other drugs.

Sixteen participants had been diagnosed with a mood disorder. Specifically, these participants had received diagnoses of dysthymia (n=2; RAN=1, BN=1), major depressive disorder (n=11; AN=5 [RAN=1, BPAN=4], BN=4, EDNOS=2 [BED=1, without BED=1]), bipolar I disorder (n=1; BPAN=1), and bipolar II disorder (n=2; BPAN=1, BN=1). Other Axis I diagnoses include schizophreniform disorder (n=1; BN=1), post-traumatic stress disorder (n=1; RAN=1), and hypochondriasis (n=1; BN=1).

The mean age of the group as a whole was 31.45 years (SD=12.65), and the oldest and youngest participants were 59 and 16 years old upon admission, respectively.

Calculation of the mean ages by diagnosis reveals that participants diagnosed with bulimia were the youngest ($x=26.55$, $SD=5.43$), followed by those diagnosed with anorexia ($x=28.13$, $SD=12.83$). Anorexics with a binge-eating/purging subtype ($x=28.70$, $SD=13.63$) were slightly older than those with a restrictive subtype ($x=27.00$, $SD=12.51$). Participants diagnosed with EDNOS were the oldest ($x=44.86$, $SD=10.17$) and, within this category, those with BED ($x=48.25$, $SD=8.34$) were older than those without ($x=40.33$, $SD=12.34$).

The majority of participants were single ($n=21$; 67.7%), the others reporting to be divorced ($n=4$; 12.9%), married ($n=2$; 6.5%), common-law ($n=2$; 6.5%), widowed ($n=1$; 3.2%), or separated ($n=1$; 3.2%). The majority of those diagnosed with anorexia were single ($n=13$; 86.7%), one was separated (6.7%), and one was common-law (6.7%). All participants with RAN were single. The marital status of those with bulimia was as follows: single ($n=5$; 55.6%), married ($n=2$; 22.2%), separated ($n=1$; 11.1%), and common-law ($n=1$; 11.1%). Three participants diagnosed with EDNOS were single (42.9%), three were divorced (42.9%) and one was widowed (14.3%). Regarding the four participants with a diagnosis of EDNOS, BED classification, two were divorced (50%), one was single (25%) and one was widowed (25%). Two of the three participants diagnosed with EDNOS without BED were single (66.7%) and the other was divorced (33.3%).

Upon admission, the participants' body mass indexes were as follows: Total ($x=25.33$, $SD=10.35$), anorexia ($x=19.03$, $SD=2.15$), BPAN ($x=19.31$, 2.36), RAN ($x=18.4$, $SD=1.69$), bulimia ($x=23.63$, $SD=3.50$), EDNOS ($x=38.97$, $SD=12.31$), EDNOS with BED ($x=47.88$, $SD=6.98$) and EDNOS without BED ($x=27.10$, $SD=3.40$). These figures are based on BMIs of 28 participants, as data for the remaining 3 participants was unavailable.

Participants' mean ages, in years, when they first engaged in dieting behaviour were: total ($x=13.26$, $SD=2.92$), anorexia ($x=12.7$, $SD=2.40$), RAN ($x=13.17$, $SD=3.01$), BPAN ($x=12.56$, $SD=2.35$), bulimia ($x=13.86$, $SD=4.01$), EDNOS ($x=13.67$, $SD=2.73$), EDNOS with BED ($x=14$, $SD=2.45$), and EDNOS without BED ($x=13$, $SD=4.24$). Data

was unavailable for 6 participants; these ages are therefore based on the experiences of the remaining 25 participants.

Twenty participants (AN=13 [RAN=5; BPAN=8]; BN=5; EDNOS=2 [BED=0; without BED=2]) had experienced periods of time in which they engaged in excessive exercise as a means of weight loss or compensation for binge-eating. Exercise behaviours included running, swimming, lifting weights, yoga, walking, cycling, dancing, and abdominal exercises. For some participants, these activities were performed for two or more hours per day, regardless of fatigue, injury, time of day, or prior commitments. Some chose jobs that forced them to be physically active. Many expressed that they did not enjoy working out but felt a compulsion to do so, or that the enjoyment that used to come from exercise had diminished.

Other methods of purging included vomiting, misuse of laxatives and diuretics, enemas, fasting, and using diet pills and amphetamines. While participants with restricting anorexia or binge-eating disorder may have engaged in purging behaviours, the occurrence and severity of these behaviours was not sufficient to warrant a diagnosis of either binge-eating/purging anorexia or bulimia, respectively. Participants with diagnoses of binge-eating/purging anorexia, bulimia, or EDNOS without BED (n=22) regularly engaged in purging behaviours in order to avoid weight gain. Fifteen participants (BPAN=6; BN=9) engaged in self-induced vomiting as a means of purging. Laxatives were used as a method of weight control by 11 participants. Seven of these participants (BPAN=2; BN=3; EDNOS=2 [without BED=2]) misused laxatives on a regular basis and four (BN=3; EDNOS=1 [without BED=1]) had misused or tried laxatives in the past. Fasting as a means of purging (the severe restriction of food intake to compensate for that consumed during a binge) was practiced by 19 participants (BPAN=9; BN=7; EDNOS=3 [without BED=3]).

