DEVELOPMENT, IMPLEMENTATION, AND ASSESSMENT OF AN EATING DISORDERS PROGRAM IN THE WORKPLACE

by

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ABSTRACT

The topic of eating disorders, compulsive eating, anorexia and bulimia has been ignored for decades and few of the resources or studies have acknowledged the needs of this population. The literature and studies have also ignored the probable loss of productivity and increased cost of health benefits to the employer by this segment of the working population.

A descriptive study was conducted to discover the needs of this targeted population and develop, and implement a program in response to these needs. The goal: Assist EAPs in establishing guidelines for this population. The hope for assisting the eating disordered is that employers will see recovery measured by increased productivity, decreased doctor visits, decreased absenteeism and lower health benefit costs.

A large company of 860 employees was selected to be presented a lecture on eating disorders at a monthly wellness program. Only 14 employees chose to hear the presentation. None of these employees would agree to participate in a worksite program.

Consequently, a program was implemented at a mental health agency with 70+ employees. Only 6 employees chose to participate in the 12 week program which was implemented and completed in December 1991.
This research study is dedicated to my family without whom this project would not have been possible. My mother, Dean O'Leary, has provided me a supportive environment and has a constant desire to see me succeed. Cathryn Olson, Sandra Dean, and Francesca Wolfe at TriCity Behavior Services have been understanding and supportive throughout my educational pursuit. The person who initially encouraged my pursuit for an advanced degree, Penny Starkey of East Valley Camelback Hospital, is an instrument. My friend, fellow co-worker and fellow student, Barbara Rabe, has pushed and pulled and cheered me on, too. Thanks Barb! Dr. Mark Rossman and Dr. Sherwin Snyder of Ottawa University and my typist/editor, Jane Daniel, have worked tirelessly in this endeavor. Thank you all! I am forever grateful to you. It is my intent that this paper will more clearly define eating disorders and raise the awareness of EAPs in order to establish a workable program for employees. I also hope that it will serve as a small resource for addictions therapists in their clinical treatment of this pervasive issue.
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Chapter 1

INTRODUCTION

Eating disorders are affecting employees in the work force which, in turn, affects the quality of work, interpersonal relationships with both superiors and co-workers and the cost of health care (including sick leave) which ultimately affects the "bottom line" PROFIT. In order for companies to remain competitive in the marketplace both nationally and internationally, employers need to use all effective means to do so.

BACKGROUND TO THE PROBLEM

As our country approaches the year 2000, we are faced with major changes in the demographics of our work force. Sixty percent (60%) of women over age 16 will be in the work force, which will be 51% of the total labor force (Van Den Berg, 1991, p. 41-58).

This change is complicated by the fact that, as more women fill the ranks, companies employing these women will have different demands for their health benefits, wellness programs, and flex-time as they try to balance family and career.

As demands increase, so do stressors; as stressors increase, so do health problems, as well as coping skills
which often are dysfunctional. Psychologists agree that compulsive behavior and addiction are common responses to stress. Alcoholism and drug addiction permeate through all companies and at all levels from line staff to CEOs. Employee Assistance Programs (EAP), both internal and external, focus on the need for rehabilitation of these addicted employees. The disease of alcoholism affects many Americans. As the next generation of workers enters the job force, the numbers of addicted will likely increase. Whether actual chemicals are involved or simply the addictive, compulsive behaviors learned from the prior generation, it will be a phenomenon EAPs will want to be prepared to tackle.

Defining compulsive, addictive behaviors or substances needs to include eating disorders, which typically is a women's issue, although men do represent a small number of these disorders. Anorexia nervosa is said to be represented by 95% women, bulimia 20% women. Only 1% to 13% of these disorders are represented by men. Bulimia and anorexia frequently coexist (International Journal of Eating Disorders, 1990, p.111). Obesity, often not considered an eating disorder, touches millions of lives.

The eating disordered person's life is affected in all areas, but a company's concern necessarily needs to be in the area of productivity, lost days at work and health care costs.
A recent survey of group health insurance costs reports the cost increased to business by at least 10% in 1990 over the previous year (Huth, 1991, p.32). The wave of the future is managed health care; however, in 1990 only 10.9% of health care premiums were labeled managed health care. CEO perceptions, according to a 1990 survey of HMOs vs PPOs, state that 65% of the companies are headed for managed health care or HMOs. Broker/consultants anticipate that 7 of 10 clients will select HMOs in the next year (Anderson, 1990, p. 18-22).

Employees with eating disorders most often need both medical and psychological care in order to arrest the disorder. Behavioral benefit costs through HMO coverage is increasing rapidly. In 1989, an average cost to the employer was $288 a year, compared to $175 per year the previous year.

HMOs have limited their liability for costs of treating mental disorders and substance abuse. The typical limitation is 20 visits out-patient and 30 in-patient days. John C. Erb, author of the Foster Higgins survey sees this as a 'quick fix' approach to cost management and may prove to be short-sighted (Caldwell, 1991, p. 11-22).

If the employer wants to maintain and retain an eating-disordered employee, the above-mentioned coverage is clearly too limited. Eating disorders are best treated with
on-going, long-term support from medical doctors, mental health care, and support groups. This, too, applies for alcoholism/chemical dependency.

A tightening of the belt for health insurance costs has a different meaning for employee and employer. Companies are trying to trim their budgets and encouraging healthy lifestyles and are giving financial incentives to pursue these changes. The wellness approach can be used in the on-going treatment of the eating disordered employee who would need to agree to certain criteria in order to receive a discount in health care benefit costs.

Financially, companies and their employees would be healthier if an on-going program for healthy lifestyles were to be put in place. Potentially insurance costs would decrease; absenteeism would decrease; productivity would increase. Most importantly, a happy, healthy person increases the likelihood of being a more contented, energetic, healthy employee. The trend currently and hopefully in the future is toward the concept of an employee being the most valued and valuable asset to a business. The climate of the working environment that projects this image cannot ignore or discount the pervasiveness the effects an eating disorder has on an employee, both personally and on the job.
It is becoming increasingly apparent that female employees will represent the majority of the work force by the year 2000. Can we ethically ignore their needs? Perhaps the larger question needs to be: "Can companies financially afford not to address their needs?" One of those needs happens to be related to self-esteem; societal norms for the way women look, their weight, etc. Job satisfaction begins with being personally satisfied. People engaged in addictive, self-destructive behaviors (specifically eating disorders) will benefit by the dysfunction being addressed, treatment provided and support given by the employer.

A company with 70% of its work force represented by females reported 61% of all employees have qualified for the discounted health care cost by demonstrating healthy lifestyles. This demonstrates a savings of $180 a year in health care costs per employee. Ninety-six percent (96%) of all employees who applied for the healthy lifestyle discount were successful.

The company using the incentive states healthy lifestyles decreased their overall medical claims because 10 to 20 percent of their claims are attributable to smoking, obesity and inactivity (Archer, 1991, p. 42-49).

**STATEMENT OF THE PROBLEM**

It is apparent then the eating disordered employee is potentially increasing the cost of health benefits and
affecting productivity which translates to loss for the employers.

As the number of women increase in the workforce, so does the incidence of eating disorders. Just as alcohol and drug dependency has been a focus of EAPs, so does another facet of compulsive behavior need to be acknowledged and addressed.

Can EAPs continue to ignore that segment of the population when obesity alone affects 25 percent of the 248.7 million residents of the United States according to the 1992 Information Please Almanac and Yearbook (p. 797)? Bulimia is affecting 19 percent of the college women in the United States and anorexia is estimated to affect one per 100,000 in the general population and one in 200 in caucasian adolescent girls (Schroeder, et al., 1992, p. 955&957).

One essential tool is an Employee Assistance Program (EAP) either internal or external. A major area of concern for the EAP is addictions and/or addictive behaviors, which in the recent past has not included eating disorders.

**STATEMENT OF THE PURPOSE**

The purpose of this study was to develop, implement, and assess an eating disorders program in the workplace.

**SIGNIFICANCE OF THE STUDY**

The agency where the program was implemented treated addictions (drug, alcohol, gambling, sex, nicotine, work,
relationship) but not eating disorders as an addiction. The concept was certainly not new as many in-patient facilities throughout the nation have included eating disorders as part of their addictions treatment. The approach helped broaden staff and therapists’ concept of eating disorders as an addiction, not a lack of willpower or a moral dilemma. The end result of the study was a broader perspective on an age-old problem.

LIMITATIONS OF THE STUDY

The primary limitation of the study was the small number of participants in the study.

Another limitation was the inability of the researcher to put in place an external positive reinforcement for completion or participation as is highly recommended by the literature on wellness programs.

Also, a primary component, exercise, was not offered in the study, only strongly encouraged by the researcher. Literature encourages companies to either provide exercise on the premises or contract with an established health facility.

DEFINITION OF TERMS

Eating Disorder: Characterized by gross disturbances in eating behavior; includes Anorexia Nervosa, Bulimia Nervosa, Pica, and Rumination Disorder of Infancy.
"Simple obesity is included as a physical disorder, and is not in this sections since it is not generally associated with any distinctly psychological or behavioral syndrome; however, when there is evidence that psychological factors are of importance in the etiology or course of a particular case of obesity, this can be indicated by noting Psychological Factors Affecting Physical Condition" (DSM-III-R, 1987, p. 71).

Eating Disorder Not Otherwise Specified:

Disorders of eating that do not meet the criteria for a specific eating disorder:

Examples:
(1) A person of average weight who does not have binge eating episodes, but frequently engages in self-induced vomiting, for fear of gaining weight.
(2) All of the features of anorexia nervosa in a female except absence of menses.
(3) All of the features of bulimia nervosa except the frequency of binge eating episodes.

Anorexia Nervosa: The essential features of this disorder are: refusal to maintain body weight over a minimal normal weight for age and height; intense fear of gaining weight or becoming fat, even though underweight; a distorted body image (DSM-III-R, 1987, p.65).

Bulimia Nervosa: The essential features of this disorder are: recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time); a feeling of lack of control over eating behavior during the
eating binges; self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain; and persistent overconcern with body shape and weight (DSM-III-R, 1987, p.67).
Chapter 2

LITERATURE REVIEW

EATING DISORDERS

The pervasiveness of eating disorders and complications that arise from these disorders have surfaced in several disciplines. Psychiatrists, psychologists, therapists, sociologists and medical doctors have attempted to educate the public regarding the growing numbers of eating disordered people suffering physically, socially, and emotionally. The literature discusses the etiology, demographics, behavioral symptoms, psychological findings, physical complications and treatment approaches. The information, scarce in the literature, is how the eating disordered person is affected and being affected in the work world. What effect does the eating disordered employee have on productivity, absenteeism and health insurance costs? Would treatment specifically geared to the eating disordered in the workplace be successful? If so, how does a company implement the program? What right, if any, does an employer have in tackling this issue?

The majority of the studies have been documented in the area of psychiatry as the eating disordered person presents a chronic history with a poor prognosis for recovery. Friends and family seek help for that person and most often end up consulting the psychiatric community after the
disorder has progressed to a near-fatal condition. Luckily, the media is now exposing the issue. Celebrities, models, doctors and lawyers are coming forth to share their stories. As a result, treatment is beginning earlier in the progression of the disorder which means other disciplines are becoming involved in the search for appropriate, ethical and results-oriented treatment. Because eating disorders are propelled by a myriad of issues, the treatment, too, needs a myriad of approaches.

Significantly, eating disorders affect more women than men. Anorexia nervosa is represented by 95% females; bulimia 20% females (Kossoy, 1991, p. 46-49). Compulsive eating does not discriminate. An estimated 60 to 70 million people in the U.S.A. are probably compulsive eaters equally represented by men and women. Thirty four million of the people in the U.S.A. are overweight.

Women will be representing the majority in the workforce by the turn of the century. Sixty percent of women over age 16 will be in the labor force. Women will represent 51% of the labor force by the year 2000 (Van Den Bergh, 1991, p. 41-58).

An analysis of these changing statistics indicates female employees will be a population to consider and so, too, will their specific issues necessitate changes for employee
assistance programs. Notwithstanding is a very real issue for women -- eating disorders.

"Eating disorders are the hidden disease of the 80's and 90's as alcoholism and drug addiction were in the 60's and 70's. We are only now seeing the tip of the iceberg. Unfortunately, before this increased awareness occurs, things will most probably get worse before they get better. My prediction and hope in the future is that by the end of the 1990's a woman will be allowed to look like a woman," according to William C. Rader, M.D. (1991, p.6 & 7).

Dr. Rader predicts that during the 1990's we will most likely see a significant number of people dying of anorexia and bulimia. Like alcoholism, through greater understanding, there needs to be more dignity for those suffering from an eating disorder which ultimately means offering more and more eating disordered people treatment.

Bulimics binge/purge to cope. They suffer from guilt, shame and depression. They have medical complications such as stomach ruptures, electrolyte abnormalities, rotting teeth, amenorrhea and fatigue.

A study at Arizona State University for bulimic women found that bulimia occurs most often in women in their late teens and early twenties and have implemented a program on campus which has been very successful according to Lillie Weiss, Ph.D. (1991, p.6). These women at A.S.U. will soon
be in the workforce and because eating disorders are an on-going issue, that behavior will necessitate further treatment. Simply graduating does not end the eating disorder. Will EAPs be ready to help these women?

Anorexia nervosa is affecting one in every 100 to 200 young women with the highest incidence in 16 to 18 year olds with middle to upper class backgrounds. Once profoundly underweight, other signs will appear such as hypothermia, bradycardia, hypotension, edema, and lanugo. The anorexic denies how much they eat and often dispose of food they are offered. Bulimia and anorexia frequently co-exist.

Liliana R. Kossoy, M.D. establishes guidelines for treatment to include nutritional counseling, psychotherapy, medical evaluations, antidepressants and family therapy. Weight and abnormal lab results should be monitored carefully (Kossoy, 1991, p. 46-49).

Obesity is defined as being 15 to 20 percent overweight. Forty seven percent of women are obese by age 50. Health risks include hypertension, diabetes, heart disease, strokes, arthritis, gallbladder disease and circulatory problems. This list doesn’t include the feelings of low self-esteem, shame, guilt, self-hatred and hopelessness. "Yo-yo dieting, a common phenomenon, is gaining and losing weight over and over again which increases the feelings of hopelessness" (Minirith, et.al., 1990, p.328).
Anorexics are thin and usually wear baggy clothes to hide it, frequently have health and relationship problems, yet see themselves with distorted vision.

Bulimics binge/vomit or use other methods of purging sometimes in excess of five or six times a day and often declare the binge won’t happen again - and it does over and over again.

This behavior or reality, does not travel the world of nonreality alone. Spouses, children, relatives, friends and employers often help build the denial and most certainly develop patterns of denial of their own to close their eyes to destructive progress of their loved-one’s behavior or disease.

**MANAGED HEALTH CARE**

Managed health care is a trend of the future. Employers' goals are to have the least amount of cost for the best coverage available and continually seek ways to trim their budgets. Employers nationwide have been experimenting with non-intrusive, non-judgmental methods of promoting weight control among their employees. A Dallas-based company with 1,900 employees has offered discounts to employees on their portion of health care premiums by producing evidence of a healthy lifestyle. The program is similar to a wellness program, but the major difference is
the employees' right to voluntarily submit and receive the discounts. The company hopes the approach will significantly decrease the number of claims (Archer, 1991, p. 42-49).

Many other large companies have switched to managed health care coverage. Allied-Signal's health care bill was projected to reach $613 million by 1990. Instead the cost was kept to $360 million. Between March 1988 to February 1991, premiums increased annually less than 10%. Employees' average cost per year decreased from $3,200 to $2,700 under the managed care plan. Because there are 70,000 employees nationwide, the plan offers a large network of providers through CIGNA with whom Allied-Signal just signed its fourth one-year agreement (Santora, 1991, p. 40-41).

