A Qualitative Evaluation of MEG: A Group Therapy Program for Women
Who Binge Eat

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0616400

Submitted as partial fulfilment of the requirements for the degree of
Postgraduate Diploma of Psychology

Faculty of Life and Social Sciences
Swinburne University of Technology

June, 2006

Word count: 12,000
Abstract

The current study utilised a qualitative approach to investigate the subjective experience of six women who were part of the MEG (Moderate Eating Program) program, a group treatment program for individuals who binge eat. This study extended the Crafti (2002) quantitative study, and attempted to contribute a richer wealth of knowledge on the effectiveness of MEG in addressing the issues of its participants, and to complement the extensive body of quantitative research carried out in the field of eating disorder treatment. Participants were interviewed individually in a semi-structured format before and after completion of the program. Transcripts were analysed to find common themes. Findings from the first interview supported previous studies on bingeing antecedents and characteristics. Participants typically reported a history of family dysfunction, dieting, and adverse events, and showed evidence of sociocultural influence. In support of the existing literature, they also showed low self-esteem, overemphasis on body image and the approval of others, difficulty with assertion, difficulty with emotion regulation, social anxiety, perfectionism, and impulsivity. Hopes for treatment outcome centred around healthy control of eating, healthy body weight, healthy attitudes toward food and body, and increased awareness. Results found MEG partially successful in meeting participants’ pre-treatment goals and effecting improvements in behaviour and awareness. All participants had shown improvement to varying degrees in eating behaviours and awareness, general awareness of eating disorders, and personality/psychological factors, but improvements had been difficult to maintain after completion of the program, and most pre-treatment issues persisted. This study raised a number of possible implications for future research and treatment directions, and is best interpreted as supplementing existing knowledge of treatment for eating disorders, and providing a foundation for future studies and treatment programs to build on.
Acknowledgements

I would like to thank the following people for their contributions to this thesis:

Dr. Naomi Crafti for her expert knowledge, guidance, and encouragement throughout the preparation and writing of this thesis. Also for her efforts to ease my anxiety, and for her patience and understanding in the face of my procrastination.

Rebecca Wickham, for hours and hours of painful transcribing.

Leanne, for her gallant efforts to motivate me, her excellent database literature search skills, and her CD burning abilities.

My friends and family, for understanding my need to become a recluse during these last few months, and for encouraging me to keep going and not give up.

The countless friends, fellow students, colleagues, acquaintances, and strangers who listened with interest, entered into discussion, and let me frequently vent about researching and writing this thesis.
An honourable mention goes to James Keck for showing me by example the
reward of intellectual pursuit, and what it takes to get there, even if in
retrospect. If you’re going to do something, you should do it well.

Most of all, I would like to thank the women in this study who generously
and with good grace gave up their time and shared their often painful stories
with me in the hope of helping others. This thesis would not have been
possible without your courage and honesty.

This thesis is dedicated to Bhima. You are never far from my thoughts and
always in my heart.
Declaration

I declare that this report does not incorporate without acknowledgement any material previously submitted for a degree in any University, College of Advanced Education, or other educational institution, and that to the best of my knowledge and belief it does not contain material previously published or written by another person except where due reference is made in the text.

I further declare that the ethical principles and procedures specified in the Faculty of Life and Social Sciences Human Research Ethics Committee document have been adhered to in the preparation of this report.

Name:

Signed:
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Chapter 1

Introduction

1.1 A Common Problem

In retrospect, my own problematic relationship with food began at a very young age. Very rarely could I save anything deemed ‘special’, such as chocolate or chips. I had to consume my goodies all at once, usually whether I was hungry or not, which I still do, more times than not. I could never understand how my brother could put aside his treats once he was satisfied, and save the rest for another time, or, more frustratingly, not open them at all until later, when he was hungry.

As a child, I received confusing messages about food. I had to finish all the food on my plate or my stepfather would send me to bed. My mother would often tell me off when I was hunting for food in the pantry or fridge. I remember her being on countless restrictive diets and obsessing about her weight. I even remember her wrapping cling-film around her body, putting on track pants, and running around the block in an effort to sweat off weight. As far as I can recall, and as evidenced in photos, my mother was a very attractive woman who always had a lovely slender figure, and I couldn’t understand what all the fuss was about.

My own hate relationship with my body began when I was twelve after an insensitive comment from a boy, and grew from there. I spent my teenage years obsessing about my body and food and see-sawed between ridiculous
restrictive diets and secret bingeing. My weight has gone up and down over the years, and I have gone back and forth from periods of healthy eating and exercise, to periods of complacency and unhealthy food choices. Though my eating problems may not have been termed clinical, they have still been very distressing to me. Most times I feel completely out of control in regards to food, particularly in times of emotional stress, and at a loss to understand my behaviour.

I share this personal information with the reader not as a means to instil sympathy, but to highlight that the subject of this thesis is a very common story. In my personal experience, I have rarely come across a woman who has no issues with food and body image. On those few occasions that I have met a woman who displays a seemingly ‘normal’ and completely healthy relationship with food and their body, I secretly wonder to myself if she is being entirely honest, either with herself or me. If so, then she is certainly an anomaly. Eating disorders, along with body image dissatisfaction, are a disturbing and rapidly growing epidemic, particularly in Western cultures, and increasingly globally (Barlow & Durand, 2005). They cause great suffering and mental anguish for those unfortunate enough to have one, and for the people around them, and have serious physical and psychological ramifications, sometimes leading to death. Eating disorders also present economic and social burdens. They place a growing strain on limited health resources, with greater use of health services by those with an eating
disorder; more indirectly, they contribute to time lost from work (Striegel-Moore, Dohm, Kraemer, Schreiber, Crawford & Daniels, 2005).

In using this personal approach, I am also attempting to introduce the reader to the sort of detail-rich data that can only be captured by qualitative research. The great majority of eating disorder research to date has been of a quantitative nature, neglecting the rich and expressive nature of information that can be gleaned from qualitative research. In fact, in undertaking a literature search, this researcher could find no qualitative research on the subject of binge eating or treatment for binge eating. Studying the subjective experience of the binge eating individual as presented in his or her own words, an important and necessary aspect in fully understanding a phenomenon, has been ignored.

This study utilises a qualitative approach to investigate the subjective experience of six women before and after completion of the MEG (Moderate Eating Group) program, a group treatment program for Binge Eating Disorder (BED). It is exploratory and evaluative in nature, and therefore no hypotheses are proposed. This study aims to build on the current body of knowledge of BED by allowing the participants to tell their story in their own words. It aims to find common themes among individual’s stories. It also aims to capture more detailed information on the effectiveness of MEG in addressing the issues of the participants, and to contribute to a richer wealth of knowledge about binge eating treatment programs in general. In interpreting the results of this study it is important to first examine the
existing literature on eating disorders and associated factors. For the purposes of this study all subsequent discussion will be focused on BED and Bulimia Nervosa (BN) unless otherwise stated.

1.2 BN and BED Criteria

Although among obese individuals binge eating behaviour has been recognised as clinically relevant for over forty years, it is only relatively recently that BED has been put forward as a distinct diagnostic category (Devlin, Goldfein & Dobrow, 2003; Stunkard, 1959). BED is currently listed in the appendix of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) as a proposed disorder requiring further study (APA, 2000). Presently, individuals who display clinical binge eating behaviour can only officially be diagnosed with Eating Disorder Not Otherwise Specified (EDNOS) (Wilson, Vitousek & Loeb, 2000; Wilson & Walsh, 1991). Whilst there has been debate over whether BED is more appropriately classified as a variant of other disorders, such as obesity or BN, most research has supported the inclusion of BED as a separate diagnostic category of the eating disorders (Devlin, Goldfein & Dobrow, 2003; Striegel-Moore, Wilson, Wilfley, Elder, Brownell, 1996; Walsh & Boudreau, 2003; Wilfley, Wilson & Agras, 2003).

Diagnostic criteria for BED share some similarities with BN diagnostic criteria. Both BED and BN stipulate recurrent episodes of binge eating, which are characterised by eating an abnormally large amount of food in one sitting, coupled with a sense of lack of control (APA, 2000). BED criteria
specify the inclusion of marked distress during a binge eating episode. While episodes must occur on average twice a week for a period of 3 months to meet BN criteria, BED criteria states frequency of occurrence must be at least 2 days a week for 6 months (APA, 2000). This is a potentially confusing criterion, as multiple binges can occur in a single day, and sometimes the absence of bingeing behaviour is unidentifiable. A criterion noticeably absent in BED diagnosis but listed in BN criteria is the excessive influence of body shape and weight on self-evaluation (APA, 2000). It is puzzling why this is not a factor in BED diagnosis, as it is apparent from research that individuals with BED share the same over-concern about body shape and weight (Barlow & Durand, 2005).

The most obvious factor distinguishing BED from BN diagnostic criteria is the absence of compensatory behaviours (APA, 2000). As well as recurrent binge eating episodes, individuals diagnosed with BN must also concomitantly engage in recurrent compensatory behaviour, such as self-induced vomiting, abuse of laxatives or diuretics, fasting, or excessive exercise (APA, 2000).

Of particular relevance to this study are sub-clinical eating disorders: eating psychopathology that does not meet DSM-IV-TR criteria but that still causes the individual considerable distress. Individuals who did not meet the clinical diagnosis of BED or BN but who reported excessive food and weight concerns and identified themselves as a binge eater were accepted into the
MEG program (DSM-IV-TR diagnostic criteria for BN and BED is included in Appendix C).

1.3 A Brief Overview of Risk Factors

What causes an individual to develop an eating disorder and how it is maintained has been extensively investigated. Dependent on theoretical perspective, research suggests the etiology of eating disorders may be due to one of a multitude of factors, or, in an integrative approach, a combination of factors (EDFV, 2000; Cooper 1995; Jacobi, Morris & de Zwaan, 2004). In the current study, participants were questioned about their history of eating problems in order to determine possible contributing and maintaining factors.

1.3.1 Familial Factors

Individuals who binge typically describe greater family dysfunction compared to that of normal controls (Jacobi, Morris & de Zwaan, 2004). Individuals with BN report significantly higher levels of parental indifference, neglect, high expectations, low contact, and critical comments about weight and shape (Jacobi, Morris & de Zwaan, 2004). Similarly, individuals with BED report greater levels of parental neglect, rejection, criticism (including comments about shape, weight, or eating), high expectations, low contact, under-involvement, minimal affection, and overprotection (Jacobi, Morris & de Zwaan, 2004).
Participants in the current study were asked to describe their past and present relationships with their parents and siblings, in particular any features of these relationships that were problematic.

1.3.2 Sociocultural Factors

As eating disorders become increasingly evident in developing countries and amongst migrants relocating to western countries, evidence grows for sociocultural factors being one of the strongest etiological contributors (Barlow & Durand, 2005). The idealisation of thinness in modern society is inextricably linked with measures of success, self-worth and happiness, and research has shown a strong relationship between amount of exposure to media and body dissatisfaction (Barlow & Durand, 2005; Piran, 2000). Ideas about body shape and weight can also be learned from peers and family (EDFV, 2000). Friendship groups contribute significantly to the development of body image and eating behaviours, and teasing from peers or family about weight and/or appearance, or a focus on appearance, have been shown to be associated with bingeing (Barlow & Durand, 2005; Jacobi, Morris & de Zwaan, 2004).

Participants in the current study were not always directly asked about sociocultural influences on their eating behaviours (due to the semi-structured format of the interview), but the subject of the media and peers was frequently raised in discussing the development and maintenance of their disorder.
1.3.3 Personality/Psychological Factors

1.3.3.1 Low self-esteem

Low self-esteem has been identified as a risk in the development of eating disorders, and can be linked to many of the other psychological risk factors (EDFV, 2000; Serpell & Troop, 2003). Individuals with eating disorders have been shown to have a lack of sense of control and confidence in their abilities and a tendency to over-emphasise external measures as a basis for self-worth (Barlow & Durand, 2005; EDFV, 2000).

1.3.3.2 Over-emphasis on the approval of others

People with eating disorders are preoccupied with how they appear to others, and have a tendency to place over-importance on the approval and wishes of others to the detriment of their own (EDFV, 2000).

1.3.3.3 Difficulty with assertion

Individuals with an eating disorder commonly experience difficulty in expressing their own needs and making demands of others (EDFV, 2000).

1.3.3.4 Over-emphasis on body image

Eating disordered individuals are preoccupied and dissatisfied with their body image, and often have distorted ideas about their body shape (Barlow & Durand, 2005; EDFV, 2000; Reas, White & Grilo, 2006). Negative
evaluations of body image contribute to low self-esteem, as an over-emphasis is placed on body image as a basis for self-worth and acceptance by others (EDFV, 2000).

1.3.3.5 Social anxiety

Due to low self-esteem and a preoccupation with external acceptance and approval, eating disordered individuals harshly judge their interactions with others and see themselves as ‘frauds’ and ‘impostors’ in social situations; they “…consider false any impressions they make of being adequate, self-sufficient, or worthwhile” (Barlow & Durand, 2005, p.273). This can lead to fear of social situations and social avoidance, contributing to social isolation (Barlow & Durand, 2005; EDFV, 2000).

1.3.3.6 Perfectionism/High Achievers

It is widely known that perfectionism is associated with eating disorders; some researchers have suggested that eating disorders are in fact a direct expression of perfectionism (Fairburn, Cooper & Shafran, 2003; Shafran, Cooper & Fairburn, 2002). Individuals with perfectionism set personally demanding standards in an attempt to exert control over areas of their lives that are important to them and place an over-emphasis on the achievement of such goals in determining their self-worth (Barlow & Durand, 2005; Fairburn et al., 2003; Shafran et al., 2002). This paired with low self-esteem and negative body image can contribute to the development and maintenance of
an eating disorder (Barlow & Durand, 2005; Fairburn et al., 2003: Shafran et al., 2002). Failure to meet standards results in self-criticism; if standards are met, positive self-evaluation is short lived and standards are immediately re-evaluated as inadequate and consequently raised (Fairburn et al., 2003: Shafran et al., 2002). Perfectionists think they are never good enough and should always be doing better than they are (Shafran et al., 2002).

1.3.3.7 Impulsivity

Although seemingly contradictory, both perfectionism and impulsivity can be seen in people who binge (Dohm, Striegel-Moore, Wilfley, Pike, Hook & Fairburn, 2002; Halmi, 2005; Steiger & Bruce, 2004). Research has found that individuals with BN often act on impulse without considering the consequences of their actions (Steiger & Bruce, 2004). This tendency toward impulsivity also appears to extend to other bingeing populations, such as BED and Binge-Eating/Purging Type Anorexia Nervosa (DSM-IV-TR diagnostic Anorexia Nervosa is included in Appendix C). (Steiger & Bruce, 2004). Other forms of destructive impulsivity, such as substance abuse, self-harm, sexual promiscuity, and suicidality, are also commonly found in bingeing populations (Steiger & Bruce, 2004).

1.3.3.8 Difficulty with emotion regulation

A great body of research has investigated the relationship between affect, emotion regulation, and bingeing. It is well known that people with eating
disorders also usually suffer from mood disorders, such as anxiety and depression, and that emotional distress has been frequently found to precipitate bingeing (Abraham & Llewellyn-Jones, 1997; Fairburn et al., 2003; Masheb & Grilo, 2006; Telch & Agras, 1995). Much research has suggested that eating disordered individuals have an inability to regulate emotions, and bingeing is an attempt to regulate or distract oneself from negative emotions (Fairburn et al., 2003; Heatherington & Baumiester, 1991; Pratt, Telch, Labouvie, Wilson & Agras, 2001). Several studies have found a high prevalence of alexithymia in binge eaters (Bydlowski, Corcos, Jeammet, Patterniti, Berthoz, Laurier, Chambry & Consoli, 2005; Carano, De Berardis, Gambi, Paolo, Campanella, Pelusi, Sepede, Mancini, Rovere, Salini, Cotellessa, Salerno & Ferro, 2006; Wheeler, Greiner, & Boulton, 2005). Alexithymia literally means “no words for feelings”, and is a cognitive-affective deficit characterised by difficulty recognising and verbalising feelings, and difficulty distinguishing emotions from physical sensations (Wheeler et al., 2005, p. 115). An individual with alexithymia, for example, may misinterpret loneliness as hunger (Wheeler et al., 2005). Individuals with alexithymia are easily dominated and overwhelmed by emotions, resulting in intense uncontrolled emotional reactions (Bydlowski et al., 2005). The inability to self-soothe and manage emotions due to emotional awareness leads to maladaptive attempts to relieve distress, such as bingeing (Wheeler et al., 2005). Binges provide momentary relief, if any, which is rapidly replaced with an even greater sense of shame and depression, contributing to
the bingeing cycle (Wheeler et al., 2005). Though some individuals with alexithymia respond to stress with bingeing and purging, they cannot connect the binge with any emotional provocation (Bydlowski et al., 2005).

Participants in the current study were rarely directly questioned about psychological features that may be a factor in the development and maintenance of their bingeing, but it was assumed that other interview questions would access these aspects. Questions design to elicit such information were asked regarding binge triggers, concerns with food and other related issues (such as body image), interactions with others, and comorbidity with other psychological problems. It was also thought that certain personality and psychological features would become apparent in the telling of participants’ stories.

1.3.4 Dieting

Dieting is strongly associated with eating disorders, and individuals with BN frequently report dieting as an antecedent to binge eating behaviour, although recent studies have found dieting is not always a precursor to binge eating (Jacobi et al, 2004; Johnson & Wardle, 2005; Wilson, 1993). Failure to stick to rigid standards paired with a sense of deprivation can lead to a perceived loss of control and overeating (Wilson, 1993). Dieting can also cause stress, which is a known precipitant to bingeing (Wilson, 1993). Restrictive eating can also increase the appeal of ‘forbidden foods’, which are
typically foods high in fat and sugar (Wilson, 1993). Individuals often alternate between periods of anorexia and bingeing disorders.