Benefits and Costs

The perceived benefits and costs that SACRED participants identified they received from their disease did not neatly align with the constructs presented in previous studies. For this reason, this author and the Executive Director derived lists of benefits and costs that we believe accurately captures the experience of SACRED participants.

This analysis is based upon the responses of 27 participants, as intake data was missing for 4 participants (RAN=1; BPAN=2; BN=1). Identified benefits and costs were derived by analyzing responses given in the intake questionnaires. Some themes, such as effects on work/school, are specifically asked on the questionnaire, while other themes were derived by interpreting answers to various questions. It is entirely possible that participants may identify with any given category if asked to comment on it specifically.

Based on the responses of participants given in the intake questionnaires, we have identified nine perceived benefits (see Table 1).

Table 1.

THEME	COUNT (N=27)	DIAGNOSIS				
		AN (n=12)		BN (n=8)	EDNOS (n=7)	
		RAN (n=4)	BPAN (n=8)		BED (n=4)	WITHOUT BED (n=3)
1) Structure	4	---	1	2	1	---
2) Guardian	13	2	1	4	4	2
3) Self-Esteem	12	3	3	4	---	2
4) Avoidance	19	3	5	5	3	3
5) Difference	7	1	3	1	---	2
6) Mastery	20	4	7	5	1	3
7) Lightness/Smallness	15	2	5	6	---	2
8) Care/Concern	1	1	---	---	---	---
9) Eat what/when I want	7	---	2	3	1	1

1) Structure.

Four participants (BPAN=1; BN=2; BED=1) identified that their disease provided them with a sense of stability or structure that was considered to be beneficial.

Statements that the disease provided them with a constant companion, where consistency was emphasized, were coded as Structure. When companionship was emphasized, the statement was coded as part of the Guardian theme.

2) Guardian

Nearly half of the participants (N=13; AN=3 [RAN=2; BPAN=1]; BN=4; EDNOS=6 [BED=4; without BED=2]) made statements that their disease provided them with a sense of comfort, protection and/or care. This theme was identified by Serpell et

al. (1999), who found that nearly their entire sample made statements fitting under this heading.

3) Self-Esteem

The Self-Esteem theme was used to code participants' statements that the disease provided them with increased self-esteem or self-worth. It was identified by 12 participants (AN=6 [RAN=3; BPAN=3]; BN=4; EDNOS=2 [BED=0; without BED=2]). This theme is similar to the Attractiveness and Confidence themes identified by Serpell et al. (1999) and the Self-Confidence theme identified by Nordbo et al. (2006).

4) Avoidance

The Avoidance theme, identified by both Serpell et al. (1999) and Nordbo et al. (2006), refers to the avoidance of negative emotions that the disease affords. This construct was also used when participants said that their disease allowed them to avoid responsibility, stress, or feelings of emptiness. The majority of participants identified that their disease provided them with such benefits (N=19; AN=8 [RAN=3; BPAN=5]; BN=5; EDNOS=6 [BED=3; without BED=3]).

5) Difference

The Difference theme was identified by seven participants (AN=4 [RAN=1; PBAN=3]; BN=1; EDNOS=2 [BED=0; without BED=2]) and refers to the participant considering her disease a means of creating a different and better identity than she had previously. These participants also made statements expressing that their disease made them feel difference and superior to other people. Serpell et al. (1999) labeled this theme as the Difference theme, while Nordbo et al. (2006) categorized these statements under the heading Identity.

6) Mastery

Twenty participants (AN=11 [RAN=4; BPAN=7]; BN=5; EDNOS=4 [BED=1; without BED=3]) made statements indicating that their disease provided them with a sense of mastery and achievement. For some, practicing their disorder was something that they could do well while, for others, adhering to their rituals gave them a sense of

accomplishment and strength. Similar categories were labeled Skill (Serpell et al., 1999) and Mental Strength (Nordbo et al., 2004).

7) Lightness/Smallness

A perceived benefit for 15 participants (AN=7 [RAN=2; BPAN=5]; BN=6; EDNOS=2 [BED=0; without BED=2]) was that their disease made them feel light or small. This is different from attractiveness or self-esteem because feeling light or small, or in one case child-like, seemed to be a benefit in and of itself, regardless of feeling attractive, receiving positive attention or having increased self-esteem.

8) Care/Concern

Nordbo et al. (2004) identified Care as a perceived benefit, referring to anorexia as a way of eliciting care from other people. This theme was identified by one SACRED participant, diagnosed with RAN. She expressed that the care and concern others offered and/or provided to her was a benefit of her anorexia. “I do consider myself a successful anorexic. I have gotten the attention of my friends and family over it”.