Major other corporations such as IBM, AT&T, General Motors, Sears, Southern California Addison and Citibank provide employees with managed health care.

According to a February 1991 survey conducted by Olsten Corp., 79% of 597 businesses surveyed now require employee contributions of $5 to $50 or more to monthly health insurance premiums. Sixty-one percent of the companies surveyed reported that their share of the cost of health plans rose more than 10% over the past year. 'Cafeteria plans' (employees select their benefits from a menu of
choices) were being used by 35% of the companies (Fields, 1991, p. C1).

"The workplace is fast becoming a war zone of stress," according to Gregory J. Wilcox of the Los Angeles Daily News (Wilcox, 1992, p. F1-F5). Wilcox's article goes on to describe how the recession is fueling stress in the workplace. The concerns are so great that job performance, health and private lives are being affected.

Management and support staff (white collar workers) will account for nearly 70% of the stress claims filed in 1991. In California alone the total claims are estimated to number between 10,000 to 11,000.

"Overeating is a real primal way of filling onself up," states John Gerstenfeld of the California Workers' Compensation Institute, a non-profit consulting firm in San Francisco (Wilcox, 1991, p. F1-F5).

Because eating disorders often necessitate treatment from several disciplines, companies would do well to concern themselves with insurance coverage and potential changes the increasing population of women in the labor force will soon represent.

As eating disorders progress, hospitalization is often the treatment modality dictated. Yet almost all hospitals surveyed (86%) said discharge was requested too early in the treatment progress if the insured were covered by managed
health care. The responding hospitals said reviewers responsible for continued care approval lacked psychiatric/substance abuse expertise. As a result about 51% of patients leave the hospital against medical advice because insurance coverage ceases (Anderson, 1990, p. 18-22).

If, by chance, the eating disordered person seeks help before hospitalization, they often find that coverage for mental health is limited most often to 20 out-patient visits per year. "This is a 'quick fix' approach and in the long-run affects both employer and employee" (Caldwell, 1991, p. 11-22). Eating disorders are chronic and treatment from the medical and psychiatric disciplines are necessary to insure recovery.

WELLNESS

As health care costs escalate, companies nationwide are attempting to save money, increase morale and improve productivity by encouraging their employees to live healthier lifestyles. More than two-thirds of America's businesses with 50 or more employees have some form of health-promotion program, according to Wellness Councils of America (WELCOA), a national non-profit organization that offers support services to community wellness councils. Robin Hanus, Director of Member Services for WELCOA states: "In the '80's people thought wellness programs were just a fad. Now
they're finding that for companies who have success with it, their health care costs are remaining flat while other companies’ costs are continuing to rise" (Schlosberg, 1992, p. 85).

Employers can make a difference by organizing and contributing to the cost of inside and outside programs. "There are a lot of creative things you can do," states Carrier (Schlosberg, 1991, p. 85).

Koss Corporation of Milwaukee, Wisconsin paid for employees to attend Weight Watchers. When employees lost a combined 2,000 pounds the company threw a 'ton party' (Schlosberg, 1992, p. 85).

Coors Brewing Company of Golden, Colorado made available to employees mammograms, a cardiac rehabilitation program and a 25,000 square-foot gym with treadmill, weight equipment and step aerobics classes. Coors offers an extra 5 percent of health insurance coverage to employees who fill out a health-risk appraisal, wear seatbelts, exercise regularly, and stay within a certain weight range (Schlosberg, 1992, p. 85).

Central State Health and Life Insurance of Omaha, Nebraska encourage employees to walk 100 miles in 100 days and can then have a chance to win a $100 lottery (Schlosberg, 1992, p. 85).
Conoco, Inc., a Huston-based oil and gas company takes an entirely different approach to wellness. Instead of promoting wellness, the traditional program resulted in yo-yo dieting and low self-esteem. The radical new concept: you can lose weight and stay fit if you abandon diet, scales and exercise goals and just listen to your body’s desires. Employees sample new foods, learn new preparation techniques and take innovative supermarket tours where no aisle is considered good or bad. "By teaching people in these ways we're calming a lot of their stress and anxiety," according to Karen Carries, M.E.d., senior consultant for Conoco’s employee wellness programs (Schlosberg, 1992, p. 85).

It’s not clear which approach works best at Conoco, Inc., who abandoned the traditional approach after three years of disastrous results. The results are just beginning to be tracked.

WELCOA urges all companies, big and small, to start wellness programs. Koss has a budget of $4,000 for 250 employees. Coors spends $600,000 a year for 10,000 employees.

WELCOA welcomes inquiries on how to start wellness programs; call (402) 444-1711 or write WELCOA, 1823 Harney St., Ste. 201; Omaha, NE 68102.

Terry Kellogg and John Friel, experienced in the area of treating adult children of alcoholics and codependency,
suggest there are two missing links in wellness programs. First, programs often lack grass-roots employee involvement and support. Second, wellness programs must do more to address the family systems dynamics that create and later maintain unhealthy lifestyles as well as addictive, compulsive, and self-defeating behaviors (Pape, 1989, p. 37-43).

A wellness program more often than not consists of an exercise component. In fact, the fitness craze is in full swing according to Anita Carcone in an article written for The Arizona Republic/Phoenix Gazette. She discussed the city of Tempe, Arizona wellness program which uses the Police Department’s workout facility and the ASU aquatic center. "People are incorporating fitness into their lifestyle more now than ever" (Carcone, 1991, C8).

A word of caution in implementing exercise into an eating disorders program is that bulimics exercise to a point of self-destruction. According to William C. Rader, M.D., "They use exercise as a form of purging the large amounts of food that they may have eaten... but when it (exercise) takes on a life of its own, it can become as addictive as cigarettes, alcohol or drugs" (Rader, 1991, p. 6-7).

The compulsive overeater on the other hand under-utilizes exercise and it becomes a challenge to not only motivate the obese to begin an exercise program, but to implement a
program that the obese person can physically do. Close monitoring of pulse rate, doctor’s permission, and a waiver to keep the company free of liability is essential.

SELF-HELP GROUPS

Self-help groups such as Overeaters Anonymous, Alcoholics Anonymous, Co-dependent’s Anonymous, and Adult Children of Alcoholics can be encouraged at the work site by the EAP professional. Kathleen Batesole, MA, MFCC, CEAP who has worked in the EAP field for the past 12 years, reports that she and a co-worker began a co-dependent assessment group at University of California at Los Angeles (UCLA). Part of the commitment to participate in this group was to attend at least three 12-step groups. She sees the clients begin to break through their denial and recognize their feelings, thought patterns and behavior. She finds incorporating the 12-step experience into the group requirement has offered "an exciting addition to the practice of traditional forms of EAP core technology" (Batesole, 1991, p. 22).

Another article by Nan Van Den Bergh encourages self-help groups at the work place. She reports it as "valuable adjunctive resources" (Van Den Bergh, 1991, p. 41-58). The article sees the benefit because employees have access to peers with whom they can identify as being 'like them,' either through experience or status and be less likely to
experience alienation and demotivation as well as being more able to handle stress that could interfere with job performance.

Guterman and Shulman (1986), noted the following positive implications for workplace support groups in Van Den Bergh's article:

1. Sharing data
2. Engaging in dialectical dialogue
3. Discussing taboo subjects
4. Being "all-in-the-same-boat"
5. Experiencing mutual support
6. Experiencing mutual demand
7. Problem-solving and rehearsal
8. Feeling strength-in-numbers

"Mutual and self-help groups have considerable roles as problem prevention methods as well as early intervention system" (Van Den Bergh, 1991, p. 41-58) "and have been likened to extended families."

Douglas W. Jones, Jr., CEAP interviewed by EAP Digest (Hearle, 1990, p. 36-42) stated: "I believe that 12-step programs are truly a gift from God given to Doctor Bob and Bill W. (founders of Alcoholics Anonymous). These programs help us develop our spiritual side. If we truly want to grow to our fullest potential, we must look at our spiritual needs, and 12-step programs are a good place to start."

**EMPLOYEE ASSISTANCE PROGRAM (EAP) CONSIDERATIONS**

Can the eating disordered employee be approached and treated like the alcoholic by an EAP? The answer is only if
the job performance is being affected by the disorder. These include poor job performance, misconduct, absenteeism, and/or long-term absence. "In these instances disciplinary action may only be dealing with the symptoms of an employee's behavior rather than the underlying cause. Where there is no medical advice to support frequent self-certified absences, the employee should be asked to consult a doctor to establish whether the underlying reason for absence is work related" (Fenlay, 1990, p. 34-42).

"Every employee assistance program practitioner has faced clients who are operating within elaborate and carefully constructed walls called denial. Denial is part of a general human reluctance to confront unpleasant issues" (Barrasso, 1991, p. 17-61). This statement was made regarding alcohol and other drug addictions.

Can it not be true of the eating disordered? Denial is being unable to recognize/own a problem despite clear evidence of the problem's existence. Obese people buy larger sizes, deny health and relationship problems and more often than not appear stereotypically "happy, jolly and fat." The cycle of weight gain/loss and binge eating goes round and round.

"The EAP practitioner, by virtue of his or her unique vantage point is in a position to help dismantle carefully
constructed walls of denial and to plant seeds of truth" (Barrosso, 1991, p. 17-61).

The EAP counselor can help alleviate anxiety in the initial session by setting a relaxed tone, paying attention to body language, obtaining a thorough history and making a careful diagnosis. Give the client an impression of competence, understanding, and knowledge of available resources. An employee wants the problem solved as soon as possible. The EAP counselor needs to explain that only by fully understanding the problem will they be able to work toward a solution. The counselor must refrain from being judgmental.

EMPLOYEE ASSISTANCE PROGRAM (EAP) GOALS

To stay on track the counselor needs to concentrate on five areas:

"Affect" - a person's outward, visible aspects.

"History" - place of birth, family patterns, religious affiliations, school and work history, traumatic experiences (and at what stage of development those experiences occurred), and whether the employee has experienced addiction or mental illness.

"The Problem" - half the cure is getting to the real problems and seldom is it stated in the first session. It is best to wait until the second or third session to delve
into troubling issues. This researcher's opinion is that it takes at least three sessions for the employee to feel safe enough to disclose a possible eating disorder due to denial and shame.

"Diagnosis" - EAP professionals place the diagnosis into six categories: depression/anxiety, addiction, marriage/family, personality, financial, and legal. A client probably has more than one category but one will be primary and the others secondary. The statement as to how the counselor sees the primary problem needs to imply that counselor and client are partners in dealing with the issues so the employee will be motivated to change.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) needs to be a working tool used by the EAP professional.

"The Prognosis" - indicates whether the employee is capable of change, is willing to change, and has sufficient resources available to change.

A successful EAP counselor possesses powers of persuasion, the ability to align with the client, the ability to read a client's thoughts, and a thorough knowledge of various psychological disorders (Fallon, 1991, p. 30-59).

The initial evaluation should be performed with the thought of possible referral for treatment. The counselor may have to be creative in developing ideas for motivating
clients as well as a host of referral sources including county mental health centers for employees with no means of payment.

CRITERIA FOR EMPLOYEE ASSISTANCE PROGRAM (EAP) ASSESSMENT

Criteria for eating disorders should be familiar to the EAP counselors. The following criteria is from the (DSM-III-R, 1987, p.65, 67 & 71).

DIAGNOSTIC CRITERIA FOR ANOREXIA NERVOSA 307.10

A. Refusal to maintain body over a minimal normal weight for age and height, e.g., weight loss leading to maintenance of body weight 15% below that expected, or failure to make expected weight gain during period of growth, leading to body weight 15% below 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, size or shape is experienced, e.g., the person claims to "feel fat" even when emaciated, believes that one area of the body is "too fat" even when obviously underweight.

D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g. estrogen, administration).

DIAGNOSTIC CRITERIA FOR BULIMIA NERVOSA 307.51

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).

B. A feeling of lack of control over eating behavior during the eating binges.
C. The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.

D. A minimum average of two binge eating episodes a week for at least three months.

E. Persistent over-concern with body shape and weight.

**DIAGNOSTIC CRITERIA FOR EATING DISORDER NOS 307.50**

A. A person of average weight who does not have binge eating episodes, but frequently engages in self-induced vomiting for fear of gaining weight.

B. All of the features of anorexia nervosa in a female except absence of menses.

C. All of the features of bulimia nervosa except the frequency of binge eating episodes.

**ANOREXIA BEHAVIORAL SYMPTOMS**

Each patient manifests a complex set of abnormal behaviors, which are the result of multiple influences. Some of the most frequent problem behaviors are:

1. Can't "live with" food or "live without" it.
2. Avoid eating food but are often involved in food preparation, urging others to eat heartily.
3. They may collect cookbooks and recipes.
4. Avoid eating anything with calories.
5. Exercise strenuously, even when inappropriate, with a driven quality.
6. Become more immature interacting socially, i.e. stop dating or abandon good friends.
7. Social skills become profoundly deficient.
8. Anorectic patients often have no interest in, or disgust at pubertal changes, and this tendency become more severe as weight loss, hormonal regression, preoccupation with food and weight issues, social immaturity, and chronic illness progress.
9. Female patients are amenorrheic and experience loss of vaginal secretions and dyspareunia.
10. Male patients manifest decreased sexual interest, impotence and oligospermia.

ORIGINS OF MEDICAL SYMPTOMS OF ANORECTIC PATIENTS

1. Starvation
2. Purging by vomiting, diuretics, laxatives
3. Compulsive exercise
4. Stimulant medications for appetite reduction
5. Illnesses secondary to starved state
6. Iatrogenic—birth control pills, appetite stimulants

THEORIES OF THE CAUSES OF ANOREXIA NERVOSA

<table>
<thead>
<tr>
<th>Theory</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologic</td>
<td>Defense against anxiety, especially psychosexual issues</td>
</tr>
<tr>
<td>Social</td>
<td>Diet fads, cultural emphasis on slimness</td>
</tr>
<tr>
<td>Family</td>
<td>The identified patient is the expression of an ill family</td>
</tr>
<tr>
<td>Biologic</td>
<td>Hypothalamic disorder</td>
</tr>
<tr>
<td>Learning</td>
<td>Anorexia behavior is the result of understandable behavior</td>
</tr>
<tr>
<td>Developmental</td>
<td>Anorexia is a coping response to feeling overwhelmed by maturational</td>
</tr>
<tr>
<td></td>
<td>crises</td>
</tr>
</tbody>
</table>

DIFFERENTIAL DIAGNOSIS OF ANOREXIA NERVOSA

A. Medical
2. Endocrine: Hyperthyroidism, Addison’s disease, hypopituitarism, diabetes mellitus.

B. Psychiatric
1. Depression, with loss of appetite and weight.
2. Schizophrenia, with delusions of food contamination.
3. Psychogenic dysphagia and globus hystericus.
IN-PATIENT TREATMENT OF ANOREXIA NERVOSA

INDICATIONS FOR HOSPITALIZATION OF ANORECTIC PATIENTS

1. Low weight (loss of more than 25% of body weight, or a lower percentage loss if rate of loss is very rapid).
2. Low serum potassium level from self-induced vomiting and/or diuretic/laxative abuse.
3. Low mood (e.g. suicidal thoughts or intents).
4. "Low" results (failure to respond to a well-designed outpatient treatment for at least several months).
5. A discouraged, demoralized family or lack of any local outpatient facilities having experience with the treatment of anorexia nervosa.

PRINCIPLES OF OUT-PATIENT TREATMENT OF ANOREXIA NERVOSA

1. Good record keeping is essential.
2. Restoration of normal weight should occur at a moderate rate: 1-2 lb/wk.
3. Relapse and plateaus are common.
4. Treatment should keep a balance between nutritional rehabilitation and psychotherapy.
5. Socialization is encouraged at all stages of treatment.
6. Age and psychologic maturity determine the choice between individual and family treatment and the specific kind of psychotherapy.