Participants in the current study were asked about the onset and history of their eating problems and characteristics of their eating disorder, which established the existence of dieting behaviour.

1.3.5 Adverse Events

Stressful life events have been associated with the development of eating disorders (EDFV, 2000; Cooper, 1995). Studies have individuals with eating disorders report experiencing more adverse life events preceding onset of an eating disorder than healthy controls (Jacobi et al., 2004). Examples of adverse events would be death of an immediate family member, severe illness or accident, history of abuse, or separation of parents (EDFV, 2000).

Participants in the current study were not directly asked about adverse life events as it was reasoned that any such experiences would be revealed in the discussion of childhood, onset and history of eating disorders, and binge triggers.

1.4 Treatment Approaches

The most commonly used and researched psychological approach for treating both BN and BED is Cognitive Behavioural Therapy (CBT) (Barlow & Durand, 2005; Treasure & Schmidt, 2003). Studies using CBT have consistently shown lasting significant reductions in frequency of bingeing (as
high as 90% for BN and 81% for BED) and abstinence from bingeing (as high as 45% for BN and 50% for BED) (Agras, Telch, Arnow, Eldredge & Marnell, 1997; Smith, Marcus, & Kaye, 1992; Thompson-Brenner, Glass, & Westen, 2003).

Interpersonal Psychotherapy (IPT) is another increasingly used treatment approach which has shown equal lasting significant improvements as CBT in symptoms for individuals with BN or BED (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; Fairburn, Jones, Peveler, Hope & O’Connor, 1993; Wilfley, Welch, Stein, Spurrell, Cohen, & Saelens, 2002). Individuals with BN or BED display problematic interpersonal relationships (Birchall, 1999). They report higher incidence of negative interactions and impaired relations with others, and poorer relationship quality than normal controls (Grissett & Norvell, 1992; Spitzer, Devlin, Walsh, Hasin, Wing, Marcus, Stunkard, Wadden, Yanovski, Agras, Mitchell, & Nonas, 1992). Research has shown interpersonal problems often precipitate and possibly perpetuate a binge, and are more influential in precipitating a binge than physiological factors (Arnow, Kenardy & Agras, 1992; Birchall, 1999). It is thought that individuals with eating disorders displace their interpersonal problems to areas they think they can control, such as weight and shape, in an attempt to increase self-esteem (Nevonen, Broberg, Lindstrom & Levin, 1999). Though it is not known if interpersonal difficulties are a cause or effect of an eating disorder, it is known that the two influence each other in a circular
manner, contributing to the maintenance of the disorder (Birchall, 1999; Nevonen et al., 1999).

Though CBT appears to be significantly more effective than IPT for BN at end of treatment measures, at 1-year follow-up IPT effectiveness matches that of CBT with no significant differences between the two treatments (Agras, et al., 2000). In the case of BED, IPT is just as effective as CBT in reduction of symptoms at end of treatment (Barlow & Durand, 2005). Research has suggested that the similar effectiveness of both IPT and CBT, two very different approaches, may be due to non-specific properties shared by the treatments (Wilson & Fairburn, 2000). Alternatively, it has been proposed that although both treatments may appear to be equally as effective, it is more likely that each treatment has unique specific effects, and that IPT and CBT work through different processes (Wilson, 1995, cited in Crafti, 2000).

CBT and IPT are also effective when administered in a group format. Participants in one study using group CBT reported that the group format provided support and motivation (Chen, Touyz, Beaumont, Fairburn, Griffiths, Butow, Russell, Schotte, Gertler & Basten, 2002). Group therapy gives individuals the opportunity to work on their interpersonal issues in a safe and supportive environment (Chen et al., 2002; Stuber & Strober, 1987). It also reduces the social isolation, secrecy, and shame that often accompany eating disorders, and, in doing so, serves to
challenge the maladaptive thoughts and behaviours that contribute to their maintenance (EDFV, 2000; Nevonen et al., 1999).

Recently, studies have investigated the effectiveness of a sequenced group therapy model incorporating both CBT and IPT in treating eating disorders (Nevonen et al., 1999; Nevonen & Broberg, 2005). One study using this model showed significant improvements in bingeing and purging frequency at post-treatment, with 70% of BN patients and 77% of EDNOS patients in full or partial remission, as well as significant reductions in interpersonal deficits and increased coping resources (Nevonen et al., 1999). These improvements were sustained at 1-year follow-up (Nevonen et al., 1999). Another study which compared the sequenced model in a group format to an individual format found that the group format resulted in greater reduction of symptoms (Nevonen & Broberg, 2005). Interestingly, this study also assessed improvement in terms of relation to ‘normality’ (Nevonen & Broberg, 2005). At 1-year follow-up, two-thirds of participants were closer to ‘normal’ group means in measures of eating disorder symptoms, interpersonal problems, and concomitant psychopathology, with continuing significant improvements at 2.5-year follow-up (Nevonen & Broberg, 2005).

An important feature of group therapy is that it is cost effective (Nevonen & Broberg, 2005). One study reports group therapy as one-fifth to one-third the cost of individual therapy (Chen et al., 2002). Group treatment modules are often easily taught and programs can therefore be led by non-specialist therapists (Waller, Fairburn, McPherson, Kay, Lee & Nowell, 1994). Another
benefit of group therapy is that a number of patients can be treated at one time without having to be on a waiting list, reducing the risk of increase in symptoms (Waller et al., 1994).

1.5 The Birth of MEG: Development, Evaluation, and Limitations

In 2000, the Moderate Eating Group (MEG) treatment program was developed and evaluated with the aim of establishing an empirically based and theoretically grounded group therapy approach integrating manual-based CBT with a focus on interpersonal issues (Crafti, 2000). It was hypothesised that since interpersonal difficulties have been shown to be a significant precipitating and maintaining factor in binge eating, an interpersonal focus would have greater clinical effectiveness in the treatment of individuals with eating disorders than CBT alone (Crafti, 2002). Of note to the researcher, IPT had also been shown to have greater client acceptability when used either in conjunction with or instead of CBT (Crafti, 2002).

The MEG program was previously been evaluated using quantitative measures and was shown to result in lasting positive changes in both eating psychopathology and general psychopathology (Crafti, 2002). MEG was initially held at a university clinic in Melbourne, Australia, and ran for twelve 3-hour sessions. Participants were 28 females divided into six groups. The program was delivered by two postgraduate psychology students. Each session covered different topics in accordance with the MEG manual and dealt with issues linked to eating disorders. Participants were introduced to
behavioural and cognitive strategies to reduce eating disorder symptoms and challenge maladaptive attitudes and beliefs, with the majority of the session focussed on interpersonal work. Two additional groups took part in the initial study: 18 females who waited three months after initial contact before commencing the program (WLC), and 12 females who completed the program in a hospital outpatient setting (led by two fully qualified clinical psychologists). In total there were 40 participants.

A number of different quantitative measures were taken at post-treatment (10 weeks) and follow-up times (3 months and 6 months after completion). Participants were asked to record their frequency of bingeing and purging using Wilfley et al’s (1993, cited in Crafti, 2002) 7-day calendar recall method. The following questionnaire measures were also used to evaluate change: the Eating Disorder Inventory-2 (measuring eating psychopathology); the CC-SE subscales (measuring cognitive control and self-efficacy in relation to eating); the Eating Self-Efficacy Scale; the Brief Symptom Inventory; The Rosenberg Self-Esteem Scale; and the Coping Response Indices (Crafti, 2002). As well as quantitative measures, participants provided a brief written qualitative evaluation of the program based on what they thought were the least and most effective aspects of MEG, and were given an opportunity for additional comments and suggestions.

Results showed a substantial and lasting impact of MEG on bingeing and purging, with the majority of participants being abstinent from both
behaviours at post-treatment and follow-up, as well as significant changes in other eating disorder characteristics (cognitive coping and self-efficacy, and eating self-efficacy) and general psychopathology (self-esteem, interpersonal sensitivity, and depression) (Crafti, 2002). Participants also reported a high level of satisfaction with the program (Crafti, 2002).

Similar changes were shown in the hospital group, indicating MEG was suitable for a diverse client population and could be used by a range of therapists across different settings (Crafti, 2002). These changes were not evident for the WLC group, suggesting that changes in the MEG university and hospital groups were directly attributable to the program (Crafti, 2002).

In discussing the limitations of the 2002 (Crafti) study, the researcher proposed further study was needed using qualitative analysis as a means of enhancing the extensive quantitative research conducted in the eating disorder field. The researcher noted the difficulty in appropriately defining and measuring ‘outcome’, and the failure of the selected measures “…to adequately assess the ‘depth’ and ‘meaning’ of the experience for participants” (Crafti, 2002, p. 145). Crafti highlighted the impossibility of quantifying the often indefinable benefits received from therapy, such as was evidenced from one of the participants:

The past six months of counselling and self-discovery have been the most fulfilling, satisfying and enriching experience – probably the most fulfilling in my life so far – and I firmly believe I could not have done this without firstly learning to accept myself and bulimia as an illness, through contact and acceptance of the group initially and, having done this,
having the confidence and self-belief to move onwards toward health and healing.


The current study extends the 2002 (Crafti) study, and attempts to address some of the limitations existent in using quantitative measures of assessment. Specifically, it attempts to capture the kind of valuable information that is elusive to quantitative methodology. On a wider scale, it also attempts to complement the extensive body of quantitative research carried out in the field of eating disorders.
Chapter 2
Method

2.1 Why a Qualitative Approach?

In choosing a methodological approach, I asked myself some questions: What do I want to find out? How can I best get at the information and present it? How can I best do the research justice? While acknowledging the essential role of quantitative research, the valuable contributions that qualitative research can add to an existing body of knowledge should not be overlooked. Qualitative research provides rich and detailed information. It can reveal feelings, give perspective, and offer new insights (Charmaz, 2003).

Qualitative research can fill in the gaps left by quantitative research.

As a researcher, I am inherently interested in how people experience their own reality in the world. How is one individual’s experience similar and different to that of another? What factors contribute to their experience? Qualitative research is embedded in context; it acknowledges that phenomena do not occur in isolation, but in the context of the real world and all of the complexity that entails (Henwood & Pidgeon, 1992).

2.2 Impact of Personal Experience

While it is relevant to acknowledge my own experience with food and body image issues, it is my opinion that these experiences are within the realm of ‘normalcy’ for what it means to be a woman in today’s society, and
I do not consider myself in need of treatment. Therefore, I did not consider that my experience diminished my ability to remain objective and unbiased in interpreting participants’ experiences.

2.3 Participants

Participants were six females aged from 21 – 35 years old who were recruited by telephone from a list of individuals taking part in the MEG program at a university clinic in Melbourne, Australia (participant names were changed in this thesis to ensure anonymity). As part of the qualifying process for MEG, participants underwent an extensive initial assessment interview, and were excluded if they had a physical or psychiatric disorder requiring treatment, or if they had a Body Mass Index (BMI) below 17, which could indicate the presence of Anorexia Nervosa (AN). The program ran for ten weeks, with two subsequent follow-up sessions. Weekly session topics were as follows (a summary of program sessions is included in Appendix D):

- Week 1: Getting to know each other; Telling your story; Keeping a food record
- Week 2: Normalising eating; Food is not feelings
- Week 3: Food is not feelings; What is hunger?
- Week 4: Restructuring Thoughts; Body Image
- Week 5: Restructuring Thoughts; Body Image
- Week 6: Self-Esteem & Mood; Stress Management (Problem Solving)
• Week 7: Forbidden Foods; Relaxation
• Week 8: Relaxation; Assertiveness
• Week 9: Finishing the 10 weeks of the MEG program:
  Maintenance/Continuing the Journey
• Week 10: Maintenance/Continuing the Journey
• Week 11: 3 month follow-up
• Week 12: 6 month follow-up

All participants gave full informed consent to participate in two one-hour audiotaped interviews, conducted before commencing the program and after completion. One participant could not be contacted to take part in the second interview. Since this was a qualitative study investigating subjective experience and no statistical analysis was performed, it was considered that this participant’s experience of bingeing was still relevant and inclusion in the preliminary part of the study should not present any problems. It was explained to participants that the purpose of the study was to investigate their experience of binge eating and to evaluate the effectiveness of the MEG program. Since MEG is targeted at individuals who fall in the functional range of eating disorder severity, participants did not necessarily comply with clinical diagnosis, but identified themselves as binge eaters who experienced distress due to their eating behaviour. Though weight was not officially measured, only two out of the six participants were what would be generally
considered ‘overweight’. This is contrary to research that cites a high prevalence of obesity in bingeing populations (Powers & Bannon, 2004).

Before presenting the results of this study it is important to mention that prior to the second interview, two of the participants, Beth and Cate, were diagnosed with medical conditions that may have contributed to their eating problems. Beth was diagnosed with an underactive thyroid condition and Cate with polycystic ovaries. In analysing Beth and Cate’s stories it was apparent that they displayed typical features characteristic of binge eaters, regardless of recent diagnoses, and that their problems had been longstanding. Beth had reported long periods of time during which she was in control of her eating behaviours, suggesting the possibility that her condition did not exist for a great proportion of her life. Cate acknowledged that her diagnosis may have been a contributing factor, but was not the whole picture. With these points in mind, Beth and Cate’s experiences of binge eating and the MEG program were still considered relevant and were included. However, these results should be interpreted with caution, as it is not conclusively known what role the medical conditions may have played in Beth and Cate’s eating behaviours.

All of the participants stated that they had come to MEG because of loss of control over eating behaviours, and were engaging in binge eating. At the time of the first interview, one participant was purely bingeing (Cate). As well as all other participants engaging in bingeing, another was purging (Anne), one used food restriction (Beth), and two were both restricting and...
purging. All but one of the participants had previously sought a variety of treatments for their problems. Some of these treatments had been effective in reducing certain symptoms, but were discontinued for various reasons. Participants often cited that they felt a particular treatment was working (usually counselling, either alone or in conjunction with other forms of treatment), but was too expensive to continue (Nina, Cate, and Anne). Two participants felt they may not have been ready or committed enough to previous treatment for it to be significantly effective (Nina and Lily). Two participants raised therapist characteristics as a hindrance in previous treatment effectiveness (Lily and Anne). Some treatments were not specific enough to the concerns of the participants to be effective or did not cover all of the relevant issues (Rachael, Nina, Cate, Lily, and Anne). For one participant, the effectiveness of the treatment - cessation of purging and subsequent weight gain - was the actual reason for its discontinuation (Anne).

All of the participants had attempted various weight-loss programs both in self-directed and guided format. Demographics of participants are shown in Table 1.
Table 1

*Participant Demographics*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Anne</th>
<th>Beth</th>
<th>Cate</th>
<th>Lily</th>
<th>Nina</th>
<th>Rachael</th>
</tr>
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<tr>
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<td>35</td>
<td>25</td>
<td>22</td>
<td>28</td>
<td>24</td>
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<td>Homemaker/ Part-time arts worker, fine arts industry</td>
<td>Full-time worker, events management industry</td>
<td>Student/ Part-time worker, service industry</td>
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<td>Long-term relationship</td>
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<td><strong>Highest level of education</strong></td>
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<td>Bachelor degree</td>
<td>Yr12</td>
<td>Bachelor degree</td>
<td>Masters degree</td>
<td>Bachelor degree</td>
</tr>
<tr>
<td><strong>Living situation</strong></td>
<td>With parents</td>
<td>With partner and two children</td>
<td>With parents and younger brother</td>
<td>With partner</td>
<td>Sharehouse</td>
<td>With parents and older brother</td>
</tr>
<tr>
<td><strong>Age first aware of problems</strong></td>
<td>13</td>
<td>10</td>
<td>2</td>
<td>-</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
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<td>-</td>
<td>-</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td><strong>Binge first</strong></td>
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<td>Yes</td>
<td>Yes</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Age started dieting/bingeing</strong></td>
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<td>10</td>
<td>9</td>
<td>19</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td><strong>History of behaviours</strong></td>
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<td>Food restriction</td>
<td>Food restriction</td>
<td>Food restriction</td>
<td>Food restriction</td>
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<tr>
<td><strong>Current behaviours</strong></td>
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<td>Purging-vomit</td>
<td>Bingeing</td>
<td>Bingeing</td>
<td>Bingeing</td>
<td>Bingeing</td>
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<td>-</td>
<td>Life coach</td>
<td>Individual counselling</td>
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<td>Life coach</td>
<td>Individual counselling</td>
<td>Individual counselling</td>
<td>Individual counselling</td>
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<tr>
<td>Note: Participant names have been changed to protect anonymity</td>
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</tbody>
</table>
2.4 Procedure

Participants took part in two audiobased interviews, which ranged between approximately 20 minutes to 1 hour 15 minutes in length. The first interviews took place in August 2004, before commencement of the MEG program. The purpose of this initial interview was to gather information on antecedents, history of eating problems, subjective bingeing experience, and to ascertain goals and expectations of the MEG treatment program. The second interviews took place in April 2005, approximately five months after completion of the program. The purpose of the second interview was to evaluate the program, and to ascertain if MEG had been successful for participants, in terms of meeting pre-treatment goals, and in effecting improvements in behaviour and awareness. Data was collected regarding individual components of the program but was beyond the scope of this study, and will not be discussed in this thesis due to limitations of length (interview questions can be found in Appendix B). Interviews were held at the university clinic where the program was conducted. Interview data was then transcribed and any identifying information was removed.