9) Eat what/when I want

A theme indicated by seven participants refers to the perception that their disease allowed them to eat as much and whenever they wanted (AN=2 [RAN=0; BPAN=2]; BN=3; EDNOS=2 [BED=1; without BED=1]). In this way, their disease was a way for them to be in control of some aspect of their lives.

In addition to the benefits described above, participants made numerous statements describing the negatives of having an eating disorder. These statements were coded into 14 themes (see Table 2).

Table 2.

THEME	COUNT (N=27)	DIAGNOSIS				
		AN (n=12)		BN (n=8)	EDNOS (n=7)	
		RAN (n=4)	BPAN (n=8)		BED (n=4)	WITHOUT BED (n=3)
1) Take-over	26	4	7	8	4	3
2) Distancing	26	4	8	7	4	3
3) Physical Effects	20	2	6	6	4	2
4) Obsession	26	4	7	8	4	3
5) Emotion	13	3	3	4	1	2
6) Effect on others	13	4	2	6	1	---
7) Occupational/Academic Effects	23	4	7	8	2	2
8) Economic Effects	15	---	4	7	2	2
9) Self-Esteem	27	4	8	8	4	3
10) Personality/Behaviour	25	3	7	8	4	3
11) Elusiveness	11	1	6	3	---	1
12) Waste	10	2	3	4	1	---
13) Deviance	10	1	3	5	1	---
14) Hopelessness	4	---	---	1	2	1

1) Take-over

All but one participant (N=26), who was diagnosed with BPAN, felt that they had been taken over by their addiction. They expressed a loss of control over eating and/or purging rituals. Take-over was also used to classify statements that one's addiction had taken over her personality and behaviours in such a way that the addicted person was considered distinct from her true self. Several participants indicated that they had lost their true selves and that they hoped recovery would restore their true identities. This theme was identified by Serpell et al. (1999) and accounted for the largest proportion of statements in that study.

2) Distancing

Another theme identified by nearly all of the participants (n=26) is the Distancing theme (one bulimic participant not make statements in line with this theme). Participants felt that their disease caused them to become isolated from others. Isolating behaviour occurred for a number of reasons including fear of getting hurt, hurting others, being present while others were eating, eating in public, and others discovering her secret. Some participants pulled away from others because they were preoccupied with their

addiction and therefore did not have time or consideration for others, and/or because they felt ashamed of themselves and their behaviours. Social distancing was also instigated by others: several participants remarked that their lies and deception had caused others to pull away from them. Some participants, despite having actively isolated themselves from others, expressed that they felt lonely and alone.

3) Physical Effects

Twenty participants (AN=8 [RAN=2; BPAN=6]; BN=6; EDNOS=6 [BED=4; without BED=2]) expressed distain for the physical toll that their addiction took on their bodies. When asked how they felt after engaging in their ritual behaviours, participants responses included feeling weak, shaky, clammy, tired and bloated, as well as experiencing heart palpitations, insomnia, headaches, and sore throats, muscles and joints. Participants experienced a number of health problems caused or exacerbated by their disease including hair thinning or falling out, problems with thermoregulation, amenorrhea or irregular periods, lethargy, dry skin, poor circulation, nosebleeds, stomach and digestion problems (Irritable Bowel Syndrome, constipation, diarrhea, flatulence, Gastroesophageal Reflux Disease, duodenal ulcers, stomach pain, bloating), insomnia or disrupted sleep, sleep apnea, hyperlipidemia, muscle damage, ridged or weak nails, disrupted hunger signals, osteopenia or osteoporosis, poor healing of wounds, bruising easily, nutritional deficiencies, erosion of tooth enamel, weakened or sensitive teeth, receding gums, dental cavities, and anemia. Serpell et al. (1999) coded statements referring to current or physical health problems as Health. While health problems were expressed as negatives in the minds of participants, this author believes that the Health designation neglects the daily physical discomfort experienced by participants while practicing their disease. It is for this reason that this category is labeled Physical Effects.

4) Obsession

Twenty-six participants made statements that they felt obsessed with thoughts pertaining to their disease. These participants said that they were constantly preoccupied with thoughts of food, caloric intake, body weight and shape, exercising, binging, and/or purging. This preoccupation prevented them from enjoying life and feeling like they were living in the present. Some also expressed that they were self-absorbed and self-

centred, which we labeled as self-preoccupation and consequently included in this category. Although an eating disorder diagnosis requires preoccupation of this sort, one of the participants, who was diagnosed with BPAN, did not express this obsession when completing her intake questionnaire.

5) Emotion

A negative consequence expressed by 13 participants (AN=6 [RAN=3; BPAN=3]; BN=4; EDNOS=3 [BED=1; without BED=2]) was emotional numbness. These participants stated that they were unable to feel any emotions at all and perceived this negatively. Serpell et al. (1999) identified Emotions as a theme, but found that only a small proportion of statements fit into this category.