BULIMIA OVERVIEW

1. Increased incidence but exact frequency in population unknown.
2. Variable relationship to anorexia nervosa: may be chronic sequel to previous anorexia or new onset. Shared psychopathology.
3. Clinical symptoms are prominent, especially associated with low serum potassium and gastrointestinal problems.
4. Psychologic distress common: increased severity and/or increased sensitivity to dysphoric states.
5. Behavioral abnormalities common.
6. Indications for hospitalization are the same as for anorexia nervosa, with added behavior that is out of control.

7. Treatment foci: Abnormal behavior, demoralization, underlying psychologic conflicts and personality features.

8. Binges are often initially a response to hunger but generalize to become self-medication for uncomfortable mood states.

**CHARACTERISTICS OF BINGE EATING – BULIMIA**

1. Large to enormous amounts of food are ingested: usually sweets or fats predominate.
2. Food is eaten rapidly.
3. Food is eaten without appreciation of taste, texture or quality of food.
4. Consumption is secretive.
5. Onset is triggered by: hunger, social disappointment, unstructured time, boredom, anxiety, depression, anger.
6. Binges are terminated by: abdominal distension, social interruption, gaining control.
7. Binges are followed by: guilt, self-blame, feeling out of control.
8. Methods of purging include: vomiting, diuretics, laxatives.

**COURSE OF BULIMIA**

1. May start at any weight.
2. Often preceded by attempts at food restricting, including classic anorexia nervosa.
3. If preceded by anorexia nervosa, bulimia is sign of chronicity.
4. Initial trigger of hunger becomes generalized, so binge serves to alleviate a variety of emotional distresses.
5. May be associated with a variety of behavioral abnormalities.
6. Specific method of purgation may vary over time.
7. Profound effect on social life, self-esteem, physiologic functioning.
8. Death may be due to hypokalemic alkalosis (cardiac arrhythmia) or suicide.
INITIAL TRIGGERS OF BINGES

Hunger: "Forbidden foods" (for example, some people have always had a hard time controlling consumption of sweets).

SUBSEQUENT TRIGGERS OF BINGES

Hunger and "forbidden foods" PLUS boredom; anxiety; depression; especially social disappointment; inability to experience other pleasures; anger; feeling "stuck".

CATEGORIES OF OVEREATING

Psychiatric Etiology
1. Hedonic bulimia: Pleasurable binge episodes with no fear of fatness. Purging occurs if physically uncomfortable or to repeat the binge (Roman-style binge: "piggling out").

2. Situational bulimia: Ingestion of large amounts of food to alleviate stress; may lead to guilt and dieting, but not purging.

3. Discontinuation of stimulant medications: Patients who stop using diet pills, whether over-the-counter or prescribed, will usually experience hunger. End of an episode of amphetamine or cocaine abuse will lead to extreme hunger.


5. Bulimia nervosa: Patient formerly met weight criteria for anorexia nervosa, and uses vomiting and/or laxative/diuretics after binges.

Medical Etiology
1. Hypothalamic tumors: Destructive lesions of the ventromedial hypothalamus or irritative lesions of the lateral hypothalamus.
2. Prader-Willi syndrome: In infants, a year or two of low weight and poor appetite follow birth; then the patient develops ravenous appetite with no satiety, leading to massive obesity.

3. Increased metabolic demand: Fever, hyperthyroidism, diabetes mellitus with renal spilling of protein and glucose, malabsorption.

4. Iatrogenic: High-dose phenothiazines, tricyclic antidepressants.

**TREATMENT OF BULIMIA: AREAS OF CONCERN**

A. Behavioral therapy addresses:
   1. Abnormal eating pattern
   2. Associated behavioral abnormalities

B. Medical treatment is directed toward:
   1. Lowered weight, if present
   2. Medical symptoms from purging; gastrointestinal problems and metabolic consequences of hypokalemia

C. Psychotherapy addresses:
   1. Psychologic consequences of weight loss
   2. Low self-esteem and demoralization from bulimic practice
   3. Underlying psychologic issues:
      a. Personality characteristics: obsessive, histrionic, and borderline features
      b. Psychodynamic features
      c. Sensitivity to dysphoria
      d. Multiple impulses
      e. Use of binges as all-purpose mechanisms to deal with feelings

**CLASSIFICATION OF ANOREXIA NERVOSA AND BULIMIA**

1. Food Restriction
   a. Mild anorexia nervosa: Loss of less than 25% of body weight, and associated with either loss of periods or preoccupation with thinness (Atypical Eating Disorder in DSM-III-R).
   b. Classical anorexia nervosa: Loss of more than 25% of body weight, fear of fatness, and abnormality of reproductive hormones.
2. Binge and Purge
   a. Normal-weight bulimia (NWB) without a history of anorexia nervosa
      i. Single impulse disordered: Only impulse disorder is bulimia (SID subtype of NWB).
      ii. Multiple impulse disordered: Many impulse disorders, such as alcohol or drug abuse, sexual promiscuity, stealing, and self-harm (MID subtype of BN).
   b. Bulimia nervosa (BN): Weight criteria for anorexia nervosa formerly met, and now associated with bulimic practice.
      i. Single impulse disordered: Only impulse disorder is bulimia (SID subtype of BN).
      ii. Multiple impulses disordered: Many impulse disorders, such as alcohol or drug abuse, sexual promiscuity, stealing and self-harm (MID subtype of BN).
   c. Anorexia nervosa with bulimic complications (ABC): Meets weight criteria for anorexia nervosa plus bulimic features.
      i. Single impulse disordered: Only impulse disorder is bulimia (SID subtype of ABC).
      ii. Multiple impulse disordered: Many impulse disorders, such as alcohol or drug abuse, sexual promiscuity, stealing and self-harm (MID subtype of ABC).

**SHARED FEATURES OF ANOREXIA NERVOSA AND BULIMIA**

1. Fear of fatness, pursuit of thinness.
2. Preoccupation with weight and calories.
3. Use of food and weight control to deal with developmental crises, emotional distress.
4. Patients are predominantly female, but 10%-15% are male.
5. Increased family incidence of depression and eating and weight disorders.
6. Transition between restricters and bulimics may occur in either direction.
COMPARISON OF ANOREXIA NERVOSA AND BULIMIA

Anorexia Nervosa                                           Bulimia

Rare vomiting or diuretic/                                   Vomiting or diuretic/
    laxative abuse                                               laxative abuse
More severe weight loss                                       Less weight loss
Slightly younger                                              Slightly older
More introverted                                              More extroverted
Hunger denied                                                  Hunger experienced
Eating behavior may be                                         Eating behavior considered
    considered normal and source                                   foreign and source of
    of esteem                                                       distress
Sexually inactive                                              More sexually active
Obsessional features pre-                                     More hysterical or border-
    dominate                                                      line features as well as
Death from starving (or                                         obsessional features
    suicide, in chronically                                       Death from hypokalemia or
    ill)                                                           or suicide
Amenorrhea                                                     Menses irregular or absent

More favorable prognosis                                        Less favorable prognosis
Fever behavioral abnormalities                                 Stealing, drug and alcohol

SEXUAL PROBLEMS ASSOCIATED WITH ANOREXIA NERVOSA AND BULIMIA

<table>
<thead>
<tr>
<th>Problem</th>
<th>Cause</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Decreased sexual</td>
<td>Pre-illness &quot;sex</td>
<td>Illness may increase pre-existing</td>
</tr>
<tr>
<td>interest</td>
<td>disgust,&quot; decreased</td>
<td>sexual problems or introduce new ones</td>
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<tr>
<td></td>
<td>reproductive hormones,</td>
<td></td>
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<td></td>
<td>pervasive anhedonia, emaciation and inanition</td>
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<tr>
<td>2. Dyshpareunia</td>
<td>Decreased vaginal</td>
<td></td>
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<tr>
<td>(female)</td>
<td>secretions, decreased pelvic</td>
<td></td>
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<tr>
<td></td>
<td>soft tissue</td>
<td></td>
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<tr>
<td>3. Impotence</td>
<td>Low testosterone levels</td>
<td>Some adolescent males may have sex-role confusion prior to illness</td>
</tr>
<tr>
<td>4. Infertility (females)</td>
<td>Regression to prepubertal, anovulatory state (secondary amenorrhea) or persistence of primary amenorrhea</td>
<td>A substantial percentage of models, ballet students, and gymnasts may have anorexia nervosa or persisting menstrual disorders from low weight and decreased body fat</td>
</tr>
<tr>
<td>5. Infertility (male)</td>
<td>Oligospermia or azospermia from decreased gonadotropin and testosterone levels</td>
<td>Some anorectic males have documented pre-illness oligospermia</td>
</tr>
<tr>
<td>6. Decreased sexual attractiveness</td>
<td>Starved appearance, spouse’s fear that the ill partner will be harmed by sex</td>
<td>Patient feels hurt and neglected by spouse’s rejection of physical contact, especially non-sexual comforting</td>
</tr>
<tr>
<td>7. Prolonged amenorrhea after weight recovery</td>
<td>Weight gain may be insufficient, continued stress or unresolved conflict may play a role, question unknown hypothalamic factors</td>
<td>Do not induce cycles; increased, weight and/or continued psychotherapy may be necessary; rare</td>
</tr>
</tbody>
</table>
8. Impoverished sexual life

All of the above, as well as personality changes associated with starvation, preoccupation with food and weight

Worsened with chronicity and severity of illness; improved with maturity of marital partners and length of stable marriage

---

**BULIMIA**

1. Same problems as anorectic patients

See above

---

2. Sexual life interfered with by strong negative emotions experienced by both partners

Pervasive guilt by ill spouse over bulimic practice, disgust and anger by well spouse at discovery of purging

---

3. Sexual promiscuity, extramarital affairs

Bulimic patient more often extroverted than anorectic patient, general disorder of impulse control often present

Bulimia may be only part of globally disordered personality

---

4. Inhibition of sexual life by drug or alcohol dependence

Same

Same

---

5. Unwanted pregnancy

May result from impulsive sexual activity without contraception

Patient feels overwhelmed by burden of child, spouse angered or depressed by extra burden of child care
STATISTICS ON OBESITY

1. Definition of obesity: 15% to 20% overweight
2. Americans are developing obesity at earlier ages
   a. 5 - 10 percent of school children are obese
   b. 10 - 15 percent of adolescents are obese
   c. 34% of men, 42% of women are obese by age 50
3. Health risks: hypertension, diabetes, heart disease, strokes, arthritis, gallbladder disease, circulatory problems
4. Americans spend more than 10 billion dollars annually looking for easy ways to lose weight: dietetic foods, drugs, fat farms, spas, mechanical devices and appliances for spot reducing

WEIGHT CONTROL

1. Balance between calories eaten and expended
2. One pound = 3,500 calories
3. Only 1 - 2 percent of obese people have "problems with glands"
4. Benefits of exercise
   a. Increases calorie expenditure
   b. Increases BMR
   c. Increase muscle strength, mass endurance
   d. Increases coordination
   e. Can decrease appetite by releasing glycogen from muscles

TREATMENT GUIDELINES

A. Where to cutback - avoid sweets, cut down on fats, reduce portion sizes
B. Be realistic - find health program you can live with
C. Slow, steady weight loss: 1 - 2 pounds a week
D. Space meals, but don't skip
E. Weigh once a week - expect plateaus
F. Pre-plan intake on special occasions
G. Exercise
H. Be committed - don't give in. If you splurge, go right back to eating plan
I. If you are not losing weight, keep food intake record
Compulsive overeating is not given the same credence, research and treatment considerations anorexia nervosa and bulimia nervosa are given even though statistics indicate that 80% of the population of eating disordered are compulsive eaters.
1. Cardiovascular: Overweight increases risk for heart attacks and heart failure. This can occur on the left side of the heart from having to pump blood through so much tissue or on the right side from an inability to lift the chest wall because of weight. Obese people don't oxygenate well because the blood vessels in the lungs squeeze down and the right side of the heart has trouble pumping. This also leads to strokes from high blood pressure.

2. Cancer: Obesity increases cancer risk, especially of the colon, breast, or uterus. This is primarily because of the increased estrogen production from fat tissue.

3. Lipid Problems: Increased triglycerides lead to pancreas and heart diseases. Increased cholesterol levels lead to heart disease and gallbladder problems.

4. Type 2 Diabetes: Eighty percent of those who suffer from adult-onset diabetes are overweight. The great majority of the sufferers of this disease could cure themselves by getting down to their ideal body weight, watching their diet, and exercising properly.

5. Joint, Tendon, and Back Problems: Such problems are far more common in heavy people. Knees, ankles, and back are especially vulnerable.

6. Pregnancy Complications: Overweight mothers are more prone to having large, difficult-to-deliver babies, gestational diabetes, blood pressure problems, and convulsions. Obesity presents a risk for both mother and child.

7. Surgical Risks: Obese patients are poor surgical candidates. They don't heal well, are prone to infections, are anesthetic risks, and they are more at risk from blood clots.

8. Aging: Because of these stressors on the body, overweight people do not age well.
12 COMMON REASONS FOR COMPULSIVE EATING

1. Overeaters may respond compulsively to cultural pressures.

2. Overeaters may subconsciously desire added pounds to protect themselves from love and intimacy.

3. Overeaters may use food to satisfy their need for immediate gratification.

4. Overeaters may use food as a tranquilizer.

5. Overeaters may concentrate on their desire for food to avoid facing their problems.

6. Overeaters may eat to punish themselves or others.

7. Overeaters may eat to relieve depression or stress.

8. Overeaters may eat to rebel against themselves or others.

9. Overeaters may eat to express their need to control their circumstances.

10. Overeaters may have a faulty perception of their body image.

11. Overeaters may have emotional feelings about food, which were developed at their parents' dinner table.

12. Overeaters use food as a nurturer to satisfy their love hunger.
Chapter 3

METHODOLOGY

PROGRAM DEVELOPMENT

The project began by interviewing four people in the employee assistance field to determine if, in fact, a need for eating disorders information would be a useful tool for EAPs.

The first interview was conducted with an external EAP hired to work exclusively with a national firm who locally employs in excess of 5,000 employees. There had been no identified eating-disordered referrals and the interviewee doubted there would be because supervisors "wouldn’t recognize an eating disorder." Further exploration of the topic proved nonproductive as the EAP said the company nurse or medical doctor would refer the medically unstable immediately to an outside physician. The interviewee further stated that supervisors are trained to recognize substance abuse and referrals are plentiful.

The second interview was conducted with a manager of employee relations who had implemented an internal EAP for the same company. The company chose to use an external model after it became apparent to them that it would be more cost effective. The interviewee said in 2-1/2 years there were three eating disordered referrals, all of which were
immediately referred to physicians. The interviewee thought that a wellness program focusing on nutrition would be beneficial "because at meetings people eat too much at lunch, snack a lot and then nod off, especially men." Women, the interviewee reported, are "too focused on their looks." Currently, there is no wellness program because "politically it is not feasible."

The third interview was conducted with a local external EAP who had been a self-employed consultant in excess of 20 years. The interviewee reported having never dealt with eating disorders, but was very comfortable in the area of addictive substances and assessments. The interviewee was in agreement that the philosophy and treatment approaches could be similar but felt inadequate to deal with eating disorders currently due to lack of interest and lack of knowledge.

The fourth interview was conducted with an occupational health nurse who also has a master’s degree in Business Management. The company had 860 employees and a human resource department of seven people of which she was one. The interviewee sees all employees before employment and introduces each one to the wellness concept. This interviewee is responsible to provide monthly wellness programs for all interested employees.
When questioned about eating disordered employees, she readily acknowledged there were "many" employed and recognized the physical symptoms of all disorders. The pre-employment physical affords her the opportunity to educate immediately. There had been no referrals for eating disorders to her by supervisors at this company. Self-referrals are overeaters usually complaining of weight-related health problems. Education is again given and, if necessary, she refers to the employees' medical doctor.