Grounded theory was used to analyse data. Interview transcripts were read and coded with applicable concepts. Constant comparison was made between data to find emergent themes. Ongoing revision of concepts and themes was made as more information was built and relationships between themes were explored to determine any central concepts. Results and Discussion sections of this thesis were combined to avoid repetition.
Chapter 3

Results and Discussion: Before MEG

The material was organised for the Results and Discussion section by dividing the coded interview data into applicable categories that described the overall theme of the participants’ comments. Data was then reanalysed to find the most commonly occurring themes and to determine key concepts. The Results and Discussion section was divided into two parts: Before MEG, and After MEG. Where possible and appropriate, quotes presented in these sections were reduced, however in some instances quote length was kept as it was a more accurate portrayal of the participants.

Several key concepts emerged from the interviews during analysis, each containing themes and some containing sub-themes. Much of the emergent data supported the existing literature, adding a more descriptive and detailed layer to the body of knowledge on eating disorders. A few themes emerged that had either not been discussed in the existing literature, or offered a different perspective.

The following sections will discuss what emerged from the first interview, focussing on the antecedents to binge eating and the subjective experience of binge eating, and how these findings compare with previous research.
3.1 Relationship with Food and ‘The Binge’

All of the participants had what could be termed a ‘love-hate’ relationship with food; in any terms, it was very problematic and distressing. Food, particularly ‘bad’ food, was bestowed with an at times omnipotent power. Participants felt powerless and consumed by overwhelming food obsessions and compulsions to eat, which were never far from their minds, and suffered greatly over the negative impact it had on their lives:

Anne:

I don’t like food that much. I’ve got my good food and my bad foods. Most of them are really...bad foods.

I’ve had an eating disorder since I was 13 years old and...I don’t know, I couldn’t deal with this anymore. I have to, like I need to give up because I don’t want to damage myself anymore.

Nina:

Sometimes there’s a sense of dread. I think with me it’s more those pleasure foods, like a piece of cake. So there’s that, I mean there’s discomfort around food, initially food I perceive as bad or not the healthiest, or indulgent foods, there’s that...I don’t know, foreboding sometimes. Not being able to trust myself I guess.

Rachael:

...I’ve always been obsessed with food.

From the participants’ accounts, a picture emerged of the binge episode starting long before the consumption of any food, and could be conceptualised as having three distinct stages. In stage one, the process was
set in motion by a trigger. Consistent with previous findings, participants mostly described emotional triggers precipitating a binge (Abraham & Llewellyn-Jones, 1997; Fairburn et al., 2003; Telch & Agras, 1995; Masheb & Grilo, 2006). Boredom was often listed as a trigger, perhaps as participants were not occupied by other tasks that may serve as a distraction from thoughts and emotions. Tiredness and alcohol were also cited as triggers, but it was unclear if bingeing was a physiological response to these conditions, or a product of lowered impulse control or emotion regulation:

Rachael:

...I was lonely and I didn't have as many friends.

...If I'm drinking, because I don't take it as seriously, because I think “Oh well it's a party”

Nina:

I guess when I’m alone, I don’t know if that’s because it’s available time, but when other people are around it just takes my mind of it. And so it’s just maybe loneliness or feeling inadequate without other people around. But it’s also times when I’ve just been so tired and all I want to do is sleep...but know that I haven’t had dinner...then I’ll end up, because I’m so tired, just end up eating junk food and then I feel ten times worse.

Cate:

...boredom would be a big one. If I have a disappointment in myself, or a disappointment from somebody else in myself, or, you know, vice versa. Letting somebody down would be a good one. Parents. My parents would be a good one...I went through a depression as well, so that was probably a big trigger...
Beth:

_Boredom...extra tired, I’ll be quite sort of bored, if I’m exhausted at the end of the day, and so I don’t really have the energy to read a book or sit and draw or paint or anything, and feeling a bit bored, so that sort of combines with the boredom and that will trigger it off._

Lily:

_Loneliness, being depressed, boredom, mostly emotional triggers._

Anne:

..._the other thing’s school, If I can’t understand then I get frustrated then I start eating._

The mere presence of food was also stated as a trigger, particularly if the food was considered ‘bad’, and participants described a compulsion to eat if food was present, regardless of actual physical hunger, and an inability to trust themselves around food. Some participants cited external antecedents as triggers, such as social situations and interactions with their parents, but the trigger was most likely a direct effect of the emotional response to such conditions, and not the situation in isolation. Occasionally participants stated environmental cues triggering a binge, and these were discussed in terms of habitual behaviour, such as always bingeing when arriving home after work or school:
Rachael:

...social situations are more difficult for me, and if something's unexpected. During the week when I've got my structure and I'm in control of what I'm taking for my lunch to work, then I'm not as likely to binge.

...if it just sits there I'll look at it and look at it 'til eventually I just pick it up. If it's sort of there and then it's goes away and then I'm like, "Oh great, that was fine”, but if I have to sit there and look at it...if I'm just sitting there and there's me and food then I won't stop...

Anne:

I'm back with my parents and...they don't understand...and so...every time I think of that or I talk to her [mother] about it, it sort of triggers me in going to the kitchen and just eating.

Nina:

...even when I'm not hungry I'll eat, and then I'll feel guilty about doing that and so a binge will start, or it might be just that I ate something that wasn’t the best choice to eat. Bad food and all that, and a binge will start... And then get to the end feeling pretty gross and so will have another two or three slices.

On ‘Sex in the City’ one time where she threw out the chocolate cake, and then she called up her friend going “I’ve just eaten chocolate cake out of a bin”...it was totally gone, out of the way, she was like pouring dishwashing liquid on it or something, so she knew she’s never go back to it. It was funny watching that, but by the same token...you do understand that, your own sense of...yeah, sometimes, that absolute mistrust of yourself, that you've got to get rid of it totally. So you don’t have it around.

Lily:

You know those people that just say “Actually, no I really don’t want any chips, I’m not hungry.” That’s just so not me. Like I don’t care if I’m not hungry, I’ll eat them anyway.

...when I get home I eat heaps of food, like chips and really bad food.
Cate:

...as soon as Mum used to go to work, I used to hit the cupboards...to this day I still do it: “Oh it’s 4:00, mum has to go to work, what’s in the cupboard, what’s she cooking for dinner, I’ll start picking at it now.”

Triggers led to obsessive thoughts about food and a compulsion to eat, which persisted and grew in intensity, resulting in a highly uncomfortable state. Compulsions could also involve the planning and purchase or preparation of food specifically for the purpose of a binge. Previous research has found associations between Obsessive/Compulsive Disorder and eating disorders (Halmi, 2005). Much like what happens with Obsessive/Compulsive Disorder, relief from this state, however brief, could only be obtained by giving in to compulsions:

Lily:

...I just can’t stop thinking about it. And then I just end up having a massive binge

Rachael:

...I've got lots of memories of being at Uni and going to McDonald's on the way home because I couldn't stop thinking about it until I got there.

Stage two of the binge episode was the actual consumption of food. Binge food was usually food that the participants classified as their ‘bad’ or ‘forbidden’ foods, but once a binge had started, other foods were often
consumed after the initial binge food choice. Participants expressed the sense of a complete loss of control and the consumption of vast amounts of food during a binge, as described in DSM criteria (DSM-IV-TR; APA, 2000). While frequently self-aware during this stage of a binge and cognisant of the trigger and the negative consequences they would suffer as a result of proceeding, participants described the sensation of a runaway train: once the process was in motion it became impossible to stop. Sometimes feelings of dread, foreboding, anxiety and shame would be experienced preceding and throughout this stage, but there was a sense of participants’ bodies and actions dissociating from any unpleasant thoughts or feelings, and the binge would continue regardless. It was as if participants were possessed by a ‘binge demon’ that had control of their body. Conversely, participants also described the binge as a sometimes seemingly random experience, not always being aware of the process as it was taking place and suddenly being immersed in a binge. In any case, it appeared that a much baser need requiring instant gratification was at work, overpowering any other desires, reasoning abilities, or awareness of negative ramifications. Binges would typically take place at home alone, as participants were ashamed of their behaviour, and needed to feel free from judgement in order to proceed. One participant (Rachael) commented that she had experienced bingeing in public, however it became clear from the second interview that what she termed as a ‘binge’ may not have objectively been classified as such:
Lily:

... you know you’re going to feel bad about it, but you can’t stop yourself even though you know you’re going to hate yourself tomorrow.

...it’s sort of just, “I want to eat this”, and you can’t think: “No, don’t eat it”, then before you know it you’ve eaten a whole packet of biscuits, chips, you know, six pieces of fruit, two sandwiches, everything that you can find...And like if I have something in front of me I just can’t say no...sometimes you don’t really have any separation from it so you can’t really remember what you were thinking, it just sort of happens all of a sudden.

Rachael:

...once I start eating something like...I just can't stop eating...

...I was at my book club and we had food and things, and I had one chocolate biscuit, and then I probably had ten chocolate biscuits, and by the end I was picking up two at a time and I was starting to think, “Shit, I hope people aren’t looking at me.” ...

Beth:

...I’ll seek out something sweet. If I don’t have it, which I normally don’t, because I don’t usually have it at home...if I don’t have it I’ll try and get it. And when I do, there’s this uncontrollable need to finish the whole thing...I’m so completely aware of it but I just can’t seem to be able to stop...if I go through a tunnel, once it’s started you’ve got to go until the end, you know what’s going to happen and you’re going to feel terrible...

Nina:

...I know I’m just going to keep going. And then there’ll be this whole thought process of: “Get over it. You can do it. One piece of cake, that’s fine, that’s normal, leave it at that”, and then I’ll start off with that, and then next thing you know, halfway through that I’ll probably feel like not finishing it but will continue. And then get to the end feeling pretty gross and so will have another two or three slices...
Stage three of the binge episode occurred once the bingeing had stopped, in which individuals experienced the resultant negative ramifications. It was undetermined what factors were responsible for cueing the end of a binge. One possible explanation is that the feelings of shame and self-loathing participants typically experienced after a binge, consistent with BED diagnostic criteria, may suddenly have become perceptible or too strong to ignore (DSM-IV-TR; APA, 2000). These feelings commonly led to depression and anxiety about weight gain. In order to decrease anxiety, participants sometimes engaged in purging or other compensatory methods, most commonly self-induced vomiting. Compensatory behaviours represented a misdirected attempt to regain control, and may have served two functions: to counteract any anxiety concerning weight gain, and to negate feelings of shame and self-loathing by virtually negating the entire event. The act of engaging in compensatory behaviours could itself cause feelings of shame and self-loathing. The negative feelings arising from a binge also contributed to the bingeing cycle. Participants had a low self-opinion due to their bingeing, and this resulted in further misdirected attempts to make themselves feel better with food.
Lily:

*I just generally feel like crap...one day I sat in front of the television and polished off a whole bag of chips, which isn’t unusual, and I just felt really disgusting. Yeah, I was really disgusted with myself. Like that real self-loathing.*

Beth:

...if you’re strong enough you feel good. And if you don’t you feel bad and then you basically don’t feel good about yourself, not being able to have had that control...It feels terrible.

Cate:

*So the fact I was eating all the time was like, “Oh, you’re pathetic. You’re hopeless. Stop eating...”...but I’d keep eating because it made me feel better.*

3.2 Secrecy and Shame

As previously mentioned, participants reported that their bingeing took place in secret. As is often the case with eating disorders, most people in the participants’ lives did not know they had a problem, reflecting previous findings (EDFV, 2000). Participants were embarrassed and ashamed of their behaviours, and feared negative evaluation from others. There was a sense of being seen as weak or pathetic for their inability to control themselves with food, and this was linked to participants’ own feelings of self-disgust and ‘ugliness’ with their eating behaviour, and with perceptions of socially acceptable behaviour. When asked why she had not told anybody about her
disorder, one participant answered: “The shame of them knowing you have a weakness” (Cate).

Cate:

And, you know, no one knows it. Everyone would be absolutely shocked if they were to find out. But I’ve mastered the art of hiding it so well. And eating behind people and sneaking food here and there when I need the release or the benefit of something. It’s actually quite scary to know that you can do something like that. Like a drug addict or an alcoholic.

Lily:

...I never thought I’d have to be dealing with these problems. You know, there’s so much stigma associated around it. It’s so hard to think that you are actually dealing with that problem.

The distress and shame experienced by these individuals as a result of feeling out of control of their eating behaviours is likely to be exacerbated by a lack of completely understanding their behaviour. This is particularly pertinent in instances where the individual is cognisant of feelings of dread and aware of the negative consequences but binges anyway. This may contribute to individuals keeping their behaviour a secret. If these individuals could not understand their own behaviour how is it possible that others could? One participant described her frustrating and painful experience of being misunderstood, and another described her affirming experience of being amongst others with the same problem:
Anne:

...for my mum it’s just trying to lose weight and be skinny...I think she thinks it’s something easy that I can just do it by myself. Like everyone else says “It’s all in your head, just eat a steak and you’ll be fine.” But they don’t know.

Rachael:

... it was all just people who have the same thing and I just heard people saying my story, you know, just identifying so much...was just a relief to hear that other people felt like that as well.

3.3 Dieting

Four out of six of the participants recall that their problems with eating began after going on a diet, supporting previous findings that dieting is a common antecedent to binge eating behaviour (Jacobi et al, 2004). Participants frequently reported diets starting as an attempt to be healthy or lose some weight, and initially being in control, but then quickly spiralling out of control as the diet seemed to take on a force of its own:

Rachael:

I think when I was about 10, 12, I started dieting...girls were starting to look different and I wanted to be...I'd go to the gym and...was eating either nothing or...but I got obsessed with food quite quickly, like the diet became me thinking about it all the time. And it sort of went to bingeing quite quickly as well...I think I was pretty much on a diet from when I was twelve to when I was about sixteen.
Anne:

...it started off like a healthy thing, I just wanted to be healthy and um...like exercise and all that crap and...after a while, I stopped the exercise and I just ate healthy. And the healthy eating went down to eating just a few things a day. So I was, I guess, anorexic. And I couldn’t hang onto that for very long so I went straight to bulimia, and I’ve been that way since I was 13.

Nina:

...well it was sort of intentional, like I was going to the gym a lot more, but actually healthy, very healthy lifestyle to get me through the end of Uni, and that turned into a bit of a food obsession, which then turned into a huge sort of issue about weight. I’d never really been on any hard core diets up until then...

Lily:

I have had a lot of trouble controlling them [eating habits], for over two years, ever since I started dieting and lost ten kilos and then I got bulimia...but only towards the very end of the diet, like when I’d lost ten kilos, that’s when it started.

Both Rachael and Anne were quite young when their eating problems began, but Nina and Lily were much older (26 and 19 respectively). Lily remembered having food issues from a young age but her problems only began in earnest after a major diet. Beth and Cate also recalled having eating problems from a very young age and attempting various diets, but did not recount a specific diet incident as being a precipitant, and recalled bingeing first, reflecting research suggesting dieting is not always a precipitant in individuals who binge (Johnson & Wardle, 2005). Cate recalled bingeing from as young as two or three while she was alone in front of the television,
and Beth remembered being ten when she realised, during an exercise at school where she keep buying and eating chocolate bars that she was supposed to sell to others, that she had a problem.

Food restriction or dieting also emerged as a common theme in contributing to the diet/binge cycle. Participants would restrict their food intake but would then start obsessing about food and binge, particularly if restriction was severe. The bingeing would lead to shame and anxiety about weight gain, which would lead to more food restriction or compensatory behaviours like purging, and so began the destructive diet/binge merry-go-round:

Rachael:

*Usually it's really restricted kind of, I eat three meals a day, I eat three main meals, and I try to make them as healthy and low fat as I can, and as small as I can, and I take laxatives, but if they're too small [the meals] then I binge, and then I take laxatives or throw up.*

Lily:

*Yes, I do [obsess about food when on a diet]. And that’s what always leads to my demise because I just can’t stop thinking about it. And then I just end up having a massive binge. It’s just a repetitive cycle...I used to go on a diet for two weeks, and then go off it for a week, and then go back on it for three weeks and then...but I just couldn’t ever go back onto the diet. And then that was when I’d start freaking out because I just couldn’t stop eating. But I was getting fatter and fatter and fatter.*

Conversely, participants described periods in their lives in which they were more in control of their eating behaviours as having less severe food restriction:
Rachael:

...I think I wasn't really restricting as much...I just kind of ate what I wanted. And in that time I was probably on lots of diets...but I probably had the most food sanity in that time, like I wasn't thinking about it all the time...

There was also a sense of ‘chasing the dragon’, a term often used to describe the behaviour of drug addicts who often keep returning to a drug in search of the elusive first high. Participants had initially experienced weight loss after dieting, and were forever chasing that again, because of their feelings and beliefs associated with the weight loss – namely, self-esteem (discussed at greater length in a later section):

Lily:

...I lost like 10 kilos. And I just felt so great about myself...I had all this confidence to start going out and doing all the things I wanted to do. And I felt invincible...

3.4 Familial Influence

Supporting findings from previous studies, all participants reported a history of family dysfunction, ranging from a mildly dysfunctional relationship with one parent to complete parental neglect or abuse (Jacobi, Morris & de Zwaan, 2004). Lack of emotional expression and emotional
support were common themes, as was criticism, lack of affection, controlling parents, and underinvolvement.