6) Effect on others

Nearly half of participants (N=13; AN=6 [RAN=4; BPAN=2]; BN=6; EDNOS=1 [BED=1; without BED=0]) made statements that an unfavorable aspect of their disease was the negative effect it had on others. These participants expressed sadness and regret that their disease had caused loved ones to worry, feel pain, or be pushed away. This category is distinct from Distancing, as the former focuses on effects on friends and family members, while the latter refers to the participant becoming isolated from others.

7) Occupational/Academic Effects

Twenty-three participants (AN=11 [RAN=4; BPAN=7]; BN=8; EDNOS=4 [BED=2; without BED=2]) indicated that their disease had negatively affected career and/or academic pursuits. Reasons for these effects included an inability to concentrate; physical fatigue; a lack of ambition; decreased enjoyment derived from working; missing school or work to binge, purge or exercise; and problems making decisions and remembering things. Some participants also explicitly stated that their disease necessitated taking a leave of absence from work or school in order to pursue treatment. In these cases, it was the disease, not the treatment program, which was viewed negatively.

8) Economic Effects

In response to a question about financial effects, 15 participants (AN=4 [RAN=0; BPAN=4]; BN=7; EDNOS=4 [BED=2; without BED=2]) indicated that their disease had caused them to experience financial difficulties. These participants revealed that they had spent large amounts of money because of their addiction. Purchases included organic food and supplements; junk food and other binge food; alcohol and drugs; medications, doctors and therapies; diet aids; and laxatives. The Economic Effects category is related to Occupational/Academic Effects. However, although the disorder affects one's financial situation through its detrimental effects on work or school, financial strain was identified as a direct consequence of the eating disorder.

9) Self-Esteem

The self-esteem of every participant was negatively affected by her eating disorder. Participants expressed self-depreciation in a number of ways including saying that they felt guilty, shameful, weak, disgusting, sinful, evil, pathetic, humiliating, worthless, empty, ugly, fat, crazy, stupid and wasteful. Participants also described themselves as scum of the earth, a loser, a black sheep and a failure.

10) Behaviour/Personality

Almost all of the participants (n=25) indicated that their disorder negatively affected their character traits or caused them to engage in behaviours that contradicted their beliefs. Perceived changes in character included becoming irritable, mean, passive, resentful, whiny, needy, angry, depressed, superficial, unfocussed, lazy, dishonest, judgmental, manipulative, controlling, greedy, introverted, defensive, and unsupportive of others. Behaviours included lying about being hungry, allergic to certain foods, having a stomach ache or illness, feeling nauseous, exercising, eating, and purging; hiding, purging and throwing away food; stealing food and money; acting promiscuously; eating, exercising or purging during the night; using alcohol or drugs; turning away from people and God; gossiping; missing work or school; purging in public washrooms; and engaging in self-injurious behaviour. Largely, these behaviours and personality changes were the root of the participant's self-depreciation. The two participants that did not express that their disease had negatively affected their character or behaviour had

diagnoses of anorexia, one the restricting subtype and the other the binge-eating/purging subtype.

11) Elusiveness

The Elusiveness theme describes statements that success was elusive and that nothing was good enough. Eleven participants (AN=7 [RAN=1; BPAN=6]; BN=3; EDNOS=1 [BED=0; without BED=1]) indicated that their disease did not allow them to reach an end point.. Participants expressed that they could never be thin enough, exercise enough, lose enough weight, or suppress their anxiety for a long enough period of time. Some also stated that they felt that their disease had told them lies. Although Serpell et al. (1999) identified a similar category, Pretend, which involved feeling cheated or tricked by the disorder and believing that it had made false or empty promises, this author feels that the disease's unattainable nature is more accurately captured by the heading Elusiveness.

12) Waste

The Waste theme, identified by Serpell et al. (1999), refers to the feeling that life or time is being wasted by the disease and that the disease has prevented the person from experiencing non-food related opportunities. Ten SACRED participants (AN=5 [RAN=2; BPAN=3]; BN=4; EDNOS=1 [BED=1; without BED=0]) made statements in line with this theme.

13) Deviance

Ten participants (AN=4 [RAN=1; BPAN=3]; BN=5; EDNOS=1 [BED=1; without BED=0]) indicated that they felt different from those who do not have an eating disorder, and perceived this negatively. These participants expressed feeling deviant or abnormal because of the obsessions or compulsions caused by their disease.

14) Hopelessness

A theme expressed by four participants (AN=0; BN=1; EDNOS=3 [BED=2; without BED=1]) is the Hopelessness theme. These participants expressed that their diseases were incurable or untreatable and that they would never be rid of the obsessions of their minds.

Ritual Behaviours

The ritual behaviours of participants varied between and within diagnoses. These behaviours included binge-eating; weighing and measuring one's food and body; purging through vomiting, laxatives, enemas, and exercise; restricting intake of certain or all foods; excessive exercise; and specific eating rituals such as cutting food into small pieces or eating only certain food combinations. Participants considered the performance of these behaviours vital to their well-being, security, and control. Their responses to being asked to recall their feelings after carrying out these rituals indicated both positive and negative thoughts and emotions.