At the time of the interview, a wellness program was being considered for the obese. After discussing the possible needs, the occupational health nurse agreed to a "needs assessment" via the response to an eating disorder lecture for the September 1991 Wellness Program.

**NEEDS ASSESSMENT**

A series of 3 one-hour lectures was planned for the company of 860 employees. If normal distributional patterns held true, there would have been potentially 215 employees who are obese, potentially eating disordered and could have benefited from the lectures.

The lectures were publicized for one month prior to the presentation via flyers (Appendix A) and the company newsletter. The day prior to the lectures, the flyers were
again distributed throughout the two lunch rooms and hung on bulletin boards, as well as a sandwich board marquis placed in the main employee entry-way.

The lecture times were chosen by the occupational health nurse in order to be made available to all shifts. Employees were encouraged to attend the wellness programs and need supervisory approval to make up the one hour during the week if done on their regular shift or could attend on their own time as well. The lectures were scheduled:

   6-7 A.M.
9:30 - 10:30 A.M.
3:30 - 4:30 p.m.

The 6-7 A.M. lecture had no participants.
The 9:30 - 10:30 A.M. lecture had 5 participants.
The 3:30 - 4:30 p.m. lecture had 10 participants.

There were 2 males, one of which was there to learn "for a family member" and did not choose to fill out the needs assessment. Consequently, there were only 14 responses.

Part of the needs assessment solicited further contact if the participant so chose and seven people requested telephone contact. Two reported having no additional needs currently, but wanted to talk about possible future needs. One participant wanted a referral to a therapist on the west side of Phoenix. Three people were left messages three times and did not re-contact. The one male who was there for a family member wanted "some advice" and was referred to marital therapy and a codependency support group.
No participants contacted by the researcher were interested in an on-site eating disorders program because they were day-time employees who could not/would not attend after work and did not want to return to the job-site location during the evening. Nor were any of the respondents willing to make a 12 week commitment.

The needs assessment questionnaire was given to the attendees at the lecture prior to the start of each lecture. Results were tabulated and presented in Appendix B.

**PROGRAM DEVELOPMENT**

A workbook was developed (Appendix C). It was adapted from Love Hunger (Minirith, 1991). The workbook was divided into twelve sessions to be completed over a twelve week period. Each week focused on one of the 12 steps of Overeaters Anonymous.

A contract was included because the researcher was aware that losing weight for others is only a temporary solution. In order to be successful, dates needed to be established and individual goals set.

A goal for weight loss and the progress each participant made was necessary feedback; thus, a weight loss graph was inserted. As the contract pointed out, if the goal weight could not be reached in twelve weeks, the concepts would continue to apply until the goal weight was attained.
Each chapter included a sample journal form for the participant to record the food intake daily, as well as exercise each day. Because the philosophy of this program assumed that eating disordered people use food to cope with feelings, the journal also included a column for the participant to track events and feelings of importance that day.

The philosophy of Overeaters Anonymous states that recovery is on three levels: physical, spiritual and emotional. The workbook addressed all three.

The area of physical recovery included education on nutrition, exercise and how to make healthy choices when shopping, choosing a restaurant or modifying self-destructive habit patterns.

Spiritual recovery suggests there is a 'higher power' in which an eating disordered person can call upon to assist in recovery from an unhealthy relationship with food. The workbook questions assisted the participant in exploring concepts about calling on a 'higher power' to help change the destructive relationship with food.

The emotional facet of recovery suggests that an unhealthy relationship with food often emerges as a result of being raised in a dysfunctional family. The workbook explored family relationships and how food was used or abused
as a means of coping instead of expressing feelings or receiving comfort by other means.

Chapter 12 addressed the relapse dynamics. Just as alcohol and drug abuse/addiction, eating disorders can be 'arrested' but never cured. Alcoholic Anonymous states: "We have a daily reprieve based upon our spiritual condition." This appears to apply with eating disorders, too. Consequently, the chapter summarized what was learned in previous chapters and applied the education to relapse and made suggestions on how to deal with relapse constructively.

The 12 steps of Overeaters Anonymous was employed, as well as cognitive therapy, education and some group sharing of feelings. The sharing was limited by time constraints as well as the fact that participants had to report to work immediately after the group. Some participants voiced concern about confidentiality.

PROGRAM IMPLEMENTATION

An out-patient mental health facility supervisor was considering a weight reduction program to be offered on-site for clerical employees. The request was employee generated and the supervisor was aware of the lectures given at the large company and asked if the researcher would be interested in implementing the program for her staff even though the number of potential employees attending would be small. The
researcher's request was that the program be made available to all staff and the supervisor agreed. A memorandum was sent to all employees (70+) at five locations two weeks prior to implementation. The day, time and length of sessions were chosen arbitrarily based on the researcher's schedule (Appendix D).

For the purpose of this program, it was determined that the focus would include self-identified employees with any eating disorder: anorexia, bulimia or compulsive eating. The respondents for the interview process were actively working in the job force; male or female. Age and race was not a factor. There was no monetary compensation. The eating disorder was either active or in remission as self-defined by the respondent. Twelve people inquired about the program; six people completed. There were five females, one male. One "drop-out" used the explanation of the time being too early in the morning. The other reported health problems which necessitated that she be on a strict diet prescribed by her medical doctor.

INSTRUMENTS

On the first day of the program the participants completed a blank form of the questionnaire that appears in Appendix E. The facilitator wanted to know the level of the understanding each participant had and to find out if, in
fact, the participants had connected on an intellectual level that eating disorders could affect their productivity, thus affect the employer financially in lost work time and insurance costs.

A blank form of the evaluation tool in Appendix F was completed by the participants on the last day of the twelve week program. That feedback would then be used in order to refine the program for the next twelve week course. The comment section was made available and used to measure the level of satisfaction each participant felt at the end of the program.

For the 12 week session the researcher asked for participants to state a goal and upon completion asked for feedback on the accomplishment of those goals (Appendix G).
Chapter 4
DATA ANALYSIS AND INTERPRETATION

This chapter presents an analysis and interpretation of data collected from four interviews, one lecture given at three different times, and the implementation and completion of the 12 week eating disorders program implemented in Mesa, Arizona.

SUMMARY OF INTERVIEWS

The consensus of three of the four interviewees was that eating disorders is unrecognized by EAPs, supervisors or companies and that there wasn't much merit in pursuing that population because it is unrecognized.

The fourth interviewee considered eating disorders as a problem for employees at her company, but was unaware of productivity problems directly related to or caused by eating disorders. Because the company had a wellness program she felt the topic was worthy of presentation.

SUMMARY OF LECTURES

The lectures were poorly attended even after sufficient publication of the topic, times and places. The occupational health nurse in charge of the wellness program offered several possibilities: 1) times inconvenient even though each shift was covered 2) shame/embarrassment to admit a
possible problem exists 3) workplace doesn't support such a "trivial" subject 4) time of year not conducive to topic.

None of the attendees at the lecture was interested in a 12 week job-site program and again the above reasons could play a part. Explanations ranged from not needing a program to being unwilling to return to the job-site after hours.

SUMMARY OF TWELVE WEEK PROGRAM

The 12 week program was requested by co-workers of the researcher. Of the five office locations, only one office was represented. Six participants completed the 12 week program.

Upon completion of the 12 week program, all attendees requested the program be presented again for 12 weeks starting in January 1992.

DATA ANALYSIS OF RESPONSES TO NEEDS ASSESSMENT AT LECTURE

The needs assessment questionnaire given can be located in Appendix H. Highlights of the assessment are as follows:

Question #1 - 11 of 14 respondents stated they had an eating disorder.

Question #3 - The respondents were aware of the problem from 3 to 20+ years.

Question #4 - 11 of 14 were compulsive eaters.

Question #5 - 12 of 14 respondents were female.
Question #6 - age range of attendees was from 21 years to 51 years.

Question #7 - 9 of 14 respondents had been to a weight loss/gain program in the last 2 years.

One person had attended 5 programs; two persons had attended 2 or 3 programs; four people had attended 4 programs.

Out-of-pocket expenses ranged from $40 to $500. Five people had spent $500 each.

Question #8 - 13 of 14 respondents were aware of support groups for eating disorders.

Question #9 - 4 of 15 had attended a support group for eating disorders.

Question #10 - 8 of 15 respondents exercised.

The types of exercise were: walking, horseback riding, swimming, running, biking, aerobics, gym work and weight lifting.

The number of times per week the respondents exercised was from 1 to 6 times.

The time spent exercising ranged from 60 to 420 minutes per week.

Thirteen of 15 respondents have exercised in an on-going program previously.

Question #11 - 7 of 14 respondents have involved themselves in wellness programs through the employer.
Question #12 - 10 of 14 respondents would participate in on-going support for eating disorders sponsored by their employer (this response contradicts the follow-up phone calls where they refused to be involved beyond the lecture).

Considerations by employer in setting up the program should be: number of times per week, time of day, self-help information and specific education.

Questions #13 - 1 of 14 had missed work due to the eating disorder.

Question #14 - 3 of 14 have received medical or psychological treatment for the disorder.

Of the 3 all were covered by insurance.

Out-of-pocket expenses ranged from $14 an hour to $150.

Question #15 - None had been hospitalized.

Question #16 - None had jaws wired shut or surgery.

Question #17 - 12 of 14 were comfortable in seeking help for their problem.

Question #18 - 12 of 14 would talk to the employer about their problem.

DATA ANALYSIS OF RESPONSES TO PROGRAM QUESTIONNAIRE FOR 12 WEEK GROUP

The questionnaire can be located in Appendix E.

Highlights of the assessment are as follows:

Question #1 - 8 of 8 respondents stated they had eating disorders.
Question #2 - 3 of 8 were self-diagnosed; 5 of 8 were medically diagnosed.

Question #3 - The respondents were aware of the problem from 1 to 35 years.

Question #4 - 5 of 8 were compulsive eaters; 1 was anorexic / compulsive; 1 was bulimic / compulsive.

Question #5 - 7 of 8 respondents were female.

Question #6 - age range of attendees was from 33 years to 51 years.

Question #7 - 7 of the 8 respondents had been to a weight loss / gain program in the last 2 years.

One person had attended 5 programs; one had attended 2 programs; five people had attended 1 program.

Out-of-pocket expenses ranged from a low of $20 to a high of $2,000.

Question #8 - 8 of 8 respondents were aware of support groups for eating disorders.

Question #9 - 4 of 8 had attended a support group for eating disorders.

Question #10 - 3 of 8 respondents exercised.

The types of exercise were: walking and rowing machine.

The number of times per week the respondents exercised was from 1 to 5 times.

The time spent exercising ranged from 30 to 150 minutes.
Three of 8 respondents have exercised in an on-going program previously.

Question #11 - 7 of 8 respondents have never been involved in a wellness program through an employer.

Question #12 - 7 of 8 respondents would participate in on-going support for eating disorders sponsored by the employer.

Question #13 - 3 of 8 respondents have missed work due to the eating disorder.

Question #14 - 4 of 8 have been treated medically or psychologically for the disorder.

Question #15 - 1 of 8 have been hospitalized for an eating disorder.

Question #16 - 1 of 8 had surgery or stomach staple.

Question #17 - 7 of 8 were comfortable in seeking help for their problem.

Question #18 - 7 of 8 would talk to employer about their problem.

** There were 2 drop-outs from the time of questionnaire to completion of the 12 week program.

Since the group was related to eating disorders and weight is a common tool for participants to measure success or failure, the participants had the choice to weigh-in or not during the 12 weeks. Four chose not to weigh-in and two did. This allowed a "psychological edge" for the
participant not to be set-up by the facilitator to fail based on weight statistics alone.

Because the facilitator was known by all participants as a co-worker, feedback was solicited as to whether or not each participant felt his or her participation was affected by the familiarity. Group response seemed to indicate participants felt too comfortable and may have worked on the assignments more had a stranger been the facilitator. Three of the six said they would probably have dropped out had they not had to work with the facilitator daily - "guilt was a partial motivator."

The 12 week group participants negotiated with the facilitator on the last day of group to re-do the program beginning January 7, 1992 with some minor changes:

- 1-1/2 hour group weekly
- a time conducive to their schedules
- no new participants
- will weigh self before and after the 12 week session

Feedback on the group process was:

- more time needed per group
- a different time of day
- participants were often late - more punctuality needed
- an exercise component was needed
- more structure on what to eat
- more external motivation by facilitator to complete assignments

All six participants will participate in the group starting January 7, 1992 they reported.
Chapter 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Until eating disorders are labelled an illness and not judged as moral or immoral, these disorders will, for the most part, remain hidden with employees unwilling or unable to seek help. Just as alcoholism has now become a treatable illness and the alcoholic treated, so should eating disorders be considered an illness and the eating disordered treated. The leveler: ingesting food is essential to maintain life; therefore, unlike alcohol or drugs, a person needs to "pet the tiger" at least once a day. With treatment the "tiger" can be tamed!

SUMMARY

The purpose of this study was to develop, implement and assess an eating disorders program in the workplace.

The recommendations were based on review of the literature, needs assessment, and the program implemented at a Mesa, Arizona out-patient mental health facility and the clinical knowledge of the researcher.

The first step the researcher took was to interview four people in the employee assistance field to determine if, in fact, a need for eating disorders information would be useful for EAPs.
One of the four interviewees thought the company she worked for as an occupational health nurse could benefit by an on-site program. A lecture was given, the needs assessment tool administered and follow-up telephone calls were made. The researcher found no one was willing to commit to a program at the job-site.

Consequently, the needs assessment provided the occupational health nurse and the researcher with feedback there was no need currently at the company for an on-site program.

The next step was to continue a search for a job-site location that had a need for an eating disorders program.

The researcher located a job-site that had several requests for bringing in a traditional weight loss program and one of the supervisors suggested the researcher implement the program, which began on September 17, 1991.

CONCLUSIONS

The interview process of the four EAPs reinforced for the researcher that eating disorders remain a pathology unrecognized. The one exception, a female interviewee, was well aware of the problem and considered the topic worthy of being presented to the employees. The interviewee was aware of most symptoms and behaviors that accompanied the
disorders. Perhaps her awareness was due to her background, nursing, or was it because she is female and eating disorders most often affect women?

Educating EAPs, male or female, about another facet of dysfunctional behaviors would be appropriate given the fact that three of the four interviewees were not comfortable with their knowledge or expertise regarding eating disorders.

The supervisor who supported the 12 week implementation of the program was also female. She had no knowledge of eating disorders except that several of her employees wanted help with their weight problems. The research project was designed for all eating disorders, not just compulsive eating. A cross-section of eating disorders was represented by the participants. This dynamic allowed the participants to gain knowledge and hopefully understanding and acceptance for all of the disorders. The supervisor readily acknowledged she was unaware of how attitude, productivity and sick leave was being affected by her employees with eating disorders. As a participant herself she gained awareness and knowledge. The supervisor requested the program continue beyond the 12 weeks, as did the other participants.

The needs assessment lectures were poorly attended. What does the attendance say about awareness and knowledge of eating disorders? One can only surmise that perhaps it was
denial that a problem existed. Denial of addictive, self-destructive behaviors is pervasive with eating disorder pathology. Only the extreme cases, obesity or seriously underweight are readily noticeable physical manifestations. Unfortunately, there are eating disordered people who exert so much control that the physical manifestations may take years to develop. By no means does that imply the person is not struggling on a daily basis with the obsessions or compulsive behaviors. A survey by the National Institute of Business Management reports that compulsive eating habits cut employee productivity up to 50 percent. Pacific Mutual Life estimates that illness due to poor nutrition cost business $30 million annually (Newman, 1988, p. 41).