Anne reported having a very violent mother who was prone to frequent extreme outbursts of anger and physical and verbal abuse:

*I was told that she was abusive. By my therapist...but at the time I wasn’t thinking that because I thought I deserved all the...remotes being chucked at me and the shoes and the saxophone case. And the hits...let’s say I would talk back, she would start banging on my door and like...like I would have to be leaning against the door because my mum...she was like banging on the door making so much noise and actually pushing it while I was like leaning against it, and in the end I would have to open it because...she was going to come get me sooner or later, then she would like drag me on the floor...but drag me on the floor by my hair and want to cut my hair. Or um, just chuck things at me...something stupid and tiny, and she would just chuck a spaz...[once] I finally had enough of my mum treating me like shit...and so I grabbed a knife, to make her stop from hitting me, and then she was like, “You’re trying to kill me, you’re trying to kill me,” then I put the knife down, and then she started whacking me, and I was like, “I’m not trying to kill you,” and then I put the knife back up because...I’d just had enough of her crap. But I wasn’t going to kill her or anything, I just wanted her to stop.*

Anne described her biological father as ‘no-one in her life’ and she had nothing to do with him. Her parents had divorced when she was 18 months old because her father had been a ‘pain in the arse’ and ‘overly jealous’ and she had only seen him about twice since then:

*The first time I saw him...he was with his new wife, and I was like, “Hey Papa,” and he was like, “I’m not your dad...go back to your real dad”...And then the second time I saw him was like a few years later...I saw him at the hospital, he had no idea who I was...*
Her stepfather, who she referred to as her father, was also physically abusive at times when Anne was younger, but seemed mild in relation to her mother:

...when he would get really mad at me, he would hang me upside down by the feet and start whacking me on the bum, or he would just whack me across his knee...And there was one time when he slapped me...

Beth recounted a complete family breakdown the year that she began to have issues with food. Beth’s mother was neglectful and more concerned with her own life than that of her children, exposing them to her lovers and her drinking problem. Beth experienced an absolute lack of family cohesion and a complete absence of support from her entire family. The one person she felt close to, her sister, moved out:

Well, a lot of things happened in my family at that age...my parents were divorced, my sister who was sixteen, she moved out of home, my mother had an affair, so, the family just broke down, and we moved from the house that we lived and the school I went to, I went to another school, [mum was] living with another man, my sister had moved out, didn’t see my father, didn’t see my grandparents, everything that was stable just disappeared. Even though my parents hadn’t been happy before that, then it really was shattering...and I had nobody.

Cate also reported parental neglect directly contributing to the development of her eating problems:

Mum used to work by day, and dad was home. But during the daytime, dad was the kind of person who’d get out in the garden, he’d do everything in the garden, where I was in the house to watch my television. I would sit at
home and watch TV...I had nobody there, I was by myself, my sister used to be at school, so I’d always find comfort in food....

Participants cited a distinct lack of emotional support and expression. This was experienced in the form of an overbearing, critical, emotionally inexpressive and unaffectionate parent. Whilst participants often described their parents or families as not expressing emotions, this did not adequately convey the complexity of emotional expression within these families. Parents typically expressed negative emotions such as anger, often inappropriately and to excess, but did not extend emotional kindness, empathy, or affection; they were ‘emotionally cold’. There was a suppression of participants’ own emotional expression, and yet, as in the case of Beth, Cate, and Lily, often a role reversal occurred, with a reliance and expectation placed on participants to be emotionally supportive:

Nina:

...very emotionally closed family...I always feel like I don’t know too much about what’s going on in my mum’s head or my dad’s head...my mum seems to bottle up her emotions, and dad’s such an easy going person that he won’t let himself get angry...I never saw emotions actually get vented. So the family, you know we sit around and we chat, it’s happy and...well it’s not even sort of happy, it’s just sort of very...nondescript. Easy interactions without much emotions behind it I guess. Quite conscious of not playing the drama queen...

...Mum’s the...the intense one in the family...what she says goes I guess...I think mum was always the authoritarian one yelling and screaming and doing all of that...mum’s pretty passionate and adamant about things...mum I probably don’t talk to about anything really personal at all...she’ll either try to make it right and tell me how to run my life, and I
don’t want to even go there. Or else she’ll just not understand, she’s strange, when she doesn’t understand something...I don’t know, she doesn’t seem to sort of...get into emotions too much, she’ll just say one or two lines, and then go, “Okay, it’ll be okay,” and then walk away, and you’re left feeling even ten times worse. You sort of explain something that’s really important to you and get no more feedback than that.

Lily:

I’ve got a mum who’s a martyr...mum’s always being so bloody negative about everything in her life...she’s like, “Well I’ve obviously done a shit job raising you kids,” and made references to me and my sister...she was saying something like how her life’s so pathetic...each time I see her now it feels like, that’s what she does...

...I try, like I actually say, “I love you” to mum on the phone, but she’s really bad at saying it, she never says it...I tried it with mum and then she didn’t say I love you back and then I was like, “Mum, I love you,” and she was like “Lily, you know I love you, oh alright, I love you, okay, goodbye.” But as well, lots of times when I’ve rung really fretting about Uni...sometimes you just want a bit of sympathy.

Cate:

And it was my role to be the one that held the family together, kept the family happy, played the jokes and ran around and made sure everything was fine, but if they ever realised that there was something wrong with me, well what happened to this girl that was the strength of the family? She’s the one that does everything for us, she’s the support. And even like my parents don’t even know...Because mum and dad are whole, this whole, “What did we do wrong?” you know, the parents that put the blame on themselves.

Beth:

...she’s not much of a mother, she’s more of a friend...more of a child actually...She was more or less fun most of the time. And then she...then when they got divorced she had a lover, so she wasn’t around very much, and was drinking a lot. And...she needed us to be strong...so I always had to be in the role of being strong and happy never being able to feel my own emotions.
Parents were often controlling and strict. In particular, fathers were commonly described as very strict and controlling, emotionally cold, and underinvolved or absent. Interestingly, though it could still be termed ‘neglect’, father underinvolvement did not seem to be as detrimental as mother underinvolvement:

Cate:

We’re not close, I wouldn’t tell my parents everything…they were very strict parents as a child…as a teenager, I’d lie to them. You know, that’s how I got around getting out ‘til four in the morning…everybody else had freedom, but I didn’t…they’ve over-sheltered us probably…they’re very controlling…

…We barely saw our father, because he works night shifts, so it was more our mother who took care of us…

Lily:

I remember being a psycho teenager because they would not let me have any freedom whatsoever, wouldn’t let me go to any parties…just trying to impose so many rules…I sort of remember always trying to please them…

…[Father is] a workaholic…pretty emotionally cold in general. Dad isn’t good at showing his emotions and is really anally retentive…

Rachael:

…I never really spent much time with dad…I’ve got two older brothers so they would kind of hang out with dad and I would hang out with mum. Dad didn’t have that much to do with anything like that. And like he was watching the TV and if the yelling got too loud then he would come and take over, but only if it was bothering him otherwise he'd kind of stay out of it.
Beth:

And my father, he was the disciplinarian...I was happy when they got divorced so that I could be away from him. He was very harsh...he’s remarried, and his wife, her family are...important in their lives...it’s very business-like, he’s very business-like.

Participants also reported being teased and criticised by parents and other family members, about eating behaviours and body image, but also criticised about others things in general:

Anne:

...my cousin...he would draw pictures of me with like fat cheeks, double chin, a protruding stomach and bottom...I got really hurt by those pictures. And so that kind of...to make me change the way I thought about myself (sic).
...[Another time] my auntie and uncle were in tenant creek and so we went over and visited them, and my uncle would say, “I don’t know who’s got the bigger arse, you or your mum.”...everyone always commented about my weight and said that I was fat and chubby. I guess it was a build up of everyone calling me fat sausage and all that before that time, but...my cousin drawing those images...it just did something to me. That’s what made me want to change.

... sometimes when I tell her [mother] that I’m doing this MEG program, she’s like, “Why the hell are you doing that stupid crap, you’re so stupid.”...

Cate:

So it’s the main joke in the family: “Remember that time you ate the kilo of bananas?”...
Lily:

He’ll [Father] get up and clean the pool filters and wash the dogs, making several comments about why I should be washing them because they’re my dogs...when I want to do it isn’t going to be good enough, he has to do it right at that minute and make me feel really guilty about it...My dad’s speech at my 21st was something like...“Lily’s always been a difficult and independent child, and I don’t think she needs us, except for money”...well they never try to make me feel welcome like how I feel (sic), and I guess they feel like I’ve never really wanted them...Except to use them, I feel like they think I’ve used them or something, when I’ve really tried the opposite...

3.5 Sociocultural Influence

Participants also reported sociocultural influences as precipitating and maintaining factors in their eating behaviours, as indicated in previous studies (Barlow & Durand, 2005). Ideas about body shape and weight and attractiveness were often influenced by peers, either by example or by negative reinforcement such as teasing or comments about others’ appearance. Participants even recalled being influenced as to what to eat and how to purge by their peers:

Anne:

...I guess it was a build up of everyone calling me fat sausage and all that before that time...my best friend...that’s what she would call me...

... my best friend would tell...that whenever her or her mum would overeat they would vomit...the food up. And...I guess I thought I could do that too.
Rachael:

*There was a girl at school that had gone away for summer and had lost lots of weight, came back with a boyfriend and lots of friends, everyone liked her, and I wanted to be like that...I think maybe we talked about it [dieting], girls talked about it at school. I remember watching the girl...I remember watching what she ate and trying to see what she ate.*

Cate:

...*I became very self-conscious about myself...they were the kind of people that forever anybody (sic), they would just say, “Oh jeez, she’s so ugly.”...my self-esteem dropped to an all time low.*

Participants also got their ideas from the idealisation of thinness in society: from messages in the media and from the way they were treated differently when they were ‘thin’ as opposed to when they were ‘fat’. The perplexing phenomenon of the arbitrary fine line between being perceived as attractive (i.e., ‘thin’) or unattractive (i.e., ‘too skinny’ or ‘fat’) was also raised in interviews. One participant had no idea which ideal she was supposed to emulate out of the avalanche of mixed messages proclaiming how the ideal woman should be:

Nina:

...*all these ideas flying around you hear in media or about, you know, the latest things that are healthy for you, not healthy for you, the proper way to eat, you know, eat five meals a day, no wait, then only eat when you’re hungry, exercise as well, okay, exercise three time a weeks for half an hour, or five times a week, every day, rah rah rah...it’s so conflicting, all these different bits of information about self esteem, okay, be assertive but don’t be a bitch, or, you know, love yourself but, oh my god I feel like crap*
today and I don’t like myself and I must be retarded, so…all those different things that are flying around...

…I used to have that weird thing of having people look at you…like excited for you because you’re losing weight, but also quite disgusted…towards the end…like, when I started getting too skinny, it was just, yeah, it was just really weird.

Rachael:

Maybe in magazines. I think you just knew [how to lose weight], I mean I knew that McDonald’s made you fat and salad didn’t, I think I just knew.

Lily:

...after my 19th birthday I actually went on a diet and I actually achieved it. And I lost like 10 kilos...And everyone was nice to you and things. You could go into any of the shops and buy any of the clothing that you wanted because ‘one size fits all’ actually fits you. And everyone is nicer to skinnier people. You know, you’d go out clubbing and stuff and heaps of guys would be interested in you. And you’d never have to wait to be served at the bar. Just so many little things.

3.6 Adverse Events

Replicating results from previous studies, four of the six participants had experienced what could clearly be described as adverse life events, in some instances more than one, precipitating their eating problems (Jacobi et al., 2004). Though only in Anne’s and Beth’s cases did an adverse event precipitate the onset of any eating problems, in the case of Cate and Lily adverse events precipitated an exacerbation of symptoms, or a full-blown eating disorder. It became apparent in the interview process that a significant part of what made a life event an adverse one was the meaning an individual
attributed to it. Some events were obviously adverse events, like the abuse suffered by Anne, and the family breakdown and neglect suffered by Beth. Others were more subjectively distressing, but were still adverse events for those concerned. Beth found her move back to Australia after fifteen years away, in combination with the birth of her second child, a hugely depressing and stressful experience that had a multitude of negative ramifications, including a resurgence in eating problems. For Anne, an abortion led to a serious depression:

Anne:

...something happened during that time, which...really got to me...I got pregnant...so I had to have an abortion... I was kind of depressed over that period and I just couldn’t be stuffed with anything. So yeah, I guess it [eating behaviour] was worse, I was just binge eating and purging pretty much every single day.

Beth:

I think it’s definitely a bit of a mixture there with post-natal depression, and coming to Australia being a...migrant, almost. That, and dealing with my sons’ adaptation to Australia, that’s been really difficult, so it has been very stressful...I think the last fifteen years [overseas] I’ve been more in control, the eating habits been more normal. It’s like a regression...My husband and I both had expectations, and they weren’t met when we arrived. So it was a pretty depressing period...I was hoping to have more of a family...but I come back and it’s not really...there’s no family, everybody’s just sort of, they’re all trying to deal separately.

Cate:

...there’s also been a lot of history of, my sister had Hodgkin’s disease in ‘96. My brother had cancer...
Lily:

*I’d broken up with this guy that I’d really liked, probably about 9 months previous [to the diet]... I was like totally devastated for about 6 months...he ended up breaking up with me because he liked someone else. Then he married her.*

3.7 Personality/Psychological Factors

Personality/Psychological factors that contributed to the development of binge eating problems were by far the most prolific themes to emerge from analysis. It became obvious during analysis that all of the personality/psychological factors were interrelated, that each factor influenced or perpetuated other factors, and it very difficult to separate the factors and to see where one factor ended and another began. For this reason findings have been presented in one continuous section, rather than dividing into separate sections for each factor.

Self-esteem was a key theme in all interviews. Endorsing previous findings, participants displayed low self-esteem, a lack of sense of control and confidence in their abilities, and a tendency to over-emphasise external measures as a basis for self-worth (Barlow & Durand, 2005; EDFV, 2000). Self-esteem was inextricably linked to body image: participants had low self esteem as a consequence of their perceived negative body image, they felt anxious and unhappy about gaining weight, and they felt confident and attractive when they lost weight. From all participants came the sense that weight-loss would lead to an end of all problems, a kind of ‘happily ever
after’ effect; most participants were aware that this belief was maladaptive, but noted that it was a powerful and persistent belief, and something that they still struggled with. All participants stated they wanted to have lost weight as a result of completing MEG:

Anne:

...I’m too embarrassed to exercise, like on the street or anything like that, if I did that I would have to wake up at 5 in the morning when it was still dark…I just don’t want people seeing me.

...I became actually pretty happy [on anti-depressants]...but after a while I noticed that I wasn’t vomiting, like...after eating I wouldn’t be as depressed as I usually would be, and so I started gaining weight. And um, soon as I noticed that, after a few kilos I quit with the Prozac...I was much more happier. I had, like, more energy for doing things and I was more interested in doing things, but...yeah, I was a bit fatter then...I just didn’t want to be fat. I just didn’t think it was attractive. And I just didn’t like it.

...everyone was telling me, “Oh, you’ve lost a lot of weight.”... and I don’t know, it felt nice being told that I’d lost weight...

Cate:

...this boy was an absolute gorgeous hunk. Liked me! You know...This guy grabbed my hand, he didn’t care to tell the world...I wasn’t used to it, I felt uncomfortable. Because I felt bad for him...I’d rather have nobody than be in a relationship where I feel paranoid, I feel like I’m embarrassing the other person...I don’t think I’m worthy of being in a decent relationship because I’ve got nothing to offer...

...deep down inside I’m just shattered with the fact that I’m the size that I am...I’m not even going to bother getting into a relationship until I feel comfortable with myself...I don’t see myself as somebody who will be able to stand naked in front of somebody...I’m embarrassed of being, you know, of being physically (sic), you know, no-one will accept me like this, you know, when they can have someone else who’s much prettier and skinnier.

...I have this idea that if I was to wake up tomorrow morning let’s say, and have lost 40 kilos, I’d never have to eat again. I wouldn’t have to binge,
why would I binge for, I’ve lost 40 [kilos], what have I got to stress about...what would I have to binge about if I’m feeling so good about myself, I could find myself a man, I could go out and buy whatever clothes I want.

Nina:

...started putting on weight and I think that’s when it all started freaking out, I started freaking out about it all. And so over the last year I’ve been sort over overly concerned about food and my weight and those sort of things.

Rachael:

I’d lost lots of weight actually, and I was feeling quite attractive...

Lily:

...I’m just struggling to think correctly about it in my head I think. You know when you’re such in a mindset of, “Go on a diet and it will fix all your problems”.

Of note, most of the comments relating to body image and self esteem appeared to be not just a function of an overemphasis on body image, but more of a function of an overemphasis on the approval of others: it seemed that participants were actually concerned about a negative body image because they thought it would lead to a negative evaluation by others. Overemphasis on the approval of others has previously been shown to be characteristic of individuals with an eating disorder (EDFV, 2000). Participants were evidently overly concerned with how others saw them, but it may be more accurate to say that they had an exaggerated perception of
being judged, which contributed to an overemphasis on the approval of others:

Rachael:

...I was starting to think, “Shit, I hope people aren't looking at me”, because I know they know I don't usually do that, so even for me to pick up one [biscuit] I felt self-conscious about it. So I know they probably were thinking, “What the hell's she doing?.”

Lily:

...you've just got so much more confidence, like you can get into your togs and not care. Not have that like the whole big important thing of your day, like people are going to be seeing me in my togs and it's going to be terrifying.

Cate:

...here people judge you, people know you, or that's what you think...I need to know that people think I'm normal...people like me, people think, “Oh, she's alright”...I don't like the idea of people...making judgement or...someone thinking of me in a form of a weak person, I can't handle that, I have a lot of trouble handling that...