Post ritual-exercise, participants reported feeling euphorically high, happy, powerful, thin, alive, accomplished, lighter, strong, energized, and free from anxiety, stress and muscle tension. Some also expressed feeling exhausted, powerless, and still thinking about food.

Participants said that restricting their food intake made them feel happy, proud, empty, taller, thinner, excited, euphoric, strong, giddy, high, loved, accomplished, satisfied, comforted, in control, numb, and like they had escaped or avoided something. Conversely, responses also included feelings of guilt, physical weakness, pain, depression, self-dismay, denial, and exhaustion.

Participants who engaged in binge-eating and who also performed compensatory behaviours said that binges made them feel emotionally numb, powerful, defiant, full, in control, and momentarily happy. They also expressed feeling evil, disgusting, guilty, shameful, and out of control. Some felt relieved at the knowledge that they would purge afterward, while others perceived this awareness as a negative. Participants said that purging made them feel relieved, numb, in control, smug, and satisfied. The act of purging made some feel as if they had permission to eat and lessened their feelings of fatness. Some of the negative emotions experienced included feeling wasteful, fat, shameful, tired, angry, physically sore, and like a failed anorexic.

Some participants did not differentiate their feelings after a binge or a purge, instead describing their feelings after a binge-eating and purging episode. These participants expressed feeling weak, shaky, shameful, guilty, frustrated, exhausted,

empty, ashamed, disgusting, embarrassed, and out of control. They also revealed feeling powerful, contented, sleepy, numb, relieved, and peaceful.

Participants with BED reported feeling in control, excited, and comforted while binge-eating. When recalling thoughts and emotions experienced after a binge, they expressed feeling physically stuffed, numb, satisfied, guilty, fat, shameful, self-hatred, hopeless, and thinking about purging.

When asked how they felt if unable to engage in ritual behaviours, participants described emotional, psychological and physical disturbances. Responses included feeling resentful, nervous, annoyed, angry, fearful, helpless, depressed, fat or worried about getting fat, panicked, weak, bored, and desperate. Some participants said that they become manipulative and short-tempered and have also cried and yelled. Physically, they reported experiencing pain, insomnia, stomach problems, restlessness, and unbearable anxiety. Several participants said that these feelings intensified as their disease progressed. Responses do not seem to significantly differ by diagnosis.

Discussion

Participants

This study used qualitative and quantitative methodology to describe both the demographics of participants of SACRED's Eating Disorders Recovery Day Program and how they experienced their disease prior to treatment. Anorexia is the most prevalent diagnosis among this group, followed by bulimia and EDNOS. Prevalence rates of each of these diagnoses in the general population are the reverse. Anorexics may be most prevalent in treatment due their elevated risk of mortality and serious medical complications. They may also receive more concern from loved ones and referrals from medical professionals than do individuals with other diagnoses because their low body weight acts as an indicator of their disease. Nonetheless, the percentages of individuals with anorexia and other eating disorders who receive treatment from a mental health professional are low. Mond, Hay, Rodgers and Owen (2007) reported that 22.2%, 13.7%, and 12.9% of anorexics, bulimics, and those individuals with BED, respectively, receive such treatment. While studies report varying rates, possibly due to differences in

samples, it is evident that the majority of individuals with eating disorders are not receiving adequate treatment.

Eating disorders and substance abuse

The results of this study support the well-established link between eating disorders and substance use, and consequently support the addictions model of eating disorders, in a number of ways. Firstly, every SACRED participant affirmed that she did not have control over her eating or purging behaviours. This lack of control is a central feature of an addiction. Substance and process addictions share three characteristics: compulsive use, loss of control, and continued use in spite of adverse consequences. Compulsive use is described as engagement in repetitive and often ritualized behaviour, loss of control as the performance of this behaviour without being accountable to reason or will, and continued use in spite of adverse consequences as the inability to avoid continued use despite increasing problems. Smith and Seymour (2001) labeled these characteristics the “Three C’s”. SACRED participants undoubtedly engaged in repetitive and ritualized behaviour, including binge-eating, restricting, calorie counting, weighing and measuring, purging and obsessively exercising. They indicated that performance of these behaviours was out of their control. It is also evident that they performed these behaviours in spite of the harm caused to their psychological, emotional, spiritual, and physical states and to their occupational, academic and social functioning.

Secondly, many of the thoughts and feelings participants reported to have when engaging in their ritual behaviours and if they were prevented from doing so are consistent with those of substance-dependent individuals. For substance abusers and people with eating disorders, ritual behaviours become a source of control and tension reduction, as their performance may reduce negative and increase positive affect (Nesse, 1994). They serve as coping mechanisms to deal with stress and feelings of inadequacy. Furthermore, the euphoria obtained by individuals with eating disorders when engaging in their rituals is similar to that obtained by those with substance dependence disorders when ingesting their substance of choice. Members of both groups may also experience a lessening of this high as their disease progresses (Butcher et al., 2004).