With these statistics alone, can business and industry ignore eating disorders? The researcher thinks not and supports wellness programs to include the treatment of eating disorders.

**RECOMMENDATIONS**

What then, are the steps necessary to integrate an eating disorders program into a company without intimidating, shaming or threatening the employee? Using an employee assistance program, a comprehensive policy for treatment of the eating disordered employee can be established. The EAP can be used for diagnosis whether the company employs internal or external EAPs.
In order to implement an eating disorders program, the following recommendations are offered:

**Education**

a. Provide an on-going educational program for addictive substances and dysfunctional behaviors and include family systems education. Also, offer education on exercise, diet and nutrition which is essential.

**Physical**

a. Put in place incentives for healthy lifestyles.

b. Begin an exercise program to include aerobics on or off the job-site which can include other than eating disordered employees.

**Psychological**

a. Use appropriate diagnostic tools for evaluation of the employee needs.

b. Offer on-going support groups at the job site.

**Referral Sources**

a. Maintain a list of referral sources for EAPs.

The above recommendations are elaborated upon as follows:

**Educational Component**

The cognitive approach (education) works well because the media attention focusing on dysfunctional, addictive behaviors is at an all-time high. Rarely can a magazine, newspaper or television be seen without at least an article
or program on the latest fad diet, addiction or dysfunctional families. The EAP can capitalize on this search for knowledge by providing the information people are longing for.

The educational process is best served by a combination of techniques. Adults enjoy experiential learning and often avoid lectures. The education can be provided by experts in different fields of eating disorders, family problems, addiction, codependency, nutrition, and exercise. An incentive for the guest speakers would not necessarily be cash, but offer a source of possible future referrals. The EAP him or herself could also provide these services depending on the budget for the program.

Education provided on eating disorders needs to include a description of each disorder, the varied behaviors exhibited, the physical manifestations, the potential health problems, and most importantly, offer an approach to recovery which includes addressing the problem physically, spiritually and emotionally.

Because the media places such emphasis on diet, the employees have a need for an in-depth education of how to eat properly to either lose, gain or maintain weight. Use the approach that good health is the goal. Without endorsing or condemning a particular diet or diet club, an expert can impart pros and cons of the current fads. A helpful task
would be for each employee who chooses to keep track of the food he/she ingests for 2 or 3 weeks.

Next, have a nutritionist give feedback as to what can be changed. Feedback for adult learners is essential in changing behavior and attitudes.

Eating disorders most often manifest themselves along with other addictive behaviors or substances; therefore, information on addiction is part and parcel of the overall education. This information is essential, too, for all employees and can be geared specifically toward eating disordered employees or preferably the whole employee population. This approach is less threatening to all concerned as the eating disorder may have preceded the substance abuse or has recently manifested itself as another substance or behavior to use/abuse.

The etiology of eating disorders is linked to dysfunctional family systems; therefore, the employee has a need to understand what happened in his/her family in which the response manifested itself as an eating disorder. This information generally helps decrease the guilt and shame which is essential in recovering from the disorder. Include in the education of families information on adult children of alcoholics, codependence, and shame-based systems. Control is a core issue - either a sense of no control or a need to
give up control. What better way to exercise options than to control what is or is not put in the mouth!

**Psychological Component**

Addictive behaviors may not be recognized as dysfunctional. Often eating disordered people are entrenched in other self-destructive endeavors which may include casual, frequent sex, serial relationships, gambling, spending money excessively, or adrenalin highs. In the field of addictions it is labelled as "switching addictions" and awareness of that concept can assist the employee in a potential self-intervention. Another concept is "cross-addiction" which means the employee may be engaged in several addictive behaviors simultaneously.

Diagnostic tools for eating disorders are secondary to a sound general evaluation tool. If an employee seeks help voluntarily, the likelihood of knowing what the problem is may be no more accurate than a management referral. The first session or two is spent by the employee "testing out" the EAP counselor. To delve into the eating disorder no matter how obvious to the EAP before the employee feels "safe" will trigger the core issue-control, and the employee will more than likely retreat. If, however, by the close of session three the employee with a suspected eating disorder has not broached the subject, it becomes time for the EAP to
causally mention it as a possible issue. Between the end of session three and the next meeting, both employee and EAP can consider the next step. Denial is not as big an issue as shame and fear of repulsing the EAP, with shameful, embarassing details.

Allowing on-going support groups on the job-site expresses a climate of caring by the company. There is little or no legal liability or cost to the company. Considerations for the type of support groups might include Alcoholics Anonymous, Al-Anon, Codependents Anonymous, Adult Children of Alcoholics, Incest Survivors, Overeaters Anonymous as well as Anorexia Nervosa & Associated Disorders (A.N.A.D.) and Self-Help for Eating Disorders (S.H.E.D.). These programs are self-supporting and exist through donations by the voluntary participants who attend at will.

Other considerations for groups might include T.O.P.S. (Take off Pounds Sensibly), or Weight Watchers. There is a cost to the employee, but it would be predetermined and participants could join or leave by choice after a pre-determined time commitment.

The essential support group for eating disorders is Overeaters Anonymous fashioned after Alcoholics Anonymous. The only requirement to belong is a desire to stop eating compulsively. The philosophy has been expanded to include not just compulsive eaters, but also anorexics and bulimics.
The "common thread" is that all eating disorders are manifested by a dysfunctional relationship with food; anorexics reduce intake to a starvation level; the bulimic binges and purges. The compulsive eater uses food dysfunctionally in many ways. The end result is most often obesity, although it may be a psychological obsession and not manifested by acting it out which is also symptomatic with the other disorders.

Overeaters Anonymous was founded in 1960 and is headquartered in Torrance, California. Currently there are over 11,000 self supporting groups in 60 countries.

A 1986 survey (the latest available) reports 90.8% of the members are female (O.A. Office 1991). The meetings are facilitated by recovering members of the program and are not paid. The philosophy is based on the 12 Steps of Alcoholics Anonymous. The recovery process approaches the physical, spiritual and emotional facets of the human being. There are no fees and members contribute at each meeting only if they choose.

Self-Help for Eating Disorders (S.H.E.D.) was founded in 1981 by Jeanne Phillips after being in recovery from anorexia and bulimia for 12 years. The group meets one time per week and ranges from 10-16 members per week. The average length of stay per group member is 6-12 months. Men's issues for eating disorders are similar. Unfortunately, in the 10
years, only 12 men have been members. Ms. Phillips also facilitates a family support group once per week. The program is located in Scottsdale, Arizona.

**Physical Component**

Exercise needs to be approached with caution. Anorexics and bulimics, misuse exercise. Overeaters underutilize. There are also health concerns. A general approach can be used and, if and when the exercise program becomes a part of the company eating disorders program, it will be essential for the company to screen and monitor participants, as well as have releases of liability signed by the employee.

Incentives for employees to maintain healthy lifestyles might include decreases in health care benefit costs on a monthly basis, or a "rebate" of insurance monies spent based on certain pre-arranged criteria. For the obese it might mean a drop in cholesterol levels or decrease in weight and/or blood pressure. Incentives for the anorectic or bulimic need to be measurable and will take creativity, as well as a possible behavioral contract to define. For the anorectic it might mean maintaining or gaining weight. For the bulimic it might mean decreasing or eliminating the purging, or perhaps seeing a dentist to fix teeth damaged by purging. Perhaps just attending the self-help groups or exercise classes can be monitored as incentives.
External motivators like fitness walks/runs or weight/fat loss or gains can be implemented. There are certain times of year the "climate" is right for these endeavors: After the holidays, late spring or fall. The secret to this form of incentive is to make it an on-going pursuit as proven by the fact that the obese people yo-yo with weight, and the anorexic and bulimic relapse into old behaviors easily.

As previously mentioned, an on-site exercise program can be both beneficial and complicated for eating disordered employees. Take precautions to protect the company legally to include approval for participation by a physician, as well as a release for company liability. It is essential to have well-trained staff and offer a variety of options; i.e., low impact and high impact aerobics; a walking and running club, toning and stretching. An alternative to on-site exercise is for the company to contract with a club or spa so employees can get reduced or no fees.

Referral Sources

Most EAPs have the constraint of brief therapy. Keep in mind that eating disorders are, in fact, long-term, chronic and need to be treated accordingly which means referral to an expert in the field. A large measure of expertise is mandatory in the treatment. Too much or too little focus on food or exercise may increase the dysfunctional behaviors. Psychological issues are the cause. Eating disorders are
dysfunctional behaviors the eating disordered employee has used to cope. To simply address the issue from a behavior modification standpoint is a disservice to the employee. The treatment approach for each person needs to be tailored to the person even though general guidelines can be used.

These guidelines will be essential in referring the employee to the appropriate service provider. The service provider will then do an assessment to determine whether in-patient or out-patient treatment is necessary. After the referral the EAP becomes a support person not a therapist.
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Overeaters Anonymous General Office Survey (1986) Los Angeles, CA


APPENDIX A
DO YOU HAVE AN UNHEALTHY RELATIONSHIP WITH FOOD?
PRESENTED BY: DEANNE PENN
THURSDAY SEPT. 12

6:00 - 7:00 am    WEST
9:30 - 10:30      WEST
3:30 - 4:30      EAST

Presentation includes information on Compulsive Eating    Anorexia & Bulimia.
DATA COLLECTION

1. Do you have an eating disorder?
yes  11  no  2  no answer  1

2. If so, is self-diagnosed?
yes  9  no  2  no answer  3

3. I have been aware of the problem for
   3, 5, 20+, 10, 20, 10 years
   months  0
   no answer  1
   just checked years  7

4. The eating disorder I have is:
anorexia  1
bulimia  0
compulsive eater  11
no answer  2

5. I am: Male  2  female  12

6. My age is:
   27y - 1  43y - 2
   31y - 1  45y - 1
   33y - 3  47y - 2
   37y - 1  49y - 1
   41y - 1  51y - 1

7. Have you participated in any weight loss/gain program in
   the past 2 years?
yes  9  no  5

   If so, how many:
   1 program -  4  3 programs -  2
   2 programs -  2  5 programs -  1

   What would you estimate the total out-of-pocket expense to
   you? Include fees, purchase of diet foods, etc.
   $40 -  1  $150 -  1
   $80 -  1  $500 -  5
   $100 -  1

8. Are you aware of support groups for eating disorders?
yes  13  no  1
9. Have you ever attended a support group for eating disorders?
   yes  4  no  11

10. Do you do any form of exercise?
    yes  8  no  6

If so, please state what type:

walking  - 11  aerobics, weight lift - 1
horseback riding - 1  walk/run - 1
walk, bike, swim - 1  gym - 1

How many times per week do you exercise?

3  - 2
5  - 1
6  - 1

4  - 2
1 to 2 - 1
1 to 3 - 1

How many minutes total per week is spent in exercise?

60 minutes  180 minutes
60 to 240 minutes  300 minutes
120 minutes  420 minutes
150 minutes  no answer

If you do not currently exercise, have you ever been involved in on-going exercise?
yes  13  no  3

If so, what?
"5 days per week":  gym, aerobics, bike, weights - 1
                   walking - 1
                   running, lifting weights, aerobics - 1

11. Have you ever participated in any wellness program offered through your employer?
yes  7  no  7

12. If the employer were to offer on-going support for eating disorders, would you participate?
yes  10  no  1  no answer  3

If yes, what should the employer consider in setting up the program?

"five times a week"
"time of day to have the meeting"
"yo-yo dieting, re-setting your set point"
"information, help, self-help information"
"it might be too personal to take at work, but would probably try"
"time of day program is held"

13. Have you ever missed work related to the eating disorder behavior or taken time off work for doctor or therapy appointments?
   yes 1 no 13

14. Have you been treated medically or psychologically for problems directly or indirectly related to an eating disorder?
   yes 3 no 11

   If yes, did your insurance cover the cost?
   yes 3 no 0

   What was your out-of-pocket expense?
   "don't know"
   "$14 an hour"
   "$150"

15. Have you ever been hospitalized for an eating disorder?
   yes no 14

16. Have you had surgery or your jaws wired shut, etc.?
   yes no 14

17. I am 12 or am not 0 comfortable seeking help for my problem.
    no answer - 1 "Both!" - 1

18. I would 12 or would not 1 not talk to an employee assistance program person.
    no answer - 1
APPENDIX C
DO YOU HAVE AN UNHEALTHY RELATIONSHIP WITH FOOD?
PRESENTED BY: DEANNE PENN
SEPT. 17, THROUGH DEC. 3, 1991

TRICITY BEHAVIORAL SERVICES
1255 W. BASELINE #296, MESA
TUESDAYS 7:00 AM - 8:00 AM RM31
I, ________________________, have wanted to be successful on a weight loss/gain program for a long time. In the past I have focused on one aspect of weight loss/gain, such as calorie control on increased exercise. I now understand that there are many causes, including psychological factors which I may or may not have even considered in the past.

I will begin my recovery on ______________________ (date) and will try hard to commit to that program for 84 consecutive days (12 weeks). I am not expected to be perfect, nor will I be, but if I do make poor choices, I will not become discouraged. I will not quit my recovery program.

The ending date of the 84-day program will be ______________________ (date). If I have not accomplished my goal by this date, I can continue on a path of recovery. The concepts I am going to learn will help me the rest of my life.

Signed

Date
You can use the Summary Weight Loss Graph above to record your weight loss in two different ways. You can either record the number of pounds you lose each week (see the dotted line in the sample graph) or you can see the total number of pounds you lose as you progress through the Twelve Week Weight Loss Diet Plan (see the solid line in the sample graph). To see your total weight loss, record in the first column the number of pounds you lose the first week. Then move to right for the second week and count down the number of pounds you lose that week.
FAMILY RELATIONSHIPS WITH FOOD

My mom seemed to think of food as ________________________________

My dad seemed to think of food as ________________________________

What did each sister and brother think of food as ____________________

How has my family's relationship with food affected me? ________________
MEALTIME MEMORIES

Sitting around the table in my childhood were:

Breakfast

Lunch

Dinner

Was some often missing? If so, who?

Describe the memories and feelings at each meal.

What type of conversations were held at the dinner table?

Does any of this information help me understand my relationship with food today? If so, how?
AM I SAFE MEDICALLY?

If you have any concerns to be discussed with your doctor, do so before you attempt to lose, gain weight.

Considerations:

Medical checkup

Lab work

If so, I will commit to this workup by _____________ (date).

My specific medical problems include:

1.
2.
3.
4.
STEP ONE: WE ADMITTED WE WERE POWERLESS OVER FOOD . . . THAT OUR LIVES WERE UNMANAGEABLE.

AM I IN DENIAL?

I eat just like everyone else. My metabolism is just slow, and my family is large-boned. THE TRUTH IS:

My weight doesn't bother me. People really don't notice. They judge me by what's on the inside. THE TRUTH IS:

My doctor says I have to lose/gain this weight, but what do doctors know? If weight doesn't get me, it will be something else. I'd rather be fat/thin and happy. THE TRUTH IS:

When my life settles down or this happens or that is finished, I'll take care of my eating/weight. THE TRUTH IS:
HOW DO I DEAL WITH FOOD?

What am I unable to resist (food) when it is in the house?
1. 
2. 
3. 
4. 
5. 
6. 
7. 
8.

I can get rid of my "trouble" foods _____ yes _____ no

If "trouble" foods are not available, I won't be tempted. _____yes _____ no

Once I break these habits, I will be able to control these foods and have them once in a while - control _____yes _____ no

As a child I thought of food as a _____friend _____ foe because

Did mom, dad or brothers and sisters tease you about your weight?