This exaggerated perception of being judged may also help explain the social anxiety felt by participants in the current study, as found in previous research (Barlow & Durand, 2005; EDFV, 2000). Four of the six participants explicitly expressed feelings of self-consciousness and anxiety in social situations:
Rachael:

*I used to get them a few years ago [panic attacks]...I used to get really really anxious about going into a party or even walking into a building where I didn't know anyone. New clients.*

Cate:

*...I can be bubbly and friendly and that, but you have to approach me...I would not have the guts to come up to you and say, “Hi, how’re you doing” because of fear of rejection...*

Participants often reported feeling judged and negatively evaluated, and fearing negative evaluation and rejection, and held themselves accountable for any perceived negative evaluations. Participants’ perceptions of being judged or negatively evaluated often seemed arbitrary and unsubstantiated, based on interpretations of minute and seemingly innocuous circumstances, or retrospectively interpreted as negative in the light of a particular outcome. As observed in previous research, two of the participants also stated that at times they felt like ‘impostors’, that they weren’t truly being themselves in a situation, and there was a sense of being found out as a fraud (Barlow & Durand, 2005):

Cate:

*My bedroom is a bloody disaster at the moment. If you see it, there’s clothes on the floor and everything. But my work desk is perfect. You know, people would not even think that I had a messy handbag, my handbag’s a mess...my life comes across to everybody as absolute perfect, you know, but in actual fact it’s not.*
Rachael:

...he never came to Melbourne. Like, he said a couple of times that he was going to come, but I preferred to go there. And I didn't really want, like he would have come here. But I didn't really (sic), like, “No, I'll just come to Sydney.” I wasn't sure how he was going to fit in with my life...it did make me a bit anxious thinking about him coming here...

...I felt like almost this isn't meant to happen to me, I'm not one of those girls, those glamorous kind of girls that this kind of thing happens to, I felt like an impostor.

...I blamed myself after it ended as well, because sometimes I was feeling like...I went out with his friends one night for dinner and I got completely pissed, I just wanted to do the right thing and I just wanted to be part of the group, and I was just, I mean I would have been embarrassed...I got drunk, like I didn't do anything ridiculous but I was tipsy quite early. I just sort of felt uncomfortable because they were sort of all talking amongst each other and then one of them would ask me a question and they'd all look...and then I'd just panic and say something dumb and not know what to do...time...I went out and had a cigarette in the middle of dinner and we were at this really classy sort of restaurant, and I knew that was the wrong thing to do...

Nina:

...he was really quiet, which for me...can make me very nervous ...then I start thinking, “Oh, what’s wrong with me why aren’t they talking?”...

The impression from participants was a sense of always being ‘on’ around other people. Participants were constantly monitoring, evaluating, and censoring their own behaviours in order to make a positive impression, to be accepted and to avoid negative evaluation or rejection. The prospect of being judged and negatively evaluated could be daunting. Social situations were hard work and could therefore, understandably, cause anxiety and lead to avoidance.
Social anxiety may be both a cause or consequence of problematic interpersonal relations, characteristic of individuals with binge eating disorders as shown in previous studies (Birchall, 1999). One participant, Anne, preferred to socialise in online chat rooms, finding it much easier than trying to make friends in ‘real life’, and had met her recent ex-boyfriend online. Apart from intermittent visits to each other’s countries and a period of living together for two years, much of this five-year relationship was conducted through an online chat room. Other participants also displayed examples of problematic or impaired interpersonal relations:

Anne:

...I’m usually in my room on the computer chatting away...only with people that I know...just friends...okay, yeah, I met them through chat rooms actually...it’s so easy to make friends in chat, and in...like real life it’s so difficult, I just can’t do it. It’s so hard for me...

Nina:

...I was probably pretty detached from my course in terms of socialising...I remember being quite conscious of trying to keep my distance from that, thinking I don’t want to get too close to everyone, you know what I mean, than sort of feel quite stifled by socialising with these people, studying with these people...I’m sort of starting to realise that now that I have this weird thing of wanting to always be able to keep an escape route there but still wanting to be a part of it too.

Cate:

...I won’t even let them make me feel comfortable...I’ve had a few episodes where I’ve felt like its, you know, hurry up and get dressed kind of thing...I don’t want to be made to feel like just an object... I pretty much back away...I create a problem to make myself end the relationship before it can get to the point where they get rid of me.
Participants also displayed perfectionistic tendencies, reflecting previous studies (Fairburn, Cooper & Shafran, 2003; Shafran, Cooper & Fairburn, 2002). All participants had high expectations of themselves; they had set rigid standards for themselves, and because they had failed to meet these standards they were very self-critical:

Nina:

...I’d been more competitive and hard on myself at times to get decent grades, and doing stupid things like spending way too much time stressing about reports and things that most other people would have gone, “Yeah, that’s good enough.”...all of a sudden, you know, my marks were everything to me, and I was just trying to get D’s [Distinctions] and HD’s [High Distinctions] ...

Cate:

...even if I need twenty dollars from my mum I can’t ask her. You know, I’m an independent person, I should be able to provide for myself...I’m always critical...that’s not only just my weight and my image, but life in general, my work...I expect more of myself. And I know I can do more...I’m not happy with where I believe I should be, so I just eat it away...the fact I was eating all the time was like “Oh, you’re pathetic. You’re hopeless. Stop eating. Get a job....”

There was also evidence of participants having met certain expectations and, rather than this having a positive impact on self-esteem, standards would either be immediately re-evaluated as not good enough, or participants would immediately shift focus to another area in which they were not meeting expectations, such as their weight. This perfectionistic attitude was also evident in participants’ fear of failure, including concerns about not
succeeding in the MEG program. This fear of failure seemed to be directly linked to the notion of letting oneself down, and the belief of being unable to emotionally cope with the detrimental impact failure would have on self-esteem. Having low expectations appeared to be an insurance attempt to guard against disappointing oneself, but participants were still hard on themselves if they ‘failed’, regardless of this harm minimisation strategy:

Rachael:

...I've got a lot of things on at work...and I always worry that I've done something wrong, that's it not going to work out, and that it'll be my fault. I'm a bit sort of hesitant to put too much hope into it.

Cate:

The only fear I have is letting myself down, and not having the result that I want at the end.

Lily:

...I think I’ll wait and see, because I’m a bit worried that I won’t do it...for some reason I’m just really like what if it doesn’t work for me...

Some participants also displayed evidence of having high expectations of others. One participant had very high expectations of MEG:

Rachael:

...I compare a lot, like I compare my boyfriends to other people's boyfriends...And I don't know if anyone will be able to tick all of the boxes that I've got.
Cate (about MEG):

*It’s like my own true makeover episode!* 

Impulsivity, found in previous research (Steiger & Bruce, 2004), was also a common feature in the current study. As evidenced throughout this study, all participants frequently gave examples of impaired impulse control, typically in relation to food. One participant recounted a history of drug use, another form of impulsivity:

Rachael:

*I can't do it, you know, I can't just have a little bit, it's so frustrating, you know I see people have half a piece of chocolate cake and then leave it sitting there and I just stare at it and think, “How the hell do you do that?” I would love to be able to do that.*

Lily:

*I used to take a lot of ecstasy, that was my drug of choice, but other things as well. Whatever was around.*

An added trait that emerged from the interviews was the ‘all or nothing’ phenomenon. Participants appeared to have difficulty with maintaining a healthy balance in many areas of their lives. This could be seen in examples of dieting and exercise, in study, and in eating:
Anne:

…the healthy eating went down to eating just a few things a day…I was still eating but just very very little, like two fruits a day.

…walking, that’s not exercise for me, I need to sweat.

Nina:

…all of a sudden, you know, my marks were everything to me…Couldn’t keep the balance.

…for some reason you sort of think you can rid of all your cravings in one go: “If I do it now, I’ll never get any cravings ever again and it’ll never happen again”.

Lily:

I remember at one stage I was really obsessed with measuring all my food...

Rachael:

…I kind of get that thought, “Oh well, now I've had a little bit I'm going to hate myself anyway, so I might as well enjoy it.”

As mentioned earlier, participants commonly reported experiencing anxiety and depression, and frequently cited emotional distress as a precipitant to a binge. Participants often described using food to self-soothe, but were not always aware of this function. Some participants appeared to display alexithymia, as reported in previous studies, expressing confusion and difficulty in recognising and verbalising emotions, or not being able to connect a binge with any emotional stimulus (Wheeler et al., 2005). Cate reported conflicting emotions, stating she was emotionally numb but could be
inappropriately overwhelmed by her emotions at other times. Beth and Anne, whilst having reported experiencing increased symptoms during times of emotional distress, did not really make the association. Beth linked her bingeing to boredom and tiredness, and Anne linked her bingeing to interactions with her mother and school. Rachael could only link her eating problems to food restriction, lack of structure, social situations, and alcohol:

Cate:

*I have numb (sic), I don’t feel emotion…I think I’m numb to everything, and I’ve numbed myself through food and everything to the point where I just don’t feel it. I’ve just got no emotion…well, no, that’s a lie, I don’t feel real emotion. When it comes to watching Ian Thorpe win his 4th gold medal, and watching him sing on the podium the Australian anthem, I can be in tears.*

Anne:

*...she’s my problem, my mum... the other thing’s school, if I can’t understand then I get frustrated then I start eating. But that’s not really like a trigger that’s just me getting frustrated, and not being able to control myself.*

Beth:

*I don’t know what’s happened, I’ve just...totally lost...that control. I don’t know, maybe it is the change, being here. I’m not really sure why it was easier there [overseas]. Maybe just happier, I’m not sure.*

An overriding theme to emerge from pre-MEG analysis was the concept of ‘control’. Control was featured in every aspect of discussion. Participants commonly reported parents as controlling. ‘Loss of control’ and ‘overcontrol’
were not polar opposites of one continuum, but coexisted simultaneously. Alternatively, ‘overcontrol’ could also be seen as a form of ‘loss of control’. Participants demonstrated impulse control and perfectionism, two seemingly contradictory traits, and had difficulty maintaining a healthy balance. Periods of normalcy were measured in terms of control over thoughts, behaviours, and body shape. Participants’ self-esteem was measured in terms of self-control over various areas of one’s life, but also by handing over control to the evaluations of others. Participants felt a lack of control over evaluation from others and in social situations. Participants often experienced being overwhelmed by emotions, and used food in an attempt to regulate or distract themselves from emotions.

3.8 Hopes for MEG

Participants had fairly similar hopes for the MEG program, with a few exceptions. The most common goals of treatment to emerge from analysis were:

- To be more in control of eating behaviours
- To be eating healthy
- To be a healthy weight
- To lose weight
- To be comfortable with one’s body
- To eat moderately
- To eat for hunger
- To cease bingeing
- To gain some tools and strategies to deal with eating problems
- To have less head talk
- To have less food and body obsession
- To have more self-awareness

Cate:

...MEG is something that will hopefully open my eyes to my eating...I’m really hoping to get like this whole...eye-opening experience...hopefully I’ll be able to take away a lot of tools...maybe on a road to even losing weight...be able to feel a bit more confident and comfortable about myself...it [bingeing] will be under control...For it to stop the emotions...I’m hoping to be able to change everything from here on for the rest of my life...starting to be honest with other people around, that I do have a problem and I need help...to bring out the real me, and show people and tell the world who I really am. So that’s what I’m looking forward to. It’s like my own true makeover episode!

Beth:

...I would like to feel good about the way I look...I hope that I’d be more in control of bingeing...hopefully some tools...some sort of technique...stopping that from happening...I hope I meet other people with similar problems and we share them...

Nina:

...I guess I’d just like to be able to be...more at ease around food...just all these ideas flying around you hear in media or about, you know, the latest things that are healthy for you, not healthy for you...I just want to have some sort of basic framework that I’m comfortable with...and just basic building blocks to work from...I guess that I hadn’t purged would be great...I want to sort of bring that boundary back a bit that says, “No, that’s out of bounds.”
Lily:

...I just want to gain control over my eating patterns so that I can make choices for nutrition rather than comfort...full control over what I eat, when I eat it...that I’m eating for hunger, and that I’ve lost weight and feel better about myself...just solve my eating problems. And other problems that may come up along the way, just generally a healing sort of situation...

Rachael:

The thing that I like about the idea of the MEG program is that...it's something that you could recover from, you know this might not be something that I have to live with forever...at the moment I want to lose weight...I would love to just be able to be a healthy weight, eat healthy food, and not think about it...some freedom around food obsession, and body image...I'd like to be able to tell you that I'm listening to my body a lot more and that I'm making healthy food choices...And I want to be comfortable enough in myself to be healthy and to be able to eat, you know, moderately...

Anne:

...I just want to learn how to stop bingeing, I wanna...take control, but in a healthy way...to eat healthy and not feel bad, not...yeah, not feel bad about what I’ve eaten. Be able to look at myself and think, “Oh, I look good today,” not like, “Oh god, you look horrible, you’re so fat,”...that I’m more aware of what I’m doing and like...I don’t think so much what I’m eating...I don’t know, just don’t want to focus on food.

3.9 Summary of Findings

Much of what emerged from the first half of the current study, investigating the antecedents to binge eating and the subjective experience of binge eating, supported previous literature. As described in the DSM-IV-TR, all participants described a loss of control and the consumption of a large amount of food in one sitting, coupled with marked distress at their behaviour;
they also displayed excessive food and weight concerns (APA, 2000). Some participants also engaged in compensatory behaviours, such as food restriction, purging, and overexercise (APA, 2000). Also reflecting previous research, binges induced shame and were typically conducted in secret, and participants’ feelings of shame contributed to the binge/diet cycle (EDFV, 2000; Nevonen et al., 1999).

In the current study, the binge episode was theorised as a three-stage process. In stage one, the process was set in motion by a trigger. Stage two of the binge episode was the actual consumption of food. Stage three involved resultant negative ramifications of the binge and counteractive attempts at relief.

Participants in the current study reported many of the precipitating factors found in previous studies of eating disorders, including a history of dieting (Jacobi et al, 2004; Wilson, 1993), family dysfunction (Jacobi, Morris & de Zwaan, 2004), sociocultural influences (Barlow & Durand, 2005), and adverse events (EDFV, 2000).

New concepts and perspectives also emerged as precipitating factors. Participants reported the experience of role-reversal in child-parent roles. The lack of emotional expression and support from parents was reinterpreted as ‘emotional coldness’. Participants discussed the phenomenon of the arbitrary line between what was ‘thin’ and what was ‘unattractive’. It was also discovered that adverse events were determined by the attribution of subjective meaning to events.
Personality/Psychological precipitating factors were frequent features to emerge from analysis. Participants displayed many of the factors discussed in previous research, such as low self-esteem (Serpell & Troop, 2003), overemphasis on body image and the approval of others (Barlow & Durand, 2005; EDFV, 2000), social anxiety (Barlow & Durand, 2005), perfectionism (Fairburn, Cooper & Shafran, 2003), impulsivity (Steiger & Bruce, 2004), difficulty with assertion (EDFV, 2000), and difficulty with emotion regulation (Fairburn et al., 2003). Supporting previous research, the strongest indicator of self-esteem seemed to be perceived body image, which appeared to be a function of perception of judgement from others (Barlow & Durand, 2005; EDFV, 2000).

In addition to findings supporting previous studies, other Personality/Psychological precipitating characteristics emerged from analysis. Participants expressed high expectations of others, fear of failure, and tendencies towards ‘all or nothing’ attitudes and behaviours characterised by an inability to maintain a healthy balance. It also emerged that emphasis on the approval of others may more accurately be seen as a function of an exaggerated perception of being judged. The overriding theme to emerge from the first interview was the concept of ‘control’, which featured in many aspects of participants’ lives in varying ways.
This chapter presents the findings that emerged from the second interview, and evaluates the participants’ experience of the MEG program in terms of changes from pre to post-treatment, areas that remained problematic, and attainment of participants’ individual pre-treatment goals. Results are discussed in relation to findings from the 2002 Crafti study. This chapter also discusses the common as well as individual complaints and suggestions for improvement that emerged from participants’ evaluation of the program.

4.1 Eating Behaviours and Awareness

Following MEG, participants reported increased awareness of what they were eating, and were better able to identify eating patterns and behaviours, specifically under which conditions they were more likely to binge or overeat.

Rachael:

...I did pick up things, like social situations I was more likely to eat more...

Anne:

...I learnt that I would binge in front of the computer all the time, I knew where I was bingeing, I knew what I felt like during the binge...it made me more aware of the things I was doing, when I was doing them, and stuff
like that...and like the reasons why I was doing it...it just made me more aware, that was like the valuable thing...it was like a real eye-opener...

Cate:

While I was eating I was going through the whole motions, which I thought was really good, and it stopped me...if I went to the cupboard I'd be like, “Okay, why do I feel like going to the cupboard now?”...

Lily:

...noticing things that I’ve done in a couple of days in a row...I’ve noticed other sort of behaviours...

All participants described increased control over eating. Most participants described a healthier balance with eating, with fewer episodes of overeating and bingeing. Cate and Rachael reported that normalising eating was taking some adjustment, resulting in being too permissive with eating. Beth and Rachael were no longer restricting their food. While improved, Anne and Rachael were still not in control of their eating. Anne reported that though she had improved, she still engaged in both bingeing and purging. Rachael stated that she was no longer bingeing, though she still did not consider herself a ‘moderate’ eater. She did not eat in response to hunger signals. She also still engaged in compensatory behaviours, though to a lesser extent, and was much more lenient with herself:

Rachael:

...I virtually don’t binge anymore so in that way it’s been a success, but my idea of bingeing has changed...sometimes just now what I have for a meal I would’ve considered a binge then, and it wouldn’t have been right, like it
wasn’t, it’s not a binge but a bigger meal including some of the foods that I didn’t want to eat, now sometimes it’s just breakfast. So, yeah, it’s changed quite a lot...I was quite restrictive with what I was eating then...before I was part of the program, I was eating three meals a day and not too many in between, and the program encouraged to have more flexibility around those things and, which it has...