Substance-addicted individuals may experience withdrawal symptoms if unable to access their drug of choice. These symptoms vary depending on the type of substance being abused; however, those common across drug classes and also experienced by SACRED participants when denied performance of ritualistic behaviour include anxiety, poor concentration, craving, and depression (West & Gossop, 1994). Denial of the drug may cause a drug-abuser to experience fear and panic. These feelings were also reported by SACRED participants. It is likely that these emotions are similar because both groups have an intense preoccupation with their dependent substances or ritualized behaviours, respectively (Szmukler & Tantum, 1984).

Lastly, the majority of SACRED participants (64.5%) have substance abuse or dependence co-morbidity. The co-morbidity between substance use and eating disorders is well documented (Holderness, Brooks-Gunn & Warren, 1994; Wiederman & Pryor, 1996). This and previous studies have suggested that binge-eating/purging anorexics, bulimics, and those with an EDNOS have higher rates of substance use than do restricting anorexics (Piran & Gadalla, 2007; Steiger & Seguin, 1999; Stock, Goldberg, Corbett & Katzman, 2002). None of the restricting anorexics in this study have been diagnosed with drug abuse or dependence, although two (40%) have abused or been dependent on alcohol. Sixty percent (n=6) of binge-eating/purging anorexics, 77.8% (n=7) of bulimics, and 71.4% (n=5) of those diagnosed with EDNOS in the Recovery Day Program had a co-morbid substance use disorder. Holderness et al. (1994), in a literature review involving 25 relevant studies, revealed that a median of 22.9% of bulimic patients in clinical samples had co-morbid substance use disorders. These authors also reported that restricting anorexics have lower rates of substance use disorders than do patients who engage in binge-eating. SACRED participants have substantially higher rates of substance-use co-morbidity than do patients in other samples. This may be a result of the fact that SACRED operates according to an addictions model. Participants may have experience working other twelve-step programs, including AA and NA (Narcotics Anonymous). Success in these programs may have attracted participants to treatment at SACRED.

There have been several explanations given for the relationship between binge-eating and substance abuse. Patients who engage in binge-eating or purging behaviours

have been found to be more impulsive and less inhibited than are non-disordered samples and restricting anorexics (Vitousek & Manke, 1994; Wiederman & Pryor, 1996). These patients have a harder time controlling the urge to binge than do patients with lesser degrees of impulsivity (Steiger, Lehoux & Gauvin, 1999).

Personality factors aside, alcohol consumption could be a driving force behind binge-eating. In one study, bulimics who drank reported that drinking led to binge-eating 43% of the time (Bulik, Sullivan, Epstein, McKee, Kaye, Dahl et al., 1992). That study also found that bulimics had an increased appetite while drinking. Therefore, alcohol use may trigger a binge by increasing the drinker's appetite. Its use may also lead to binge-eating because its physiological effects impair the user's judgment and lower her self-control, which may cause her to satisfy a desire that is normally kept in check (Butcher et al., 2004).

Restricting anorexics may also refrain from drinking alcohol due to its high calorie content. Since they do not engage in some form of compensatory action to prevent weight gain, restricting anorexics typically subsist on low-fat and low-calorie foods.

Another explanation for the link between eating disorders and substance abuse involves co-morbid depressive disorders. Twelve of the sixteen participants diagnosed with a mood disorder also had a substance abuse or dependence diagnosis. A participant's depression, eating disorder, and substance abuse likely exacerbate one another. For example, she may become depressed because of her eating disorder and begin to use substances as a coping mechanism.

Benefits and Costs

Many of the perceived benefits and costs seem to be dichotomous variables. A facet that was initially considered to be beneficial becomes a negative force in the lives of participants. Control is a central feature of eating disorders and an underlying theme of several identified benefits; participants believe that their respective disorder allowed them to gain a sense of control. Control is implicated in the Structure category, as the eating disorder allows the participant to feel in control over the events in her life; the Mastery category, as she feels in control of her body, food, and actions; and the Avoidance

category, as she believes that she has found a way to cope with stress, problems, or difficult emotions. Although many participants are searching for a way to gain control in their lives, every participant stated in her intake questionnaire that she felt out of control and taken over by her disease. Eating, exercising or purging rituals that were once performed voluntarily had become compulsions fueled by obsessive thoughts of food, calories, body shape and weight and purging.

The dichotomy inherent in eating disorders was apparent regarding the avoidance of emotions. The majority of participants in every diagnostic category made statements indicating that their disease protected them from negative feelings and stress. Their eating disorders were coping mechanisms, allowing difficult feelings to be stuffed down, purged out, or exercised away. However, nearly half (48%) of participants reported an inability to feel any emotion, including pleasurable ones. The numbness that was once desirable became pervasive as the diseases progressed.

I was popular, out-going, and enjoyed my friends, boyfriend and family. However, now I have become numb to every emotion, am extremely depressed, and obtain pleasure from nothing. All I have the energy for is to eat, sleep, exercise, and work.