As a teen my relationship with food was _____friend _____ foe because

Once I left home food became a different matter _____yes _____ no because

Today my relationship with food is: (check those that apply)
_____ has become increasingly important in my life.
_____ I eat or starve or binge/vomit when I am nervous or angry.
_____ I crave food and think about it more than I'd like.
_____ I might eat to keep people from getting close to me.
_____ I could be addicted to food or starving.
**OTHER OBSESSIVE/ADDICTIVE BEHAVIORS**

If you are feeling out of control in any area of your life, it is now time to take an honest look at these behaviors. Check any that might apply.

**ALCOHOL AND/OR DRUGS**

- At times in my life it seems necessary to drink more than I would like.
- I do things when I’m drinking I normally would not do when I’m sober.
- My husband (or wife) or parents are concerned about my drinking.
- I go to a party and end up drinking more than I had planned to drink.
- I’m usually quiet, but when I drink (or take drugs), I’m the life of the party.
- At times I recreationally use drugs even though I know they’re illegal and in some ways they violate my moral values.
- I need more drugs to get the same high.

**OBSESSION WITH ILLNESS (HYPOCHONDRIA)**

- I’ve had vague, physical problems for years, but the doctors don’t seem to be able to identify my illness.
- If I am fully honest with myself, I will notice that my physical symptoms escalate during times of stress.
- Medical doctors have suggested that I get a psychological (or psychiatric) assessment of my symptoms.
- I am often worried that I have some serious illness the doctors haven’t diagnosed.

**EXERCISE AND PHYSICAL CONDITIONING**

- I engage in vigorous aerobic exercise more than three times a week. (Could you be doing this for reasons other than your health?)
- I look forward to getting that runner’s or exerciser’s high.
- I’ve had some recurrent joint pain (or injuries).
- If I don’t get my full regimen of exercise, I am irritable or depressed.
- I exercise vigorously more than six hours per week.
- I continue to exercise even though I have bone and joint pain caused by overuse.
- I am such a fanatic about exercise I cannot tolerate getting off my program even one time.

**RELIGIOUS LEGALISM**

- I’m constantly judging myself (and others) about whether or not we are conforming to the doctrines of our faith.
- I seem to be moving farther away from my friends at church since I became so concerned about doctrine.
- The more I work at adhering to the doctrine of my faith, the more distant God seems.
- Sometimes I catch myself arguing with myself about what to do. I’m almost afraid to make a decision because there are verses to support each side.

**SMOKING**

- I’ve tried to quit smoking, but I just can’t.
- When I’m upset, I need a cigarette.
- I smoke every day. (If you do, you are probably addicted.)

**BULIMIA**

- I sometimes eat everything in sight and then use laxatives to purge the food from my system.
- When I am full, I vomit.
WHO WILL SUPPORT YOU?

Are you willing/able to talk to your spouse, significant other about your problem with food? ____yes ____no

What about roommate, friend? ____yes ____no

Has the extra weight (or underweight) caused friction in relationships? ____yes ____no  HOW?

What do you want from the people in your life (including co-workers) to do to support you?

RELATIONSHIP HISTORY

My relationship with mom was ___________________ because ___________________

My relationship with dad was ___________________ because ___________________

My relationship with my brothers and sisters was ___________________ because ___________________ (list them all separately)

Who else influenced your life (grandparents, special teachers, etc.)?

Relationship #1
Relationship #2
Relationship #3
Etc.!!

My relationship with myself currently is: ___________________
MY BODY AND OUR RELATIONSHIP

MY APPEARANCE: How much I weigh, how I dress to change/distort my body size.

Do you recall what remarks were made about your body as a child?

What did or do you do to feel better when your feelings are hurt about your body size, what you eat/don't eat?

Were you happy to be a boy or girl?

Were your parents happy about the sex you were? If so, what do you remember? If not, what do you remember? (Be specific)

How do you feel about your body now?
<table>
<thead>
<tr>
<th>Date __________________</th>
<th>WEEKLY FOOD AND EXERCISE JOURNAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (First day of week only)</td>
<td>Breakfast/ A.M. Snack</td>
</tr>
<tr>
<td>Day One</td>
<td></td>
</tr>
<tr>
<td>Day Two</td>
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<td>Day Six</td>
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<td>Day Seven</td>
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</tbody>
</table>
STEP TWO: WE CAME TO BELIEVE THAT A POWER GREATER THAN OURSELVES COULD RESTORE US TO SANITY.

What's eating you?

I get hungry in (the afternoon, evening)

I get hungry when (I'm working)

Now think about that time of day and/or that activity. Could this be related to a need for love, affection, attention, time, security, or identity?  yes  no

Now think back to the time of day when you get hungry. How were you feeling? Does that have something to do with your desire for food?  yes  no

I might be overeating at this time of day because

I might be overeating when I am (working) because

As a child, I first turned to food as a substitute for affection or attention or time or security or identity when

Later in high school I turned to food as a substitute for affection or attention or time or security or identity when

Once I left home, I turned to food as a substitute for affection or attention or time or security or identity when

WHAT'S THE "TRIGGER" If one event or feeling was present all of these times, write it here.

I don't have to eat when I feel
YOUR RELATIONSHIP WITH GOD

My family (did, did not) attend church
I went by myself
I did not attend church
I went to church with one parent while one stayed home or attended another denomination
My family alternated between two denominations

I was taught that God was  

I became disillusioned about God when  

because  

Do you feel your faith has failed you? If so, how?  

FALSE GODS can be giving time or devoting oneself habitually to an addiction, etc.

Do any of these apply to me?

INTELLECTUALISM

SELF

OTHER HUMAN BEINGS AND INSTITUTIONS

I renounce the false gods of  

POSITIVE EXPERIENCES

AFFECTION:
I remember a time when I felt that Mom and/or Dad really loved me. They (he or she)__________________________

ATTENTION:
I remember a time when I felt as if I had my mom's and/or dad's full attention. They (he or she)__________________________

TIME:
I remember a time when I felt as if I had lots of my mom's and/or dad's time. They (he or she)__________________________

SECURITY:
I remember a time when I felt very secure as a child. I was_______

IDENTITY:
I remember a time when I really felt as if my mom and dad knew who they were and what they wanted out of life. I saw their goal in life as__________________________

This is______ is not_____ my goal in life.

What is your goal in life if it is not your parents' goal?
NEGATIVE EXPERIENCES

AFFECTION:
I remember times when I felt that Mom and Dad didn't love me. _____

Did I sometimes fill this love hunger with food? Yes no
I would __________________________

ATTENTION:
I remember times when I felt that Mom and Dad were not interested in what I was doing. They were preoccupied with __________________________

TIME:
I remember times when I felt that Mom and Dad never had any time for me. Their agenda was filled with __________________________

SECURITY:
I remember times when I felt very insecure. We, in the family, felt threatened by __________________________

I sometimes filled this love hunger with food. I would __________

IDENTITY:
I remember times when I felt very uncertain of who I was and where I was going. Mom or Dad's own identities seemed fragmented by_______

I sometimes filled this love hunger with food. I would___________

In a twelve step program, God can fill that love hunger. What do you need from Him?
FACE THE NEGATIVE FEELINGS ABOUT YOUR CHILDHOOD

What is the feeling in the pit of your stomach as you approach the front door of your childhood home?

I feel __________________________________________

Who will greet you? __________________________________________

As I open the door I am wondering __________________________________________

Are you happy to be home? _____yes _____no

I am happy to be home because __________________________________________

I am unhappy to be home because __________________________________________

As I walk through that door I am feeling __________________________________________

because __________________________________________

Is there any association between your feelings now and the trigger event you identified earlier this week? _____yes _____no

If not, could this experience be another trigger event? _____yes _____no

Another trigger event for me is __________________________________________

WRITE A JOB DESCRIPTION FOR GOD AND LIST CHARACTERISTICS.
## WEEKLY FOOD AND EXERCISE JOURNAL

<table>
<thead>
<tr>
<th>Date</th>
<th>Weight (First day of week only)</th>
<th>WEEKLY FOOD AND EXERCISE JOURNAL</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Breakfast/ A.M. Snack</td>
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<td>Day One</td>
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<tr>
<td>Day Seven</td>
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</tbody>
</table>
Step 3. We made a decision to turn our will and our lives over to the care of God, as we understood Him.

PREPARING TO TURN THINGS OVER TO GOD: FOCUSING AWAY FROM SELF

Shortly after Bill Wilson recognized God as the key to recovery from his addiction to alcohol, he discovered a principle that Bible authors wrote about centuries ago. They called it “dying to self,” and what it really means is that, in order to experience God and life and even self in the fullest senses, we have to focus off ourselves and refocus onto God and the needs of others. In Alcoholics Anonymous, Wilson wrote about his newfound faith:

I was to sit quietly when in doubt, asking only for direction and strength to meet my problems as He would have me. Never was I to pray for myself, except as my requests bore on my usefulness to others. Then only might I expect to receive. But that would be in great measure.

My friend promised that when these things were done I would enter upon a new relationship with my creator; that I would have the elements of a way of living which answered all my problems. Belief in the power of God, plus enough willingness, honesty and humility to establish and maintain the new order of things, were the essential requirements.

Simple, but not easy; a price had to be paid. It meant destruction of self-centeredness. I must turn in all things to the Father of Light who presides over us all.

These were revolutionary and drastic proposals, but the moment I fully accepted them, the effect was electric. There was a sense of victory, followed by such a peace and serenity as I had never known. There was utter confidence. I felt lifted up, as though the great clean wind of a mountain top blew through and through. God comes to most men gradually, but His impact on me was sudden and profound.

I feel I am in control of_____________________________________

People have told me I'm really good at_____________________________________

If I could be known for just one thing, I would want it to be_____________________________________

Turn these things over to God, too!!!
WHO is GOD?

Does God genuinely love and accept me? One reason I may doubt God's love for me is that

The thing I think He might have a hard time accepting about me is

My perception of God's love for me and His acceptance of me could be influenced by how much I love/accept myself because

I see God as a harsh, stern disciplinarian and I fear his punishment and wrath. My concept may differ. It is

Parts of me feel unworthy - can I ever win God's love and approval? God could never love me in light of the fact that

In my mind, to win God's love and approval I would probably have to
PERFECTIONISM: A form of passive abuse.

Describe some procedures and rules that played a significant part in your family of origin______________________________

How flexible were these standards?

How inflexible?

Which was more important: policy or people?

Describe one incident from your childhood that illustrates your answer to the previous question:______________________________

How did this impact your relationship with food?______________________________

Did eating ever seem like one way to break out of the perfectionism that may have ruled your home?  ___yes ___no

Did food ever seem to provide a replacement for relationships?  
Yes_____ NO_____

If so, which relationships from your childhood seemed most lacking in warmth and substance?______________________________

How would you have liked these relationships to be different?
HOW TO TAKE YOUR PULSE

How many times does your heart beat during 60 seconds while at rest? ____________

To obtain your own exercise pulse rate:
1. Subtract your age from 220 to find your maximum heart rate.
2. Multiply your maximum heart rate by .65 and then by .85 to give your exercise pulse rate range at 65 and then at 85 percent of your maximal cardiac output.

If you are a forty-year old:

\[
220 - 40 = 180 \text{ (maximum heart rate)}
\]
\[
180 \times .65 = 111 \text{ (65\% of cardiac output)}
\]
\[
180 \times .85 = 153 \text{ (85\% of cardiac output)}
\]

My exercising pulse rate range is from ____ to ____ beats per minute.

The easiest and most accurate way to check your pulse is to count your pulse for 10 seconds and multiply by 6.

My "quick-check" exercising pulse rate range is from ____ to ____ per 10 seconds.
### Benefits of Various Exercises

<table>
<thead>
<tr>
<th>Activity</th>
<th>Developing Cardiovascular Fitness</th>
<th>Developing Strength</th>
<th>Developing Muscular Endurance</th>
<th>Controlling Body Fat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Backpacking</td>
<td>...</td>
<td>...</td>
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<tr>
<td>Basketball</td>
<td>...</td>
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<td>Bicycling</td>
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<tr>
<td>Bowling</td>
<td>.</td>
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<tr>
<td>Circuit training</td>
<td>...</td>
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<tr>
<td>Cross-country skiing</td>
<td>...</td>
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<tr>
<td>Dance, ballet</td>
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<tr>
<td>Dance, exercise</td>
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<tr>
<td>Dance, modern</td>
<td>...</td>
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<tr>
<td>Dance, social</td>
<td>.</td>
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<tr>
<td>Football</td>
<td>...</td>
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<tr>
<td>Golf (walking)</td>
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<tr>
<td>Gymnastics</td>
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<tr>
<td>Hiking</td>
<td>...</td>
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<tr>
<td>Jogging</td>
<td>...</td>
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<tr>
<td>Racquetball</td>
<td>...</td>
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<tr>
<td>Roller skating</td>
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<tr>
<td>Skiing, downhill</td>
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<tr>
<td>Soccer</td>
<td>...</td>
<td>...</td>
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<tr>
<td>Swimming</td>
<td>...</td>
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<tr>
<td>Tennis</td>
<td>.</td>
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<tr>
<td>Walking, fast</td>
<td>...</td>
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<td>...</td>
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</tr>
<tr>
<td>Weight training</td>
<td>.</td>
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</tr>
</tbody>
</table>

... = excellent      ... = good     ... = fair     ... = poor

Which activities could you begin? ________________________________

The chart above clearly shows the benefits of cross training (participating in more than one activity). Do you feel that your exercise program is balanced and trains all parts of your body?  ____ Yes  ____ No

1. Slow but steady
2. Activity in any form counts
3. Diversify your activities
4. Find an exercise partner
5. Allow enough time for exercise
6. Make it fun and have a good attitude
**CALORIE VALUES FOR TEN MINUTES OF ACTIVITY**

<table>
<thead>
<tr>
<th>Personal and Housekeeping</th>
<th>125 Pounds</th>
<th>175 Pounds</th>
<th>250 Pounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping</td>
<td>10</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Sitting (watching TV)</td>
<td>10</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>Dressing or washing</td>
<td>26</td>
<td>37</td>
<td>53</td>
</tr>
<tr>
<td>Standing</td>
<td>12</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>Making beds</td>
<td>32</td>
<td>46</td>
<td>65</td>
</tr>
<tr>
<td>Washing floors</td>
<td>38</td>
<td>53</td>
<td>75</td>
</tr>
<tr>
<td>Washing windows</td>
<td>35</td>
<td>48</td>
<td>69</td>
</tr>
<tr>
<td>Shoveling snow</td>
<td>65</td>
<td>89</td>
<td>130</td>
</tr>
<tr>
<td>Light gardening</td>
<td>30</td>
<td>42</td>
<td>59</td>
</tr>
<tr>
<td>Weeding garden</td>
<td>49</td>
<td>68</td>
<td>98</td>
</tr>
<tr>
<td>Mowing grass (power)</td>
<td>34</td>
<td>47</td>
<td>67</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Locomotion</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Walking downstairs</td>
<td>56</td>
<td>78</td>
<td>111</td>
</tr>
<tr>
<td>Walking upstairs</td>
<td>146</td>
<td>202</td>
<td>288</td>
</tr>
<tr>
<td>Walking (30 minutes/mile)</td>
<td>29</td>
<td>40</td>
<td>58</td>
</tr>
<tr>
<td>Walking (15 minutes/mile)</td>
<td>52</td>
<td>72</td>
<td>102</td>
</tr>
<tr>
<td>Running (11 minutes/mile)</td>
<td>90</td>
<td>125</td>
<td>178</td>
</tr>
<tr>
<td>Running at 7 mph (8.5 minutes/mile)</td>
<td>118</td>
<td>164</td>
<td>232</td>
</tr>
<tr>
<td>Cycling at 5.5 mph (11 minutes/mile)</td>
<td>42</td>
<td>58</td>
<td>83</td>
</tr>
<tr>
<td>Swimming (backstroke)</td>
<td>32</td>
<td>45</td>
<td>64</td>
</tr>
<tr>
<td>Swimming (crawl)</td>
<td>40</td>
<td>56</td>
<td>80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Light Work</th>
<th></th>
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<tbody>
<tr>
<td>Assembly line</td>
<td>20</td>
<td>28</td>
<td>40</td>
</tr>
<tr>
<td>Auto repair</td>
<td>35</td>
<td>48</td>
<td>69</td>
</tr>
<tr>
<td>Carpentry</td>
<td>32</td>
<td>44</td>
<td>64</td>
</tr>
<tr>
<td>Bricklaying</td>
<td>28</td>
<td>40</td>
<td>57</td>
</tr>
<tr>
<td>House painting</td>
<td>29</td>
<td>40</td>
<td>58</td>
</tr>
</tbody>
</table>

Which activities will you be able to incorporate into your everyday lifestyle to help you get into a habit of burning more calories?