...I’m not happy with my food choices at the moment...I kind of choose something that I know won’t make me feel good later, but that I want right there...I’m not moderate...I would have, um, you know, three pieces of cake one day...then next day I don’t eat so much, you know, so I wouldn’t really consider myself a moderate eater...I’ve found that it might just be part of my progress that you do kind of go one way and you might kind of come back to some more sense of um, I don’t know, constant, um, more healthy, more balanced.

Beth:

...I’m not dieting...I’m not abstaining, I’m just trying to learn that balance...not over-indulge...

Lily:

...I’ve gained so much more control over what I eat and I don’t binge anymore...I used to either be, you know, all healthy all the time, never allowed to eat anything...or all off the rails...and now there’s like a middle ground I’m finding. And sometimes it’s all healthy and sometimes it’s all not healthy, but I’m having more times where there is a middle ground of normality...It’s sort of getting rid of that all or nothing thinking...

Anne:

...I was more in control. I’m more in control now...in terms of the eating disorder, I’m going to have to go to that place on High Street because um, although I’ve noticed some behaviours, I’m still doing what I ... like the bingeing and purging thing, I’m still doing that. Even though I have weeks where I don’t...or days where I don’t, I still do it, and I know it’s a problem.

Participants were more able to identify signs of true physical hunger and to stave off hunger-related binges, and were better able to distinguish real
hunger from other prompts to eat. They reported increased awareness of fullness signs, which consequently served to discourage overeating, and were also able to identify when they were most likely to overeat or binge. Though improved, all participants were still eating for reasons other than hunger, and still eating past fullness. This was especially apparent in times of stress or social occasions. Cate and Lily also reported still being tempted to eat if food was present, particularly food considered ‘forbidden’. Rachael was not eating for hunger at all, but rather went by the time of day. She stated that she rarely let herself get hungry. Anne, though aware of hunger signals, was more overwhelmed by her emotional needs:

Anne:

...I know what hunger is...I just wish I could learn to eat when I’m hungry and not when I just want to.

Rachael:

...I sort of go by what’s going on in my day...I wake up and have breakfast and you know, a few hours later when it gets to, it looks like about lunch time, start thinking about lunch you know, it’s um, more like that than, “Ooh, I’m hungry.” I still don’t think that if it got to 1:00 or 2:00 and I wasn’t hungry, I’d say, “Well, I’ll just wait.” I kind of think, “Lunch time – eat something.”

...social situations I was more likely to eat more...when I’m with people, like if there’s finger food going ‘round I eat a lot of that, or with my girlfriends and it feels like a bit of a celebration and um, a special occasion...
Cate:

...it actually taught me how to be hungry again. 'Cause I never felt hunger. I didn’t know I could feel hungry...and it all comes down to that two line sentence of, um, if you want it you can have it but do you really need it? Do you really feel like it? ...when I'm ready to take it more seriously, health-wise, then that will come. Now I'm just eating to celebrate that I can....

...I find any excuse. “Oh, it's a celebration, let's eat,”...probably still be persuaded to have something if it is with everybody else...I work in an environment where there's always food...that's something that I've got to learn to deal with, my temptations...I think I have a problem with, um, stopping eating...I've actually done it a couple of times, gone, “I'm so full,”...keep eating...because they're so good, it's there, it's like, “Why don't you eat? It's good food, you take it while you can.” You know, so you end up eating more.

Beth:

...I was surprised at how often I was actually thirsty, rather than hungry...

Lily:

...I realised that...I do often eat to past my fullness. And that some foods I choose to eat don’t even effect my hunger...my hunger rating is the same from before I’ve eaten it to after I’ve eaten it...I still use food as celebration a lot...

...I still do eat...in some ways that I’m really not happy with, but it’s definitely not as bad as it used to be...I can have chips in the house now and butter in the house now. I couldn’t have them in the house at the start of the MEG program because it would just precipitate a binge, so I’d just be like, “Oh if they’re in the house I’m going to eat them right now.” And like I still come home and I search for them in the cupboard and um, and if they’re there sometimes I can’t resist them, but sometimes I can...

Participants had increased awareness of the binge/diet cycle. They were more aware that if they abstained from eating, or deprived themselves of a particular food, they were more likely to binge. Participants reported no
longer restricting or abstaining from food and were now able to incorporate
‘forbidden’ foods into their diets

Beth:

...Understanding the cycle...understanding the mechanisms of why you were doing something... like if you abstain from eating it always...turns into a binge at some point, so realising that, that was great, that information...

Rachael:

...understanding the binge-diet cycle ...I think that’s helped me...eating every three or four hours was you know, healthy for me and I wasn’t getting as hungry...before I went to the MEG program I binged because I was really hungry...or you know, just restricting and wanting what I couldn’t have...I eat a lot of stuff quite regularly now that I wouldn’t have had before...

Cate:

...if I'm hungry I've got to eat. 'Cause if I don't eat, the binge will come on...

Anne:

...I would be eating five times a day and I felt good about myself...eating more normal than what I was before. And allowing myself to eat foods that I wouldn’t have eaten.

Most participants reported an increased awareness and ability in identifying emotions, particularly precipitating and following a binge. Rachael seemed to struggle with this concept the most, and did not appear to be any more aware of underlying emotional links to her eating behaviours
since the first interview. Participants also reported feeling more prepared to deal with emotional triggers. Beth in particular stated that the strategies she had learned in the MEG program had been very helpful in preventing a binge. Rachael and Anne, the two participants with a history of engaging in the most restrictive and compensatory behaviours, had the greatest difficulty implementing emotional awareness strategies and showed the least ability or desire to self-examine emotional links to eating behaviours after MEG:

Beth:

...I was more aware of how I was feeling...there was some very basic knowledge that they gave us that has been very helpful...things to do when something was been triggered off or you realised you were feeling a certain way, then there was something you could do...

Rachael:

...I found it difficult...I'd think, I don’t know, “I just want to eat lunch”...it was never that overt for me like, “Oh I’m stressed, I’m going to go eat something,”...there wasn’t a time when I’d just aimlessly find myself eating some chips, and think, “Ooh what am I thinking,” you know, I’d be thinking, “It’s afternoon tea, I’m having my apple.”...

Anne:

...it didn’t really work for me. Like I tried it but it didn’t last for very long, like maybe a day, and I just thought, “Bugger it, I’m just going to eat, I don’t care if I’m not hungry”...when I want to eat, I want to eat, I don’t want to spend time thinking...

Cate:

...before I went into this, anything before that was numb...I think I can see now when I'm eating for stress, or anger...
Lily:

...I haven’t really got to this step yet...sometimes when I’m feeling low, I don’t want to acknowledge it because I don’t really know how else to deal with it yet...

Participants reported that overeating or bingeing did not result in as much guilt and shame as before. As a consequence, this resulted in less bingeing and compensatory behaviour. The same could be said for eating ‘forbidden’ foods:

Cate:

...if I do overeat...it stops.

Beth:

...even when I do binge, every now and again, I don’t feel so bad about it.

Lily:

...it’s not like, “Oh well I’ve blown it now, I’m just going to eat the entire fridge.”...if I have something bad in the morning that’s okay, but the next eating episode is not. It doesn’t have to be bad...

Rachael:

...having something to eat at lunch time that, you know, I might’ve considered to be bad food...now, it’s just, I wouldn’t torture myself with that for the rest of the day, wouldn’t make that a binge...

Anne:

...after a binge, sometimes I would like think, “Okay, I binged, but I don’t need to vomit afterwards.”...
All participants were less inclined to use food to cope with stress. They reported improved coping ability and had been able to effectively implement strategies learnt in the program to manage difficult and stressful situations. Although better able to identify emotional triggers and prevent binges, and albeit to a lesser extent than prior to commencement of the program, participants were still eating for emotional reasons, especially in times of stress. Lily and Anne reported still resorting to food and bingeing at particularly stressful times. Lily had been able to implement stress relief strategies with some success, but Anne had not. The greater the level of stress the more difficult it was to implement strategies, and the more overwhelming the desire to fall back on food as a means to cope. Participants showed an awareness of control over their lives and their ability to effect change. Participants also appeared to catastrophise less, and were able to see things more realistically:

Cate:

...my biggest issue is, I eat regardless...I find any excuse: “Oh, it's a celebration, let's eat. Oh it's really depressing, let's eat.”... 

...I've learned to deal with things...I used to blame it on people, blame it on the world, blame it on everybody else. Nah...it comes from here, let's deal with it from here, not blame anybody else. Just sort it out...who cares...Nothing's that bad...And you know, maybe I will have to get off my arse and do more exercise, and all that sort of stuff...um, but that's okay.
Lily:

...that’s still the main thing I just want to work on...when it’s so ingrained in a part of your life you don’t even notice...when I’m feeling particularly low or like, really, really low or something, I don’t really have enough coping strategies yet to deal with that without food...I’ve had a few successes along the program with this...but that’s only a small percentage of the time that I can do that.

...Finding other ways of dealing with stress other than eating. And I have been able to use those sometimes, which is good...burn lavender oil, get myself a cup of herbal tea, put on some good music, whereas before, I would have probably used food...in that acute point of stress, I did resort to food...I really was freaking out about it and having bad anxiety, and stuff like that...but now that’s more under control...

Anne:

...I wanted to eat...I wanted to get that food inside, already....it’s easy to understand why food isn’t feelings but I couldn’t use that to help me...I know it’s my problem with food, but...my other ways of dealing with my emotions aren’t as attractive as food is to me...when something big happens like an exam...I just can’t handle the stress of it...I’d just be on overload and that’s when I would just binge...It was just too much to handle, I just went for the food...And I would waste an hour more just eating.

...if I just do something about it, eat healthy and don’t eat...like I sort of restrict in the junk area, but not restricting with eating, then I could feel better about myself...Yeah it’s possible...I can easily fix it.

Beth:

They gave me some strategies...when I’m stressed, uptight, learning the breathing, that’s good.

Rachael:

...To have a plan or to put a little bit of something in place if you know a situation is going to be a problem...Just having a practical strategy...that was one of the most helpful things I got out of it, actually.
4.2 Body Image, Dieting, and The ‘Thin Ideal’

All participants displayed less emphasis on body image than they previously had, but consistent with Crafti (2002) body image remained a significant issue after completion of the program. Participants were still not happy with their bodies, and still suffered low self-esteem as a result. Lily, Rachael, and Anne were particularly unhappy due to weight gain; no participants reported weight loss, an aspiration all participants had expressed prior to MEG. Lily and Beth appeared to understand the link between body image and self esteem, and Lily was aware of her tendency towards emphasis on body image. Cate showed the greatest improvement in regards to body image. Before commencement of the program she had linked all of her happiness to losing weight. After completion of the program she had greatly decreased her emphasis on body image, greatly increased self-esteem, was able to challenge maladaptive beliefs about herself, society’s ideals, and negative evaluation from others, and had a healthier ideal. It is interesting to note that those participants who had been assessed by this researcher as not having a weight issue prior to MEG still showed concern with their body image after completion, while Cate, assessed as ‘overweight’, showed great improvement:

Cate:

...that whole body image thing, really was probably the most...the significant thing that hit me...the reality sort of...kicked in that um, that's what it's been all about for me. It's been trying to fit in. It's all about been trying to fit the mould, why can't I fit the mould? I didn't go out, and if I
went out, it felt like everyone was watching me...MEG basically showed that no-one really cares...no-one's just going to focus on me. The guy next to me is probably thinking about all the bills that he's got to pay or the fact that, you know, something major's going on rather than, “Oh gee this big girl's sitting beside me. Jeez, how could she go out at night?”...I’ve never expected to come out like that, to have that whole reality check...if I want to say what my ideal is? To be healthy, at the moment, whereas before, it was a size 12...The shift was just so amazing, and it’s that realisation that I’m worthy, I’m as worthy as the next person, it doesn’t matter what size you are...I can’t say that I don't want to lose weight, I don’t care if I get bigger and bigger. That's not true. I mean, 'cause I know that if I was to lose some weight, I'd feel more comfortable getting up in the morning, 'cause I do feel...sometimes I feel like I'm a 26-year old in a 40-year old body...'cause I am lugging a lot of weight around...

Beth:

...I do find it hard when I go to get dressed in the morning or if I’m out or something, I don’t like the way I look...not just totally accepting...the way I am, I find that hard...Which probably I think is linked with self-esteem...I still have lots to do there I think...

Lily:

...I’m still not there, like I still haven’t um, sort of dealt with a lot of my body image issues, and I’ve actually put on weight since I’ve left the program which I’m really not happy about...and I was talking to my doctor about it yesterday and he’s like...if I saw you on the street I wouldn’t look at you and think, “Oh my God, she’s enormous.” But I look at myself and think that, so I’m still struggling in that area...I think, with a lot of people that are like me...it’s like...if your body image isn’t great or if you don’t have a great body then you aren’t a great person...I don’t think I’m quite there either with that one...I know that I’m a good person...but, probably because I’m like a perfectionist, I’m like, “Why can’t I have a good body as well?”...I didn’t even bring into the equation that I may look beautiful just as I am, because I don’t think I do...I think that has improved, a little bit...I’ll say, “Well, you know, I’ve got a lot of friends and maybe they don’t like me because of what I look like, but because of what type of person I am.”
Rachael:

I’ve put on quite a bit of weight...I kind of can see some benefits have been made but I’m uncomfortable with my body...my ideal...I don’t know what it is in kilos...I don’t want to be any taller or...my boobs to be any bigger...I just want to be thinner...I maybe think about my weight or my body shape less than I did then, but still a lot more than I think I was aiming for...But I think progress has been made.

Anne:

...I have gained weight since the MEG program...I’m going through a bad period so I’m not comfortable at the moment...I still think in terms of fat weeks, good weeks.

Some participants were now able to challenge the ‘thin ideal’ and aspired towards healthier ideals. They were more aware of the role that family and society play in the development of eating disorders. Participants were also more able to challenge to concept of dieting and the belief that being thin leads to happiness. Some participants reported that they still struggled with ideas of dieting and thinness:

Lily:

...if I start eating normally and I do a bit of exercising, then my body will just go to what it’s supposed to be at. You know, and then, once it’s there maybe I can look at it then and then say: “Well am I that unhappy with this?...I’ve actually got really good self-esteem in other areas...I think I’m smart and I think that I can achieve things if I put my mind to it and I’m quite confident and I’ll say what I think and things like that...there were a couple of times when I was feeling particularly out of control...not happy with my weight, not happy with how I was looking, you know, wanting to go back on a diet, knowing that I couldn’t...And then I heard somebody talking about body image, and then I thought: “What if I have to stay at this body image for the rest of my life?”
...I'd like to feel more in control of my actual physical being, ‘cause at the moment I’m feeling very separate from it, like, this is my brain and this is this body that I’m stuck in that I have to like, lug around and deal with, as opposed to...you know those people who are like, their body is their tool and it does all the things they want it to do, because I’m quite unfit at the moment...I find it more cumbersome and um, hampering and hindering sort of, what I always want to do...I don’t feel very empowered in my body...

Cate:

...it's sad now, to see other people who are talking about being on a diet 'cause I want to be this size (sic) and they want to have liposuction on their butts, to me that's not being a human being, putting yourself through physical torture every single day...I can go through a magazine and just think, “You poor things.”...It doesn't mean they're happy...it's all fake and phoney.

...I was on diets since I was probably nine years old...and I was thinking now if I ever have kids, I'll never do that to them, never ever...I'll just do the best I can to let 'em know that it's no drama. If they're hungry, eat something, if they're full, stop eating. Don't matter about what size you are...you just don't know, how easily it affects somebody, throughout their whole life...if I see diets now, I'm like, “No, get real.” And I hear people are on diets...and I want to tell people: “Just eat, be normal.”...I sit there and think about how many diets I've been on, everything I've tried. Every food I haven't eaten for six months, the no carbs, high carbs...you name it, had the surgery done...Nothing has worked for me and there's a reason for it...after the MEG program, I think it still took a while to kick in, and I ended up purchasing the Beta Life Program...You have to eat broccoli for breakfast...and I just got so pissed off, I spent 200 dollars on it...it's still sitting there, haven't watched the last CD, the DVD, I was over it...never again, I don't care how desperate I get, I'm not wasting my money. I don't care what bullshit they spin and what they tell you it's going to give you...

Beth:

...my mother has an eating disorder too, and it's just generations of it really...my auntie, and when I think back to my grandmother, and my sisters, and my cousins, all females in our family.
Anne:

…it kind of make me think maybe I should go back to laxatives again...I thought, maybe I could do purging and laxatives, maybe it would help...I was just going through a really, really fat period...

Rachael:

…I was quite restrictive with what I was eating then...now I’ve sort of gone the other way...and I’ve put on quite a bit of weight, and, so I’m not really happy...Every now and then I think, oh, you know, maybe I should go back to that...