The excerpt above is from the intake questionnaire of a 21-year old participant with anorexia. In addition to clearly illustrating emotional numbness, the passage indicates that this participant distanced herself from others. Since the thoughts of this and other participants pertained only to their diseases, they did not have time or energy to devote to other people or other aspects of their lives. They had physical, mental, emotional and psychological energy only for their disease. This was captured in the Take-over, Obsession, Distancing, Effect on others, Occupational/Academic Effects, and Waste themes. The following, an excerpt from the intake questionnaire of a 31-year old participant with bulimia, illustrates how pervasive the illness can become. The excerpt also specifically exemplifies the Take-over theme.

I experience every aspect of life with it by my side. My disease ties my running shoes, purchases laxatives, and holds back my hair for me. My disease has taken over my life and prevented me

from living an authentic life....It determines the extent of my social life. It decides whether or not I am able to go to work, spend time with friends and family, enjoy time on my own. It filters the perception of the world so I often feel like I am living against the world not within it.

This dichotomy was also evident regarding self-esteem. Weight loss associated with anorexic or bulimic behaviour often elevated self-esteem and self-worth. The participants felt more attractive and popular, especially if they received compliments or positive attention from others due to their weight loss. However, nearly all participants made self-depreciating statements in their intake questionnaires. These statements included thoughts and feelings of being shameful, bad, worthless, and disgusting. The transition from one's eating disorder increasing to decreasing her self-esteem, as well as the Take-over theme, is evident in the following quotation from the questionnaire of a 29-year old participant diagnosed with bulimia.

In the beginning, skipping meals made me feel free, light, airy. It gave me confidence to talk with people. No one could hurt me. Slowly, I began to feel like some sort of disgusting animal who doesn't think or feel just carries out its urges because it is programmed to not because of want – because of need.

Participants who engaged in binge-eating or purging, versus those who did not, generally made more statements indicating disgust with themselves and their actions. Many indicated that they would try not to eat all day or to only eat very little. Those who could not resist the urge to binge felt weak and worthless, although often these feelings were accompanied by feelings of defiance, pleasure and power because they were doing what they wanted. The act of purging also elicited mixed feelings; participants felt relieved and in control because they eliminated food and calories but also felt disgusting, weak, guilty and shameful because they viewed purging as wasteful and humiliating.

A recurring theme across diagnoses is that restricting is something to be proud of because it demonstrates control, while binge-eating, which for bulimics necessitates purging, is shameful and illustrative of lack of control. This theme is supported by a

number of previous studies (Powers & Bannon, 2004; Serpell et al., 1999; Skadarud, 2007). A surprising finding, however, is that no participants with restricting anorexia reported feeling different, in a positive way, because of their disorder. Still, every participant with restricting anorexia reported feeling masterful because of her disease, while several participants who engaged in binge-eating reported feeling like failed anorexics. A higher percentage of participants with restricting anorexia (75%) expressed elevated self-esteem than did any other diagnostic category. This could explain why there have been twice as many anorexics with the binge-eating/purging subtype than the restricting subtype in treatment at SACRED. It is likely that restricting anorexics are reluctant to enter treatment due to the feelings of control, elevated self-esteem, and sense of accomplishment that they derive from their disease. Treatment reluctance and lack of motivation to change has been supported by previous studies (Geller, Williams, & Srikameswaran, 2001; Serpell & Treasure, 2002; Vitousek, Watson, & Wilson, 1998). It is also possible that the overall prevalence of restricting anorexia is lower, accounting for the proportion of restricting versus binge-eating/purging anorexics in treatment at SACRED. No studies were found that indicate the proportion of anorexics who are restrictors as compared to binge-eaters/purgers. Determination of this proportion may be complicated by the fact that a large number of anorexics move from restricting behaviour to binge-eating and purging. It has been reported that between 8% and 62% of individuals with restricting anorexia develop bulimic symptoms during the course of their illness and that most cross over within the first five years (Tozzi, Thornton, Klump, Fichter, Halmi, Kaplan et al., 2005). Restricting anorexics may represent eating disorder patients who have not have crossed over into binge-eating and purging. Several studies have found restricting anorexics to be younger and have a shorter duration of illness than those with binge-purging anorexia (DaCosta & Halmi, 1992; Tozzi et al., 2005; Vervaet, van Heeringen & Audenaert, 2004a)

There are also high rates of diagnostic crossover between binge-eating/purging anorexia and bulimia,. Patients with binge-eating/purging anorexia have scores on personality measures that are more like patients with bulimia than those with restricting anorexia (Vervaet et al., 2004a). Furthermore, between 22% and 37% of bulimics in clinical samples have a history of anorexia (Braun, Sunday & Halmi, 1994; Bulik,

Sullivan, Weltzin & Kaye, 1995; Sullivan, Bulik, Carter, Gendall & Joyce, 1996). This transition is much more likely than one from bulimia to anorexia (Tozzi et al., 2005). There is also evidence of diagnostic crossover from bulimia to binge eating disorder (Vervaet, van Heeringen & Audenaert, 2004b). It is possible that non-purging bulimia may evolve into binge eating disorder. Vervaet et al. (2004b) found that patients with BED were older and had a longer duration of illness than did bulimics, which would be expected patients with BED had a history of bulimia. More research is needed to investigate this possible transition.