Activities I already participate in include ________________________________

Activities that I can begin now in order to increase my overall activity levels include:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

I anticipate that by including these extra activities in my daily living, I can burn _______ calories per day that was not previously part of my daily routine.
<table>
<thead>
<tr>
<th>Date ____________________</th>
<th>WEEKLY FOOD AND EXERCISE JOURNAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (First day of week only) ________</td>
<td></td>
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<tr>
<td></td>
<td>Breakfast/ A.M. Snack</td>
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<tr>
<td>Day One</td>
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<td>Day Seven</td>
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</tbody>
</table>
NEGATIVE MESSAGES

What did you hear about GOD? _________________________________

What did you hear about weight? ________________________________

What did you hear about food? _________________________________

What did you hear about your size? ______________________________

What did you hear about hunger? ________________________________

What were the verbal messages you remember Dad saying? __________

What do you remember what Mom was saying? ___________________ 

What did your mom and day say or not say about feelings? ________

Were the messages spoken or unspoken consistent with the treatment and behaviors exhibited? If not, sight examples. __________________________
STEP FOUR: WE MADE A SEARCHING AND FEARLESS MORAL INVENTORY OF OURSELVES.

Split-off feelings or needs are often expressed in camouflage.

**Example:**

<table>
<thead>
<tr>
<th>Split-off feeling or need</th>
<th>How need resurfaced in my life</th>
<th>Relation to food</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raised voices were not permitted.</td>
<td>With no legitimate expression for my anger, I developed a sarcastic tongue.</td>
<td>This isolated me from relationships; I ate to numb feelings.</td>
</tr>
</tbody>
</table>

Look at the previous page and cite examples of split-off feelings (one thing said, another acted out or expressed).

1.  
2.  
3.  
4.  
5.
MODIFY YOUR BEHAVIORS

Choose an appropriate eating place. Describe it.

Make your eating place special. Describe it.

Eliminate associated eating activities. What do I need to quit doing while I eat?

Out of sight will mean out of mind. What do you need to do to make your home 'safe' from visual cues? (refrig, cupboards, counters, hidden stashes, etc.).

Change your driving routes. Avoid the "pitfalls." Where do you need to avoid?

Use smaller plates.

Set some of your food aside - don't clean the plate! How do you feel about leaving food on your plate?

Talk about taking "seconds."

Don't be afraid to toss food? How do you feel about that?

Eat. Then wait 20 minutes.

Don't eat food you don't want? How does it feel to tell someone no?

Minimize your contact with food and the places related to food.
Who do I need to talk to about needing help with this problem with food. What do I need to say?
Name ___________________________ Message __________________
I now clear myself with __________________________
Name ___________________________ Message __________________
Name ___________________________ Message __________________

Where do I need to quit eating?
car
shopping at a mall
at work at my desk
from the snack machine
while walking around the house
while cooking
while preparing food
while on the phone
watching television
while reading
at the movies
while doing errands
grocery store

What else do you have to do to break a habit with food?
BREAKING THROUGH FOOD-RELATED DENIAL (food, diets the way I look)

I now abuse myself with ____________ by __________________________

WRITE as many examples as you can.

THE GOOD NEWS!!!! Check the ones that apply to you.

I recognize my problem and am taking action
I have completed the fourth step
I am changing my life
I have asked God into my life
I am peeling back the layers of denial related to food
I am learning to confront guilt and shame
WEEKLY FOOD AND EXERCISE JOURNAL

<table>
<thead>
<tr>
<th>Date</th>
<th>WEEK #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (First day of week only)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Breakfast/A.M. Snack</th>
<th>Lunch/P.M. Snack</th>
<th>Dinner/Nite Snack</th>
<th>Exercise</th>
<th>Feelings and Major Events of the Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day One</td>
<td></td>
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<tr>
<td>Day Two</td>
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<td>Day Seven</td>
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</tbody>
</table>
STEP FIVE: WE ADMITTED TO GOD, OURSELVES AND TO ANOTHER HUMAN BEING THE EXACT NATURE OF OUR WRONGS.

To prepare complete the following statements:

When someone I care about opens up to me about something hurtful in their life, I feel:

I think friends trust me with their secrets. Am I trustworthy or do I gossip? If my friends were to find out I did betray them, how would they feel? (Be specific with each betrayal).

What about the trust my family has put in me and I have broken? (Be specific).

My greatest fear in opening up to someone else about __________

___________________________ is ______________________________

It's time I open up about: (Just a word clue to jog the memory)
1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9. 
10. 

(week 5 has not been numbered - there's enough to do for the whole week with what was given!)
More to consider when preparing to do Step 5.

1. What are all my addictions?

2. What went wrong in my family of origin to initiate and fuel my dependent behavior on food?

3. What multi-generational wrongs have I been unable to face?

4. What are the wrongs that have occurred in all my major relationships, and what have I done?

5. How have I harmed others by practicing my food addiction? What about the harm related to the other addictions?
CHECKLIST OF GOOD EATING HABITS AND BEHAVIORAL GOALS

THE FOLLOWING summarizes the behavioral goals we hope will become a part of your own lifestyle. Place a check mark by the things you either already do or are willing to improve.

- I will use smaller plates for breakfast and lunch.
- I will purchase some smaller plates if I do not already have some with my current set of dishes.
- I will prepare a snack box for other members of my household to avoid so much food passing through my hands.
- I will attempt to cook at times of the day when I am not hungry and fatigued.
- I will attempt to do more cooking and freezing on the weekend so that I am not around food so much on a daily basis.
- I will fight the urge to finish all the food on my plate even though that was a part of my upbringing.
- I will consciously make a decision to leave at least a scrap of food to be thrown away at the end of each meal for a period of one month.
- I will not serve family style meals anymore except when absolutely necessary.
- If seconds are a problem for me, I will clean my kitchen before sitting down to eat.
- I will designate leftovers so that they will not be haphazardly eaten.
- I will not be afraid to throw away food that has no purpose.
- I will slow down my pace of eating and now realize that at least twenty minutes is required for food to make me not hungry anymore.
- I will no longer accept food that I do not want which is foisted upon me by others.
- I will attempt to identify and keep in check any behavioral chain patterns which seem to always end in overeating.
<table>
<thead>
<tr>
<th>Date</th>
<th>WEEKLY FOOD AND EXERCISE JOURNAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Breakfast/ A.M. Snack</strong></td>
</tr>
<tr>
<td>Day One</td>
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<td>Day Two</td>
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<td>Day Three</td>
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<td>Day Five</td>
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<td>Day Six</td>
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<tr>
<td>Day Seven</td>
<td></td>
</tr>
</tbody>
</table>
STEP SIX: WE WERE ENTIRELY READY TO HAVE GOD REMOVE ALL THESE DEFECTS OF CHARACTER.

I've been told more than once that I

I came into this group (and recovery) because:
HIDDEN FLAWS

I've been told more than once that I

One of the areas in my life that my family and/or friends have a hard time living with is (and why)

I wish (name of spouse, family member, friend, or coworker)__________________________
would stop nagging me about (list them all).

Is there a pattern emerging from the above list? Write it down.

I am__ or am not__ willing to ask God to remove all of these defects of character.
RELATIONSHIPS: The opposite sex.

Who are the persons in my past who have most influenced my perceptions of the opposite sex?

My feelings about the opposite sex in general might be described as:

I feel wounded by the opposite sex in the following ways:

I feel resentment toward the opposite sex because:

How have these feelings helped my relationships?

How have these feelings harmed my relationships?

In what areas might I need to make peace with the opposite sex?

RELATIONSHIPS: The same sex. Go through the above questions and answer them.
RELATIONSHIPS: My work family

What is the quality of my relationships with the people I work with? ____________________________

List 5 people with whom you interact while on the job and write a sentence or two about the relationship (good, poor, or difficult).
1.

2.

3.

4.

5.

Are the relationships healthy or is the work family suffering from dysfunction?

Who are the authority figures - "parents" in my work family? How do I relate to them?

Can I set boundaries? Yes____ No____
Are they honored? Yes____ No____
If not, why and how are they dishonored?

Am I being passively or actively abused in the work family? Yes____ No____
If so, by whom and how?

How do I feel when I go home? At whom are the feelings directed?

What is my emotional state when I head to work each morning?
RELATIONSHIPS: WITHIN THE FAMILY

Do I have the freedom to set appropriate boundaries? Yes ___ No ___
Are these boundaries honored? Yes ___ No ___
Am I being passively or actively abused in this family or relationship? ___ Yes ___ No
If so, how and by whom?

Am I subjected to someone else's unfinished business? If so, what and from whom?

How do I perceive the distribution of power in this relationship(s)?

The distribution of affection?

The distribution of time?

The distribution of money and material resources?

RELATIONSHIPS: MARRIAGE (Use notebook paper and answer thoroughly)

1. how do we share sexuality?
2. How do we share decisions and authority?
3. How do we share time?
4. How do we share money?

RELATIONSHIPS: Consider friends, peers, church groups, etc. Ask yourself the same questions.
<table>
<thead>
<tr>
<th>Date</th>
<th>WEEKLY FOOD AND EXERCISE JOURNAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (First day of week only)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Breakfast/ A.M. Snack</th>
<th>Lunch/ P.M. Snack</th>
<th>Dinner/ Nite Snack</th>
<th>Exercise</th>
<th>Feelings and Major Events of the Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day One</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Two</td>
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<tr>
<td>Day Three</td>
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<tr>
<td>Day Four</td>
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<tr>
<td>Day Five</td>
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<tr>
<td>Day Six</td>
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<td></td>
</tr>
<tr>
<td>Day Seven</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The following list includes many of the persons or things which can become addictive agents in your life. Place a check by the ones you suspect may be problem areas for you.

- Control addictions, especially if they surface in personal, sexual, family, and business relationships
- Sex
- Approval dependency (the need to please people)
- Rescuing patterns (the need to rescue or fix other people)
- Toxic relationships which are damaging or hurtful
- Cosmetics, clothes, cosmetic surgery, or other efforts to look good on the outside
- Academic pursuits and excessive intellectualizing
- Religiosity or religious legalism (preoccupation with the form and the rules and regulations of religion, rather than benefiting from the real spiritual message)
- General perfectionism
- Cleaning and avoiding contamination, and other obsessive-compulsive symptoms
- Organizing, structuring (the need always to have everything in its place)
- Materialism

(I am, I am not) willing to ask God to remove all of these defects of character. (Circle one.)
1. Plan ahead.
Remember the last time you were influenced by the menu or someone you were with and made a decision you had to live with - eat - and were unhappy. Describe what happened and how you handled it.

How can you better handle it next time?

2. Don't hesitate about making special requests.
salad dressing in a cup on the side
do not cook in butter
do not add butter
place the sauce on the side
remove the skin from the poultry
bring only the leanest cut of meat
don't leave a bread or chip basket

3. Deal with the restaurant portion size.
request a child's portion or senior's portion
take home half of the meal
take a friend and split one dinner
don't return to the restaurant if your wishes aren't considered

4. Avoid high-calorie drinks and desserts.

5. Don't fall for the extras!
### FOOD SELECTION GUIDELINES FOR EATING OUT

YOUR MENU exchanges will be your first and primary guide to what to eat when you eat out. This chart is provided as a quick reference and summary of what types of food you will find on the menu exchanges for both the breakfast and lunch/dinner entrees. For specific menus and portion sizes, review pages 349 through 362.

#### BREAKFAST

<table>
<thead>
<tr>
<th>Order These</th>
<th>Avoid These</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oatmeal or grits</td>
<td>Hash brown potatoes</td>
</tr>
<tr>
<td>½ bagel or English muffin</td>
<td>Biscuits (usually very high in fat)</td>
</tr>
<tr>
<td>Lean ham or Canadian bacon (best meat)</td>
<td>Sausage, bacon</td>
</tr>
<tr>
<td>Whole grain muffins, pancakes</td>
<td>Waffles, other bakery items</td>
</tr>
<tr>
<td>Juices</td>
<td></td>
</tr>
<tr>
<td>Black coffee or tea</td>
<td></td>
</tr>
<tr>
<td>Fresh fruits</td>
<td></td>
</tr>
<tr>
<td>One egg a la carte, one toast</td>
<td></td>
</tr>
<tr>
<td>High fiber cereals, low-fat milk</td>
<td></td>
</tr>
</tbody>
</table>

#### LUNCH

<table>
<thead>
<tr>
<th>Order These</th>
<th>Avoid These</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chef salads including limited amounts of meat, cheese, egg, low-cal dressing</td>
<td>Heavy creamed soups, salads with regular dressings</td>
</tr>
<tr>
<td>Ask for sliced tomatoes instead of extra side-dishes</td>
<td>Chef salads with unlimited amounts of toppings and/or high-fat salad dressings</td>
</tr>
<tr>
<td>Clear soups, salads with low-cal dressing</td>
<td>Chips, potato salad, cole slaw served with sandwiches</td>
</tr>
<tr>
<td>Sandwiches with mustard and lean meats and/or low-fat cheese</td>
<td>Sandwiches made with mayo or other dressing and processed meats (bologna, salami, etc.)</td>
</tr>
<tr>
<td>Regular-sized hamburgers, no mayo or butter (omit ½ bun if possible)</td>
<td>Hamburger with mayo, salad dressing, and/or cheese (they use high-fat cheeses)</td>
</tr>
</tbody>
</table>
### AMERICAN RESTAURANTS

**Order These**
- Clear soups
- Green salads (low-cal dressing)
- Lean meats (grilled, broiled, or served au jus)
- Fish or poultry (steamed; poached in wine, lemon or lime juices; grilled; baked; or broiled)
- Lean beef (4 oz. maximum)

**Avoid These**
- Buttered
- Creamed
- Fried
- Batter-fried

### CHINESE RESTAURANTS

**Order These**
- Steamed vegetables
- Steamed rice
- Fish and chicken dishes with vegetables (Moo Goo Gai Pan, Chicken with Snow Peas, etc.)