4.3 Self Esteem and Mood

All participants reported improved self-esteem. Participants were not as hard on themselves as they had been previously. Some participants also reported an improved state of mind. For these participants, there was less ‘head talk’ around food, body image, and less worry in general. As previously mentioned, though improved, participants still suffered low self-esteem which seemed a direct result of persisting dissatisfaction with body image. The exception was Cate, who showed greatly improved self-esteem and confidence, and a newfound positive outlook on life. She also reported improved mood, stating that she was much calmer and less anxious. Cate no longer displayed an exaggerated perception of being judged or cared about the approval of others. Other participants, while improved, still struggled with this issue, possibly as a consequence of lingering body image concerns:
Cate:

...I think it's really sky rocketed...I've always said, "If they don't accept me for me"...But it never actually registered as real...now it's like, I'm not bullshitting anymore...If I'm going to feel this good, I want it to excel in my clothes, my make-up, my hair...Whereas before I just used to wear whatever...I think it's looking up in the world of my confidence with males. When someone does come along or something...I'll feel a little bit more open to the idea, rather than, “Oh no...no-one's seeing me naked.”...I've just become more blasé I suppose in a way...it was pretty much the 90 percent of what I thought about the day, what other people think...[now] it's like, I don't care what anybody thinks. If they don't accept me for me...I feel like I have the confidence now to be able to be my own boss. And that for me is huge, I've always dreamt of owning a business. Never thought I was worthy enough of it...

I just feel more calm...just more relaxed, and the chatterbox has stopped...I'm not as crabby as I used to be, that's for sure...to have come this far in, whatever it's been, eight months...of twenty-four years and nothing but bantering and mental, mental craziness...I sleep so much better now. I don't have my anxiety attacks...normally I have the freak-outs while I sleep...and I can't think the last time I've had one. During MEG I think that stopped...

Beth:

...not just totally accepting...the way I am...I still have lots to do there...

Lily:

...except for my body self-esteem, I’ve actually got really good self-esteem in other areas.

...if you’re going to judge me on the size I am then I don’t want to be your friend anyway...

Anne:

...a lot of the times I am feeling good about myself...I don’t think so bad about myself...but if I’m like, eating a whole lot of food like I am now, then I’m not going to feel good about myself...like, if I keep on going for
another two weeks, then I’m just going to be like, “Shit, I’m just going to kill myself.”

Rachael:

...it’s changed the head talk...it’s probably made it less...probably berated myself more than I do...it’s not as bad as it is used to be and not so much fear around it...not so much of the irrational or unnecessary panic about stuff that wasn’t important...

...I thought something was wrong with me...in a way I think that’s probably still there...wanting that constant...affirming that I’m okay, and you know, obviously I’m sexy and desirable...and wanting everyone else to know that, like I love it when he [boyfriend] sends me flowers at work because everyone sees them and thinks, “Wow,” you know, she’s always got these men that love her and you know, that gets that affirmation, not only from men, but from the girls at work, and I love it when people say, “Oh, Rachael’s got such a glamorous life, she’s going out here.” and he also, the guy I’m seeing is a pilot, and he takes me flying sometimes, and I think, “Oh, that makes me sound so glamorous,” and it’s all really superficial and I can see that and I know what I’m getting out of it so...shit, that means I haven’t made much progress...

4.4 Perfectionistic Tendencies

Participants still displayed perfectionistic tendencies. Cate, albeit greatly improved, reported still having high expectations of herself, though this was a minor feature in the interview. Lily also stated that she still struggled with her perfectionistic tendencies but was now able to question herself. All participants, to varying degrees, displayed a tendency to not give themselves credit for improvements made so far but rather to focus on aspects they were still unhappy with. This was particularly apparent when participants were reminded of the goals they had stated in the first interview, how many of these had been achieved, and how far they had come. Despite the persistence
of this trait, participants were able to acknowledge that they had made definite progress:

Cate:

...on myself and on my life I have a huge expectation, and anything I do I want to do it well, I want to do it over the top...

Lily:

...he was like, “Look at how far you’ve come though.” I was like, “Yeah, I suppose,” but it’s just not good enough and I sometimes don’t really give credit...myself credit for that, because it’s still not good enough for me, you know...I think it’s easier to forget sort of what little things you have achieved...now I’m just like, “Oh well, little steps.” It’s just going to take time...it’s more under control, and I’m feeling more confident about where I’m going...I think that’s quite important.

Rachael:

...it might just be part of my progress that you do kind of go one way and you might kind of come back to some more sense of um, I don’t know, constant, um, more healthy, more balanced. So I kind of have a bit of faith in that.

4.5 Assertiveness

Typically, participants had not considered assertiveness an issue for themselves before MEG, and since completing the program had become aware of a tendency to be a ‘people pleaser’ and to put others’ needs ahead of their own. Participants reported increased assertiveness, though this was an area most participants still needed to work on:
Cate:

...Probably don't do it as much as I should of (sic). I think I'm...probably I'm too much of a people pleaser. Someone says, “Hey darl, let’s have this for lunch.” “Okay.” I suppose I should be like, “Actually no I’m going to have this.”...assertiveness wasn't a big thing but I really...I understand where that one was coming from.

Beth:

...not wanting to cause...upset a situation, maybe putting up with things you don’t want to put up with really...I found that really helpful...it was nice, the tools they gave us.

Lily:

...it does teach you how to say no to people, um...who don’t understand what having that packet of chips might actually do for you...looking at this now, I’m like, “Oh yeah, I should remember to do that more.”

Rachael:

...I wasn’t as assertive as I am now, at work, and yeah in life really. And it has improved since then...it is always helpful to do these role-plays and to talk about it, it’s more sort of affirming that, I can be assertive and, you know, I think these things are always helpful...

Anne:

...I’ve done that a few times...usually I accept whatever comes my way. But, on a few occasions I’ve spoken up... ‘Cause I’m always thinking, “No they’re going to hate me, I can’t say no, I have to do it, even thought I don’t want to.”...so it was good in that way, ‘cause I thought, “Oh stuff it, I can’t be bothered, I’ll say no.”

4.6 Interpersonal Improvements

Interpersonal Therapy was an underlying focus of the MEG program, and some participants showed an improvement in this area. Cate and Anne
reported an improved social life and improved relationships with others.

Before taking part in the program, Cate had avoided social situations because of low self-esteem based on her body image, and an exaggerated perception of being judged negatively by others. In the second interview Cate stated she felt more comfortable with her friends and described a sense of support from one friend in particular, and was going out more. At the time of the first interview, Cate had described a very problematic relationship with her sister; in the subsequent interview, she cited an occasion in which she had attended a social gathering organised by her sister and had had a great time:

...probably a little bit more confident with my friends now...a girlfriend of mine, she knows what I've been going through...it's good to have someone like that around who can just, you know, keep me on the ball...I'm going out...going out is more fun...The social life has really kicked in a little bit more...

In the first interview Anne had stated that she was introverted and found it difficult to make friends. She had, in fact, made most of her friends in online chat rooms, and spent a great deal of her time in online chat rooms. By the second interview, Anne had a new job, a new set of friends, a new boyfriend, and an active social life:

...I managed to settle on the fruit and vegie boy at work...we’re now living together...I’ve made quite a few good friends...I got a new job, I made friends with all those people...I just kind of loosened up and I went out there and I made my friends...just wanting to go out and have fun...
4.7 Social Comparison and Group Support

Of note, participants showed evidence of ‘social comparison’ with other group members. Most participants expressed a strong identification with other participants. They reported relief and validation at discovering others shared the same problems, and liberation in being able to disclose their secret shame. Participants reported feeling understood, accepted, and supported:

Beth:

...the support of the people, being in a group, other people going through things that were similar...I had felt very alone in that respect there, so yeah, it was great...we actually bonded...the good thing about being in a group like that is that everyone knows those things about you, you don’t have to explain yourself, and that’s what’s really nice, there’s no judgement...

Lily:

...just even seeing other people with the same problems, it’s really amazing as well...

Rachael:

...there was a lot of identification I think with all of us.

Anne:

...being able to talk about it with people who knew exactly what we were all going through was good too...socialising with people who know exactly what we’re going through, like we could help each other along and all that.
Cate cited much less identification with other participants, and expressed frustration that the discussion often focussed on participants with anorexic and bulimic issues (i.e., food restriction and purging). She reported that other participants were ‘skinny’ and did not have a weight problem like her, and therefore did not understand her experience, and she could not understand their body image concerns.

...I did struggle a little with those people that weren't overweight...It just frustrates me. I feel like saying, "You don't have any real physical issues, what is your problem?"...there was a lot of focus on anorexia, and bulimia...they don't understand what I'm going through and they don't have the same problems that I do...

Anne, though strongly identifying with one participant in particular, expressed feelings of frustration and competitiveness. She also expressed discomfort and feelings of competitiveness with one of the facilitators who had disclosed having her own issues with eating:

...I was doing the purging thing, and I knew she was doing the laxative thing. I thought, maybe I could do purging and laxatives, maybe it would help. I did it for a period...I think she was just too similar to me and I just wanted to compete... I wanted to be that strict...

...I kind of sometimes felt uncomfortable... 'cause I thought she was anorexic...She’s really skinny. So I’d just be like, looking at her... sometimes and be thinking to myself, “Shit, I wonder what she’s got.” ‘Cause I know she had an eating problem, so I’m assuming it was anorexia, 'cause she’s like, really skinny. And so I just couldn’t help but think what was going through her head, or what she was eating, or was she really doing everything that we were doing? Or was she like being a fraud and actually being anorexic on us...It would just make me think...like I would want to know what she was going through...I'd just think: “She’s really, really skinny. I wish I could be that thin.”
4.8 Attainment of Pre-MEG Goals

For the participants as a group, MEG was partially successful in meeting their goals for outcome. All participants had gained tools and strategies to deal with their eating problems, and were more in control of their eating than before commencing the program. Most participants were eating healthier than prior to the program, though three of the five remaining participants had experienced a loss of control around eating behaviours, and had reverted to bad eating habits. Two of these participants had regained control by the time of the second interview; one was still out of control with eating behaviour, including making frequent bad food choices, though this was still an improvement from the first interview. Most participants were eating for hunger more often than they had before but still ate for emotional and other reasons (such as social occasions) to varying degrees, and often ate past fullness signals. One participant was not eating according to hunger signals at all.

Participants were also eating more moderately than previously. All participants had been able to incorporate ‘forbidden foods’ into their diets, and reported less anxiety around eating these foods and overeating. Some participants were still struggling with a healthy balance, and had experienced bingeing, but to a much lesser degree. Two participants still used compensation behaviours, such as purging and minor food restriction, but again, to a much lesser degree. One participant referred to ‘overeating’ rather than ‘bingebing’. Only one participant stated unequivocally that she no longer
binged, but had also re-evaluated her pre-MEG perception of bingeing as not bingeing at all.

Though weight was not officially assessed either pre or post-MEG, three of the five participants appeared to be a healthy weight; these participants had also been assessed as appearing to be a healthy weight at the time of the first interview. No participants were completely happy or comfortable with their body, though all participants placed less emphasis on body image than before entering the program. One participant had greatly improved body image since the first interview. No participants had lost weight, and three participants reported gaining weight.

All participants reported less head talk and less food and body obsession than they had previously. Thoughts about food and body image were still apparent, but much less prevalent. One participant had improved greatly in these areas since undertaking the program. All participants also showed more self-awareness; some participants had made great progress in self-awareness, while others had only improved slightly.

All participants had experienced difficulty with maintenance and sustaining improvements in the ‘real world’. This was particularly apparent in periods of stress, when participants reported reverting back to previous coping strategies, despite having developed maintenance plans that were intended to guard against slip-ups. All participants stated that, though improved, in some instances greatly, the MEG program had not solved their problems.
4.9 Complaints and Issues

Not many complaints were expressed by participants regarding the MEG program. Most commonly, complaints related to other members of the group and homework tasks. Cate and Beth expressed dissatisfaction with not being able to relate to the other members in certain significant aspects. Cate reported that she experienced the program as focussing on people who displayed symptoms more characteristic of bulimia and anorexia rather than pure binge eaters. She particularly could not relate to discussion concerning food restriction or purging, and described often feeling frustrated at not being able to relate to the other mostly ‘skinny’ group members. Cate also stated that this had the consequence of other members not being able to empathise with what it was like to experience life as ‘big girl’:

...I did struggle a little with those people that weren't overweight...It just frustrates me. I feel like saying, “You don't have any real physical issues, what is your problem?”...there was a lot of focus on anorexia, and bulimia...I would've preferred something to focus more on...people of my sort of state of mind...I spent half my time being frustrated with what they were saying than actually listening to them...Most of them were not big, they ate, binged, but then they threw it up to not become big...they don't have a problem with their weight. They could walk into a store and buy clothes. You know, any ordinary store...I've gone there, hoping to feel like I'm going to be with all these people that understand exactly what I'm going through, we're all going through the same thing, and then they really actually don't, and you sort of get this reinforcement...no, they don't understand what I'm going through and they don't have the same problems that I do...we should put people together who are of the same categories.

Beth reported disappointment that there had been no other parents in the group she could share her specific concerns with regarding trying to instil
healthy attitudes towards food and body image in her children whilst being an individual with an eating disorder:

...the only thing that was hard for me was nobody else was a parent. I would’ve liked having another parent, because um, there was lots that I couldn’t really relate to anyone else, no-one else had that issue, I couldn’t really talk about it…it’s like a whole new whole other thing on it. Because it wasn’t just for myself, it was trying to find the best way to teach them...it would’ve been good to be able to talk to somebody else about it.

Another issue for Beth during the MEG program concerned one member in particular, whom she had experienced as being ‘bitter’ and ‘negative’ within the group:

There was just one person, I felt that was a bit difficult, was a bit negative and um, a bit aggressive, and that was a bit hard with that person...had a bit of an attack at me...I was feeling, you know, you feel vulnerable and you’re opening up and one person was a little bit... a bit bitter...on one occasion when I was talking and she made some quip...that I thought was totally unnecessary, it wasn’t sort of the place for it...it didn’t seem like anybody else sort of seemed to be upset by it or I didn’t really want to sort of stir the pot.

Anne also expressed having an issue with a fellow group member. She described feelings of discomfort, jealousy, anger, and competitiveness. As previously mentioned, Anne also expressed having similar feelings towards one of the facilitators:

...she’s a bit...I think similar to me in what she does. I don’t know if she purges, but I know she does do laxatives, and it kind of made me think, “Maybe I should go back to laxatives again.”...I thought, maybe I could do purging and laxatives, maybe it would help. I did it for a period...I just wanted to compete for like a short period...the stuff that she said
really...sometimes pissed me off. She was like; “I had a binge today. I had two bowls of ice-cream.” Bloody hell... ’cause I wanted to be that strict, I just couldn’t. I was like eating all over the place...

Anne also reported experiencing bingeing episodes brought on by the group discussion. She had additional issues with the time of the sessions in relation to eating dinner. Beth had also mentioned that she had frequently felt hungry during the group session, but had not eaten because no one else had. It is worth mentioning here that a regular practice of each session, designed to encourage normalisation around food and eating, was the inclusion of a meal break in which a selection of healthy food and drink was provided for participants:

...on the first session, I was scared that I was going to go home and binge because I don’t know, I thought that because it was so late at night, these programs, that I would be bingeing every night that I got home because the topic would be out in the open, I’d just be thinking about it. And it did happen, like the first three times I did go home and binge... ’cause you haven’t really had your dinner yet and...I would be scared going in after eating ’cause all I’d be doing is sitting on my bum doing nothing, and just all the energy, that would just go straight to my arse like it always does. So I was scared of eating too much ’cause I thought I’d get fat. And then I’d be scared of leaving because I knew I would binge.

Cate, Beth, and Anne described the homework tasks and food journal as impractical, inconvenient, and time consuming. Some participants felt keeping a food journal was too conspicuous. Rachael had been in a new relationship and expressed not wanting something like a food journal lying around. Cate also stated keeping the food journal was too conspicuous, particularly at work:
Cate:

...I was so bad at it. Just because at work, no-one knew what I was going through and writing down...got a very nosy office, we're all around each other...I didn't want anybody to know about it...It just wasn't something that I felt was practical...they're smart, and they're good for people who are more of a writer I suppose, but not for me.

Beth:

...I found that really difficult...just not having that time to write it down at all...it was just really hard to stop and if I did it at the end of the day it wasn't the same.

Anne:

...I just couldn't be bothered...it wasn't strict homework, we weren't getting checked up on it...

4.10 Suggestions for Improvement

Suggestions for improvement revolved mainly around the length of the program and support after completion of MEG, and seemed to be a direct consequence of participants’ difficulty with maintenance. Participants most commonly suggested the idea of a refresher course to reinforce what they had learnt. Lily and Cate had stated there had been a lot of information covered in a short period of time. Cate reported that she had found it difficult to absorb all of the information:

Cate:

...it covered so much in such a little period of time...there's so much to learn...I wouldn't mind coming back in a year and do this again. You know, to refresh those things that weren't so meaningful to me then, maybe more meaningful now (sic) or make more sense, then I could take it back on...so even a refresher would be good of some sort.
Beth:

*I’d like to do it again…I’d like to have that time again to be able to have an hour for myself once a week, to um, touch base with that…I really looked forward to every Thursday, it was great.*

Rachael:

...maybe a second course, I would definitely do it if there was one... having a second group...I think maybe that’s the way forward.

Along with a refresher course, participants equally most commonly suggested making the course longer and having more frequent catch-up sessions. Beth stated she felt the ending had been a little abrupt and had not felt ready. Lily expressed feeling left on her own without more regular catch-ups. She stated she had also felt like the sessions were rushed at times, and making the course longer would allow extra time to guard against this:

Lily:

...a closer follow up time, not three months, just because I felt a bit left on my own and a bit “Oh, I’m all out on my own.”...we were rushing sometimes. Make the course longer, even just a couple of weeks longer, twelve weeks or something, because then they could probably just have those extra six hours to just put into spots where they felt like they were rushing too much.