It is evident that not all patients with eating disorders neatly fit into and remain in any one diagnostic category. This may be attributable in part to the slight differences between formal diagnoses. For example, a binge-eating/purging anorexic becomes bulimic if she reaches a normal body weight, as body weight is the only distinction between these diagnoses (APA, 2000). Several participants of SACRED's Eating Disorders Recovery Day Program have histories of other eating disorders. Furthermore, participants of all diagnoses have many thoughts, behaviours, and experiences in common. This is one of the primary reasons that SACRED does not differentiate participants based upon their current eating disorder diagnoses. It is possible that specific diagnoses represent snapshots of the same disease and that diagnostic crossover denotes a progression (see Figure 1). For example, an individual may be diagnosed with an EDNOS because he or she does not fit the criteria for anorexia. He or she may later meet this criteria and be diagnosed as having restricting anorexia, transition into binge-eating and purging because restricting sets up the binge and purge cycle, gain sufficient weight to warrant a diagnosis of bulimia and, finally, discontinue compensatory behaviours and consequently meet the criteria for binge eating disorder.

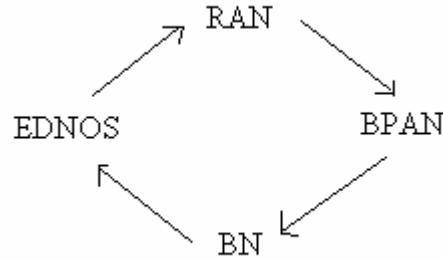


Figure 1. Eating disorders as one disease.

Eating disorders have affected most or all aspects of participants’ lives. It is evident that participants wanted to recover but did not believe that this was possible by their own volition. The importance of treatment in the restoration of participants’ physical, mental, and spiritual health can not be overemphasized. Unfortunately, the majority of people with eating disorders do not receive treatment for their disorder from a mental health professional.

The holistic nature of treatment at SACRED allows healing to be just as extensive as the disease. Physical, emotional, psychological and spiritual recovery is emphasized. SACRED’s treatment model allows participants to be relieved of the obsessions of their minds by surrendering control of food, exercise and body weight to a Higher Power (ABA, 2002). As they find and develop a relationship with this Higher Power, participants are enabled in their recovery. In addition to healing themselves, they are facilitated in healing their relationships. Guilt is alleviated as participants are facilitated in rectifying the harms that they have caused to others.

It must be acknowledged that SACRED’s treatment participants are not representative of all women with eating disorders in the community or in any other treatment program. In order to participate in SACRED’s Eating Disorders Recovery Day Program, applicants must be medically and psychiatrically stable, willing to dedicate 12 hours a day, 7 days a week to the program, surrender control of their meals and exercise, explore their spirituality, become actively involved in ABA and AA, and take personal responsibility for their recovery. They must also have the economic means necessary to

fund treatment and be considered by the treatment team to be appropriate candidates for the program.

Past and present SACRED participants comprise a relatively small group. The number of participants that can be admitted into the program is limited by funding for the facility and program counsellors and by participants' length of stay. The average length of stay is relatively long; 215 days on average. This figure is based upon available intake and discharge data for 22 past participants. Nonetheless, this study is comprehensive in that it sheds light on the demographics and experiences of all participants who have received treatment at SACRED since January of 2003.

It is likely that eating-disordered people who are less progressed in their diseases would be more conscious of the benefits that their diseases offer and less conscious of the costs. Upon admission and prior to the completion of their intake questionnaires, participants have attended ABA and AA meetings on a regular basis, had intake appointments with SACRED's Medical Advisor, and visited the SACRED treatment center as drop-in participants. Their demonstrated willingness to go to any length to get well, including letting go of the control that they have worked so hard to achieve, signifies that the negative features outweigh the benefits that their diseases conferred to them, and that the initial highs experienced from restricting, binge-eating, excessively exercising, or purging have lessened or stopped. Their desire to enter treatment distinguishes them from many others who share their diseases.

Conclusion

This study provides an in-depth examination of how SACRED's participants perceive their diseases have affected them both positively and negatively. Although the histories, thoughts, feelings, symptoms, and recovery of each individual are unique, participants and their loved ones have been dramatically affected by their eating disorders. This study is a likely precursor to others involving SACRED participants. Further research is anticipated to investigate causal links as well as treatment outcome.

By and large, the academic community does not consider eating disorders to be addictions or even utilize the term addiction. Addiction is not mentioned in the DSM-IV-TR, let alone in reference to eating disorders. In preparation for the publication of DSM-

V, there has been dialogue concerning the creation of an addictions category to group substance use disorders with specific mental health disorders including pathological gambling, sex, and food (Coombs, 2004). This study lends support to the addictions model of eating disorders. It also supports the holistic therapeutic approach used and endorsed by the SACRED organization.

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