Beth:

*I would’ve liked it to be for longer, or...to get together a little bit more frequently. I’m mean I know they can’t do that holding your hand for the rest of your life, but it would’ve been nicer...just a bit sort of abrupt...the ending. I don’t know if we were all ready for it.*
Participants also commonly suggested regular support meetings after completion of the program. Rachael liked the idea of being able to regularly ‘check-in’. Beth expressed being able to have that time each week when she could focus on herself had been rewarding, and would have liked to be able to do that again. Anne had described sadness at no longer being able to derive support and empathy from the group, and was planning on attending regular support meetings at another venue:

Rachael:

…I like that checking back in, and um, it would be great to have a regular meeting…I think it’s a really thorough program and I can see all of the benefits in it…The only concern I have is how it can be maintained… there are all these options like having groups…

Anne:

...now we don’t get to interact and talk about…like bring up the issue of an eating disorder in like a comfortable environment...we’re going to have to deal with people that surround us who have to deal with us…It’s a bit hard dealing with those people when we could be socialising with people who know exactly what we’re going through, like we could help each other along and all that…I’m planning on going to the place on High Street... they’ve got like meetings every week or every two weeks....
4.11 Summary of Findings

Many of the results that emerged from post-MEG interviews support the major findings of the Crafti (2002) study. Reflecting findings from the previous study, participants in the current study showed post-MEG improvements in food restriction, bingeing and purging frequency, awareness of hunger, coping and self-efficacy, ideas about thinness, interpersonal relations, and self-esteem, but still reported difficulty in the areas of body dissatisfaction, perfectionism, and impulse regulation (Crafti, 2002). The current study found an association between the objective body size of participants and how accurately they were able to perceive their own body image both pre and post-MEG. Participants in both studies reported the most effective aspects of the program were those relating to generic characteristics of counselling and group therapy (such as support, acceptance, the opportunity to talk about issues, and self-awareness), and aspects relating to CBT (changes in behaviour and cognition) (Crafti, 2002). Similarly, participants in the previous and current studies expressed difficulty translating the knowledge they had gained from the program into behavioural changes (Crafti, 2002). Participants in both studies also reported a high level of satisfaction with the program (Crafti, 2002). A new finding to emerge from the current study was the engagement of participants in ‘social comparison’.

MEG was partially successful on both an individual and group basis in meeting participants’ goals for outcome. All participants were more in
control of their eating than before commencing the program, but though improved, eating problems still remained. Participants still showed evidence to a lesser degree of bingeing, eating for reasons other than hunger, and eating past fullness. One participant was still purging. All participants had more freedom around food and body image to varying degrees. Most participants had a greater understanding of their eating disorder and the underlying mechanisms; Anne and Rachael did not seem to have gained much understanding, and showed the least ability or desire to self-examine emotional links to eating behaviours, and the greatest difficulty implementing emotional awareness strategies. This is in contrast to previous research which found individuals with anorexia and bulimia showed less alexithymia than individuals who binged (Wheeler et al., 2005). All participants stated that, though improved, in some instances greatly, improvements had been difficult to maintain in the ‘real world’, and the MEG program had not solved their problems. It is worth noting that Anne and Rachael, the two participants who had reported a history of engaging in the most restricting and compensatory behaviours prior to MEG, had found the program the least successful in meeting their pre-treatment goals. Conversely, the participant who most closely met criteria for BED, Cate, appeared to get the most out of MEG.

Complaints most commonly expressed concerned other group members, and included not identifying with other members, feeling antagonised by another member, and feelings of competition toward another member. Other frequent complaints concerned homework tasks, which were considered
inconvenient and time-consuming. Suggestions for improvement of the
program mainly centred around the length of the course and the frequency of
follow-up sessions, as participants had expressed feeling insufficiently
prepared to deal with the end of the program, and unable to adequately cope
on their own. These findings are further discussed in the following chapter in
relation to implications for future treatment programs.
5.1 Limitations

The current study was based on information gathered from participants’ subjective and often retrospective recall of experiences. As such, it was representative of what was happening at the time of the interview, but may not reflect reality either before or beyond that moment in time. The findings presented were also subject to the researcher’s interpretation, and directly influenced by her individual life experience. Due to the nature of qualitative enquiry, and the small sample size used, this thesis can only make definitive statements about the participants who took part in the current study, and the specific MEG program these participants were part of. It cannot make definitive claims about eating disorders in general, and cannot be generalised to other populations or MEG groups. However, the purpose of this study was to focus on the subjective experience of its participants, and this was accomplished.

A possible limitation on evaluations of treatment success relates to group dynamics. The group dynamic of the current participant group may have influenced participant evaluations of treatment success. There had been particular problematic issues within this group, and participants reported specific concerns regarding other group members that had affected their experience of treatment. While this may occur regularly in therapy groups
and is impossible to control for, it is important to consider in terms of treatment outcome.

Another possible limitation of the current study was the inability, due to time constraints, to investigate the longer-term effects of the MEG program. This study was unable to examine if participant success ratings and improvements increased with time beyond six months after completion of MEG, as has been found with previous treatment programs utilising IPT (Agras, et al., 2000).

7.2 Implications for Future Research and Treatment

This researcher acknowledges that the current study was a preliminary qualitative investigation, and has presented many potential future research and treatment directions, for the MEG program specifically, and for eating disorder research in general. Obviously, further qualitative studies need to be conducted in order to extend the results of this thesis before findings can be generalised to other eating disordered populations and treatment groups.

It would be interesting to further investigate the theory of a binge episode as a three-stage process, and also to investigate if other individuals report alcohol, tiredness, social situations, presence of food, and environmental cues as antecedents to bingeing. Other new concepts warranting further investigation relate to Personality/Psychological precipitating factors. In support of Crafti’s (2002) findings, perceived body image emerged as the strongest indicator of self-esteem in the current study, and was linked in the
current study to perceived evaluation from others and an exaggerated perception of being judged. Participants in the current study also reported tendencies towards fear of failure, high expectations of others, and an overriding theme of control throughout many aspects of their lives. Linked to control was also the ‘all or nothing’ phenomenon, where participants were unable to maintain a healthy balance both in attitudes and behaviours. It would be worthwhile to explore further, and investigate the links between these concepts, in order to determine how to most effectively address these concerns in treatment.

Potential future directions for MEG mainly relate to the structure of the program. Most complaints and suggestions for the program indicated specific areas participants reported dissatisfaction with, and it would be interesting to determine if amendments in these areas would result in increased participant ratings of success.

With regard to specific components or modules, a concern for all participants in this study had been weight loss and fitness. While any focus on weight-loss conflicts with the philosophical stance of MEG, most participants expressed confusing or maladaptive ideas about weight-loss, and accurate advice on health, nutrition, and fitness could perhaps be an added component of future courses. It also emerged that the most difficult sections of the program for participants, and the issues that persisted most frequently after completion, had been restructuring and challenging negative thoughts and beliefs, the link between emotions and eating behaviours, body image,
and maintenance of improvements. Increased focus on these areas may be of benefit to future participants.

In support of previous studies, participants in the current study reported a history of family dysfunction (Jacobi, Morris & de Zwaan, 2004). Though this is a widely known precipitant of eating disorders, typically the only treatment approaches that specifically address family history issues are psychoanalysis and family therapy. Although some eating disorder treatment programs include the use of IPT, as does MEG, the focus is on present interpersonal relationships, not those of the past. As a history of family dysfunction is clearly a common issue for individuals who seek treatment for eating problems, it may be beneficial to consider addressing this issue in future treatment programs, and investigating the effectiveness of such inclusion.

While all therapy groups share common features, every group dynamic is different. Group idiosyncrasies contribute uniquely to the subjective experience of treatment, and may also have an effect on subjective evaluations of treatment success. Some participants in the current study had issues with fellow participants but had not felt able to discuss issues either in the session or with other participants directly. As assertiveness and expression of needs are areas individuals with eating disorders have particular difficulty with, it may be beneficial to include some focus on the ‘process’ of the group sessions; to use what happens in the group as a model
for participants to become aware of patterns in their interpersonal interactions, and as an opportunity to work on interpersonal skills.

Further to group dynamics, the individual variability in participant improvement after completion of the program has possible implications for future MEG groups, as well as research. Anne and Rachael, the two participants who had reported a history of engaging in the most restricting and compensatory behaviours prior to MEG, had found the program the least successful in meeting their pre-treatment goals. They also showed the greatest difficulty implementing emotional awareness strategies and the least ability or desire to self-examine emotional links to eating behaviours.

Moreover, participants who had been assessed by this researcher as not having a weight issue prior to MEG still showed concern with their body image after completion. Cate, assessed as ‘overweight’, showed great improvement in perceived body image after MEG. These findings suggest an association between the objective body size of participants and how accurately they were able to perceive their own body image both pre and post-MEG. Therefore, all of these points considered, participants who showed greater pathology before the program also showed greater persistence of pathologies after completion. Cate, the participant who most closely met criteria for BED, had also shown the greatest improvement overall after completion of the program. This suggests that the program, designed primarily to address issues relating to BED, may be most effective for individuals who most closely meet BED criteria. It would be beneficial to
further investigate these findings in order to determine how to most effectively treat the differing pathologies of future MEG participants.

Concerning the MEG program in general, it would be interesting to investigate if lengthening the course, conducting a refresher course, or conducting more frequent catch-up sessions or regular meetings after completion of the program would result in increased success ratings for future participants. Online counselling has been shown as a promising treatment approach for eating disorders, and could be a viable alternative to regular meetings (Zabinski, Wilfley, Calfas, Winzelberg, Barr Taylor, 2004). It would also be worthwhile to conduct further follow-up studies on the success of MEG for participants, to determine if participant success ratings and improvements increase with time.

7.3 Conclusion

The current study extended the Crafti (2002) study, and provided a detailed description of the subjective experience of six women who entered the MEG group treatment program for eating-related concerns. The antecedents and characteristics of binge eating in these individuals were also investigated, and the program was evaluated in terms of individual improvements, attainment of pre-treatment goals, and subjective ratings of success. A qualitative approach was used to address some of the limitations of quantitative research in adequately assessing experience and meaning, and
to supplement the body of quantitative research in the field of eating disorders.

The findings of this thesis added support to previous findings of the antecedents of eating disorders and bingeing behaviour, as well the 2002 (Crafti) evaluation of the MEG program. It was found that participants reported many of the antecedents, and displayed bingeing behaviour characteristic of that discussed in previous studies. Overall, participants had found the MEG program partially successful. While all participants had shown improvements in many areas, the consensus was that participants still had a long way to go on the road to recovery. This study also introduced new concepts and proposed different perspectives that emerged from the investigation of antecedents and bingeing behaviour. Included in this study was an examination of participants’ complaints and suggestions for improvement of the program.

Like the participants in this study, in researching this thesis I have learnt a great deal about eating disorders and my own issues with eating in the process. Unfortunately, knowledge alone does not solve the problem, and existing treatment programs rarely result in complete recovery. Eating disorders remain a major problem in society, and are steadily growing throughout the world and appearing in increasingly younger populations. They are persistent in nature, complex in treating, and result in much suffering. In some cases, they are fatal. It is therefore imperative that research in this area continues, to more fully understand the complexity of eating
disorders with the aim of delivering more effective treatments, and to
determine suitable prevention strategies.

The results of this study present many potential future research and
treatment directions, both for eating disorder research in general, and for the
MEG program. The findings of this thesis cannot make definitive claims
about eating disorders or the MEG program, but are best interpreted as
complementing the existing knowledge of eating disorders, and providing a
foundation for future studies and treatment methods to build on.
References


Appendix A

Information Letter and Consent Form
Information Letter

A Qualitative Evaluation of 'MEG':
A Group Treatment Program for People with Binge Eating Problems

This letter provides important information in relation to the MEG qualitative evaluation project. Please read this information carefully before deciding whether you wish to take part in the current project.

Evaluating programs such as MEG are essential to enable researchers and clinicians to understand what constitutes successful treatment of binge eating and related problems, and whether current programs are successful in meeting these goals. The author of the MEG program, Dr. Naomi Crafti, is committed to providing the best possible program to clients, and therefore evaluation is an important part of the treatment process. Your evaluation will help ensure the provision of successful and well-integrated treatment programs in the future. While the MEG program itself contains measures of evaluation (questionnaires), this project is an independent evaluation, and is separate from the program, and, therefore, the convenors of MEG will not have access to any information relating to this project. Participating in this project gives you the opportunity to provide a much richer, more detailed and more individualistic evaluation of the program. It also allows the freedom to discuss aspects of the program that may not be possible within the confines of a structured questionnaire.

Requirements for participation in the current project include a commitment to participate in 2 audiotaped interviews, each approximately 1 hour in length. The first interview will occur prior to commencement of the MEG program. The purpose of this initial interview is to gather background information, and to ascertain goals and expectations of the MEG treatment program. The second interview will occur approximately 3-4 months after completion of the program. The purpose of the second interview is to evaluate the program.

As a participant in this project, the confidentiality and anonymity of your interview material is assured. This material will be given a code number to ensure anonymity, and only the Principal and Associate Investigator will have access to your personal information. All material collected as part of this study will be kept locked up and will only be seen by the senior researchers. Results of the evaluation will be used for the purposes of research only and, if published, will contain no identifying information.

If you decide to participate, you are free to withdraw your consent and discontinue participation in the study at any time. Further, if you have any questions or concerns in relation to the project, you are encouraged to contact the Principal Investigator, Dr. Naomi Crafti of the School of Social and Behavioural Sciences, Swinburne University of Technology. Further, if you have any query or concern that the investigators have been unable to satisfy, please contact:
The Chair, SBS Research Ethics Committee  
School of Behavioural Sciences, Mail H24, PO Box 218  
Swinburne University of Technology, Hawthorn, Victoria, 3122

If you have a complaint about the way you were treated during this study, please write to:

The Chair, Human Research Ethics Committee  
PO Box 218  
Swinburne University of Technology, Hawthorn, Victoria, 3122

If you are satisfied with the commitments of this project and are willing to participate, please complete the attached informed consent letter. We appreciate your expression of interest in this project.

Yours Sincerely,

Dr. Naomi Crafti  
Principal Investigator

Ms. Fiona Robertson  
Associate Investigator
Consent Form

I __________________________________________
of________________________________________

have read and understood the information in the attached letter, regarding the project: A Qualitative Evaluation of 'MEG': A Group treatment Program for People With Binge Eating Problems. Any questions I have asked have been answered to my satisfaction.

I agree to participate in this study and understand that I am free to withdraw at any time.

I agree that the interview may be recorded on audiotape as data on the condition that no part of it is included in any presentation or public display.

I agree that research data collected from the study may be published or provided to other researchers on the condition that anonymity is preserved and that I cannot be identified.

________________________________________
Signature

________________________________________
Date

Principal Investigator: 
Dr. Naomi Crafti
9214-5355

Associate Investigator: 
Ms. Fiona Robertson
9867-6574
Appendix B

Interview Questions
Interview Topics and Questions

First Interview:

- What brought you to the MEG program?
  Prompts:
  Specific concerns
  Specific issues surrounding food
  Any other related issues (triggers?)
  Any other psychological/psychiatric problems; any other problems sought counselling for?

- What have you tried previous to MEG for eating behaviour?
  Prompts:
  What worked, what didn’t?

- Tell me about the first time you noticed you had issues with eating and food
  Prompts:
  Binge eating symptoms
  What else happening in life at time (situation, relationships [family, friend/peer, romantic])

- From that time have your eating problems remained constant over time, or have their been times, or a time, in your life when you felt less bothered, or perhaps not bothered at all by these issues?
  Prompts:
  Tell me about those times - what was happening in life
  Situations, relationships, feelings associated
  Why do you think you were not/less bothered by your eating behaviour at this time?
- What's happening in your life right now?
  Prompts:
  Situation, relationships

- Family History (briefly)
  Prompts:
  Parents
  Demographics, characteristics of relationship with parents (always been the same, or changed over time?)
  Siblings
  Demographics, characteristics of relationship with sibs (always been the same or changed over time?)

  Anything else you feel is relevant about family or childhood history?

- Romantic Relationship History (briefly)
  Prompts:
  Patterns/characteristics of relationships

- What are your expectations and hopes of MEG?
  Prompts:
  What are you hoping to get out of it? What would you like to have changed/improved? What would you like to be able to tell me in 6 months time (after completion of the program)?
  End result/goals and aspirations for the program
Interview Topics and Questions
Second Interview

- Remind participant of their stated expectations, goals and aspirations from the first interview. Interviewer will go through goals one by one to determine if participant labels these goals as met, and to discuss in terms of the effect MEG had on reaching these goals.

- Participants will be asked: “Was MEG a success for you?” and to explain why, or why not.

- Interviewer will go through a summary of individual components of the program with the participant, which will be used as a prompt for the participants. Participants will be asked to go through the list and discuss individual components in terms of what they found helpful/not helpful, effective, or difficult, and why; changes they have made, behavioural and cognitive, in particular areas, and areas they are still struggling with; and to discuss the most meaningful moments to them.

- Participants will be asked to discuss any complaints or suggestions for improvement for the program.
Appendix C

DSM-IV-TR Diagnostic Criteria for Eating Disorders (APA, 2000)
Diagnostic Criteria for Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:

1. eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
2. a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviours occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify type:

Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

Nonpurging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.
**Diagnostic Criteria for Eating Disorder Not Otherwise Specified**

The Eating Disorder Not Otherwise Specified category is for disorders of eating that do not meet the criteria specific Eating Disorder. Examples include:

1. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual’s current weight is in the normal range.
3. All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
4. The regular use of inappropriate compensatory behaviour by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
Diagnostic Criteria for Anorexia Nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Specify type:

*Restricting Type*: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

*Binge-Eating/Purging Type*: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)
Appendix D

Program Summary