**Avoid These**
- Fried foods
- Nuts
- Fried rice

### SEAFOOD RESTAURANTS

**Order These**
- Broiled, steamed, poached or grilled
- Lemon and cocktail sauce
- Seafood cocktails
- Clear or tomato-based soups

**Avoid These**
- Fried foods
- Cheese sauces
- Cream-based chowders
- Crunchy coating mixes

### MEXICAN RESTAURANTS

**Order These**
- Bean tostadas, no sour cream or guacamole
- Lean meat tacos
- Taco or Fajita Salads, with limited cheese, sour cream, and guacamole
- Chicken fajitas, one tortilla, meat, and pico de gallo, salsa, lettuce, and tomatoes
- Rice (if cooked with little fat)
- Grilled meats

**Avoid These**
- Cheese
- Chili con queso
- Large dinners
- Tortilla chips
- Chili con carne
- Enchiladas
- Fried dishes
**FRENCH RESTAURANTS**

<table>
<thead>
<tr>
<th>Order These</th>
<th>Avoid These</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Nouvelle cuisine” or “Cuisine minceur”</td>
<td>Chicken, seafood, or veal (without heavy sauces)</td>
</tr>
<tr>
<td>Poached dishes</td>
<td>Clear soups</td>
</tr>
<tr>
<td>Simple fresh fruits, vegetables</td>
<td></td>
</tr>
<tr>
<td>Cream sauces</td>
<td>Brown gravies</td>
</tr>
<tr>
<td>Béarnaise sauce</td>
<td>Butter enrichments</td>
</tr>
<tr>
<td>Mornay sauce</td>
<td>Pastries and crust</td>
</tr>
<tr>
<td>Béchamel sauce</td>
<td></td>
</tr>
</tbody>
</table>

**ITALIAN RESTAURANTS**

<table>
<thead>
<tr>
<th>Order These</th>
<th>Avoid These</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vegetable soups</td>
<td>Tomato sauce</td>
</tr>
<tr>
<td>Bean soups</td>
<td>Pasta</td>
</tr>
<tr>
<td>Clear soups</td>
<td>Veal, chicken, or fish dishes (without heavy sauces or cheese)</td>
</tr>
<tr>
<td>Vegetable antipasto</td>
<td></td>
</tr>
<tr>
<td>Fresh fruit</td>
<td></td>
</tr>
<tr>
<td>Bread</td>
<td></td>
</tr>
<tr>
<td>Fried foods</td>
<td>Heavy use of oil</td>
</tr>
<tr>
<td>Italian sausage</td>
<td>Pastries</td>
</tr>
<tr>
<td>Cheeses, to excess</td>
<td></td>
</tr>
</tbody>
</table>

**“STEAKHOUSE” RESTAURANTS**

<table>
<thead>
<tr>
<th>Order These</th>
<th>Avoid These</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salad bar (with low-fat dressing)</td>
<td>Baked potato (with low-cal dressing or 1 Tbsp. sour cream)</td>
</tr>
<tr>
<td>Best beef choices: sirloin, tenderloin (no more than 4 oz.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PIZZA RESTAURANTS**

<table>
<thead>
<tr>
<th>Order These</th>
<th>Avoid These</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plain cheese pizza</td>
<td>Vegetable toppings (especially onions, pepper, and mushroom)</td>
</tr>
<tr>
<td>Salad (low-cal Italian dressing)</td>
<td></td>
</tr>
<tr>
<td>Best meat topping: Canadian bacon</td>
<td></td>
</tr>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Avoid These</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salami</td>
<td>Sausage</td>
</tr>
<tr>
<td>Pepperoni</td>
<td>Extra cheese</td>
</tr>
<tr>
<td>Extra oil</td>
<td></td>
</tr>
</tbody>
</table>
STEP SEVEN: WE HUMBLY ASK HIM TO REMOVE OUR SHORTCOMINGS.

1. Recognize the severity of your character defects.

2. Acknowledge the limits of human power.

3. Appreciate the enormity of God's power to transform your life.

The use of material things will never by themselves bring contentment. Complete the following sentences; use several examples.

I have accomplished:
1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 

I have amassed (material things):
1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 

An example of "rainbow thinking" WHEN I TURN SIXTEEN, THEN MY PROBLEMS WILL BE OVER. OR WHEN I LOSE TWENTY POUNDS, I'LL BE HAPPY.

Add your own statements.__________________________________________

Material needs will never satiate your codependent hunger. List two situations that have driven you to eat this past week. Put an X by the example if eating helped bring resolution.

1. 
2.
Protein is a key factor in a weight loss program in that it takes your body more effort to metabolize protein than either fat or carbohydrates. Incorporate the best protein sources available that contain the lowest amounts of fat. Fish is the best meat choice. Skinned white meat of turkey is your next best choice.

List the types of meats your family ate as children and how they were prepared.

1.
2.
3.
4.
5.

Now, look for an alternative way to prepare them using less fat. Consider purchasing a cookbook with alternatives.

Are you willing to take some extra time to prepare food in a more healthful manner? ____yes ____no

Write down your plan to include healthful cooking or food preparation that you could try but haven't considered doing in the past.

What protein can you NOT LIVE WITHOUT? Go ahead and plan to have it!! Can it be prepared in a more healthful manner?

Remember food choices, portion sizes and the way protein is prepared can be altered and you can feel satisfied that you are starting a new, healthy way of life.
OTHER CONSIDERATIONS

VITAMIN AND MINERAL SUPPLEMENTATION:

If you consume a balance of all food groups, vitamin and mineral supplements are probably not necessary. People tend to short them selves in milk or vegetables. Calcium supplementation for women is important. Pills do not make up for a poor diet, however.

CALORIE DISTRIBUTION:

<table>
<thead>
<tr>
<th>Component</th>
<th>Percentage of Total Daily Caloric Intake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protein</td>
<td>25 to 35 percent</td>
</tr>
<tr>
<td>Carbohydrate</td>
<td>40 to 60 percent</td>
</tr>
<tr>
<td>Fat</td>
<td>15 to 25 percent</td>
</tr>
</tbody>
</table>

FIBER:

Increasing fiber will help move digesting food in the intestine along at a faster rate. Include one-half cup of a high fiber cereal in your diet daily.

EXERCISE:

It helps you burn more calories during the actual exercise period and afterwards for the following four to six hours.

It has been nearly 2 months since you started this program. Are you exercising at least 30 minutes per day? If not, how much exercise are you getting?

It will pay off in the end. If you are not satisfied with your exercise program, examine the reasons.

Can you make further changes in your schedule to make it a priority?

IN SUMMARY: THE FACTORS TO INCLUDE IN WEIGHT LOSS ARE:
1. Exercise regularly.
2. Plan on decreasing your caloric intake slightly with advancing age.
3. Decrease your fat intake.
4. Eat very lean sources of protein and include complex carbohydrates in your diet.
5. Consume at least 25 grams per day of dietary fiber.
FATS

IF YOU EAT FAT, IT TURNS INTO FAT!!!

There are two types of fat: Saturated and unsaturated.

SATURATED FATS are primarily found in foods of animal origin, including meats, cheese, whole milk dairy produces and butter. Cholesterol is generally found in foods of animal origin.

UNSATURATED FATS are usually of plant origin and can be mono-unsaturated like olive oil or can be polyunsaturated like corn and safflower oil. Mono-unsaturated fat is known to work best to lower total cholesterol.

No matter what kind of fat you choose, the calories are about the same. Thus, if you want to lose weight, lower the fat intake.

How much fat is enough? Never go below 10 percent of your total caloric intake. Most Americans consume a diet of 40 to 45 percent fat. To lose weight, try to keep the fat to 25 percent of your total caloric intake.

What foods do you need to eliminate from your diet now to lose weight?

To determine the fat content of any food from the food label information, use the following equation:

\[
\text{%fat} = \frac{\text{grams of fat per serving} \times 900}{\text{calories per serving}}
\]

Just plug the number of grams and calories per serving into the correct spot and you can determine the "true" fat percentage.

MODIFY, LIMIT, DILUTE

1. Read labels and recipes carefully.
2. Dilute recipes.
3. Limit oils.
4. Watch the cholesterol.
5. Use a separating cup.
Missing
FOOD FLAVORINGS AS A REPLACEMENT FOR SALT

<table>
<thead>
<tr>
<th>Beef</th>
<th>Bay leaf, dry mustard, green pepper, red wine, sage, marjoram, mushrooms, nutmeg, onion, pepper, thyme.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken and poultry</td>
<td>Cranberries, mushrooms, paprika, parsley, poultry seasoning (unsalted), thyme, sage, lemon juice, orange juice, lime juice, white wine.</td>
</tr>
<tr>
<td>Lamb</td>
<td>Curry, garlic, mint, pineapple, rosemary.</td>
</tr>
<tr>
<td>Pork</td>
<td>Apple, applesauce, garlic, onion, sage, cranberries.</td>
</tr>
<tr>
<td>Veal</td>
<td>Apricots, bay leaf, curry, currant jelly, ginger, marjoram, oregano.</td>
</tr>
<tr>
<td>Fish</td>
<td>Bay leaf, curry, dry mustard, green pepper, lemon juice, lime juice, marjoram, mushroom, paprika, onion, dill weed parsley.</td>
</tr>
<tr>
<td>Eggs</td>
<td>Curry, dry mustard, green pepper, jelly, mushrooms, onion, paprika, parsley, tomato.</td>
</tr>
<tr>
<td>Asparagus</td>
<td>Lemon juice.</td>
</tr>
<tr>
<td>Corn</td>
<td>Green pepper, tomato, sugar.</td>
</tr>
<tr>
<td>Green beans</td>
<td>Marjoram, lemon juice, nutmeg, dill seed, sugar, unsalted French dressing.</td>
</tr>
<tr>
<td>Peas</td>
<td>Onion, mint, mushrooms, parsley, green pepper.</td>
</tr>
<tr>
<td>Potatoes</td>
<td>Onion, mace, green pepper, parsley.</td>
</tr>
<tr>
<td>Squash</td>
<td>Ginger, mace, onion, basil, nutmeg.</td>
</tr>
<tr>
<td>Tomatoes</td>
<td>Basil, marjoram, onion, sugar.</td>
</tr>
</tbody>
</table>

1. Fish is your best meat choice.
2. Remove visible fat and skin from meat.
3. Substitute herbs and spices for fat and salt.

FIGHTING FAT

1. Avoid high-fat breads, chips, and dips.
2. Don't fry.
3. Avoid high-fat crackers.
4. Substitute egg whites for whole eggs: two egg whites for each whole egg or one-half cup of egg beaters instead of two egg whites.
5. Use butter substitutes.
6. Avoid regular salad dressings.

TRIM YOUR DAIRY FAT

1. Use skim milk or ½ percent milk.
2. Use a part-skimmed cheese or one that is lower in fat.
3. Use skimmed or evaporated milk.
4. Use lean sandwich meats.
5. Substitute yogurt for sour cream and cream cheese.
6. Low-calorie ice milk can be OK as a frozen dessert.
7. Use angel food cake.
8. Avoid soggy, packed lunches.
NUMBING THE PAIN

Food can tranquilize pain for a short time. It is a false gratifier because it is short lived, self-destructive, and allows you to ignore the real issue.

Learn to set boundaries to deal with addictive agents or behaviors. This may mean total abstinence or moderation.

I am addicted to ____________. My recovery goal for this addiction is (balance or abstain) _____________.
If it is balance, set specific boundaries: _____________.

What are the trigger events that "set" of my eating behavior?
List at least 5 examples using the above model.
GUILT AND SHAME

Guilt is about what you did; shame is about who you are.

Guilt: I shouldn't have eaten that bag of candy.
Shame: I am a bad person. I don't deserve to be thin or look better.

I feel guilty or ashamed whenever I think about ______________________

Did I produce this behavior? ___ yes ___ no ___

If not, who did? ______________________

Exactly how did I influence this even, crisis, or behavior? ____________

If I am, indeed, responsible for this event, crisis, or behavior, are there any persons, including myself, who have been hurt as a result? ___ yes ___ no ___

If so, who are they, and how have they been injured? ______________________

If I am, indeed, responsible for this event, crisis, or behavior, is it morally or legally wrong? Is there anything I can now do to remedy the situation and thus move past the guilt?

Consider this format for dealing with your guilt. This letter or discussion is to get in touch with the painful feelings.

Dear ______________________,
I've been thinking about ______________________ and the way you have been hurt by this. I realize that I'm the one responsible - that I should have _______________________
(continue on!!)
SELF-HATRED

Guilt says, "I shouldn't have done that," and shame says, "I'm a bad person." Self-hatred takes it a step further and says, "I don't even deserve to live."

Food is a form of slow suicide if you use it as a drug.

List the specific, self-destructive features of your food addiction.

What are several health risks that are associated with obesity or with a diet high in fat or sugar?

When I think of death I (check all that apply):

feel scared  
think death would be a relief  
wonder what it would be like to escape all the pain  
think about who would miss me  
feel anxious  
wonder how I'll die  
keep waiting for life to really begin for me  
think about how I've mistreated my body  
feel sad, but sometimes I think I deserve it  
try not to think about it  
think about disease a lot  
am afraid of any pain involved  
look forward to a happier afterlife  
don't feel I'm really living very fully now

The 7th Step Prayer taken from the Twelve Steps and Twelve Traditions:

My creator,

I am now willing that You should have all of me, good and bad. I pray that You now remove from me every single defect of character which stands in the way of my usefulness to You and my fellows. Grant me strenght as I go out from here to do Your bidding. Amen.

THERE ARE NO MIRACLE CURES!!
<table>
<thead>
<tr>
<th>Date __________</th>
<th>WEEKLY FOOD AND EXERCISE JOURNAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (First day of week only) __________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Day One</th>
<th>Breakfast/A.M. Snack</th>
<th>Lunch/P.M. Snack</th>
<th>Dinner/Nite Snack</th>
<th>Exercise</th>
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STEP EIGHT:  WE MADE A LIST OF ALL PERSONS WE HAD HARMED AND BECAME WILLING TO MAKE AMENDS TO THEM ALL.

Every time you hurt someone, it leaves a toxic residue. Often we carry that residue for years - which is why Steps 8 and 9 are important ways of reducing shame and guilt.

This step is not contingent on the other person's returning the apology; it's not necessarily reciprocal. Make the amends for your own peace of mind so you feel cleared of your responsibility for what went wrong it the relationship.

In your family of origin, how did your parents resolve relationships when they had done something to damage the bond?

Did members of your family readily admit fault or guilt to one another? ____yes  ____no

When such an admission was made, how did your parents react?

Were your parents able to admit their own imperfections to their children? ____yes  ____no

If not, what image did they present instead?

In your adult life, are you able to easily apologize to people you have hurt? ____yes  ____no

If not, what is your alternative approach when you realize that words or actions of yours have damaged a relationship?

Looking at your present day relationships, do they "go back" any length of time or are they all fairly new relationships?

When you hit a "glitch" in a relationship, is it easier to let the relationship fade and begin a bond with someone new, or have you learned to work the relationship past the troubled spot?

A list of relationships that are closer because of working through the mistakes and problems.

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A list of relationships that have faded and died because one person offended the other and things were never patched.

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 Spend a little time writing about how the above relationships might have flourished had either party "worked" through the conflict.
SAYING GOOD-BYE TO YOUR WISHES

YOU NEED to say good-bye to the hope, wish, or fantasy that you could never change your family of origin. You aren't responsible, and saying good-bye to that notion is important because if you, at any level, believe that you are responsible then the sense of failure you may experience can propel you deeper in the food addiction cycle. Use additional paper if necessary.

It's time to say good-bye to the wish that ________________________________

It's time to say good-bye to the wish that ________________________________

SAYING GOOD-BYE TO YOUR NEED TO MIMIC OR REBEL

YOU ALSO need to say good-bye to your need to mimic or rebel against members of your family of origin. This "good-bye" must take place before you can choose the parts of your emotional heritage you want for yourself, and freely leave the parts you don't want.

An aspect of ________________'s role that I choose to reject for myself is ________________________________
(fill in the name and use additional paper to complete.)

An aspect of ________________'s role that I choose to incorporate in my life is ________________________________
(fill in the blank and use additional paper to complete.)

I no longer need to mimic ________________. Instead I can ________________________________
(Make a complete list using additional paper).

I no longer need to rebel against ________________________________ by ________________________________
Instead, I ________________________________
(Make a complete list using additional paper).
REVIEW YOUR CURRENT RELATIONSHIPS

Consider family, friends, co-workers.

I realize now that I harmed my relationship with ____________________
when I ________________________________

As a result, my carelessness has impacted the relationship in the following manner: ________________________________

The reason I have not sought to repair any hurt resulting from this event is that ________________________________

Clearing the air is
   Important to me because ________________________________

   Not important to me because ________________________________

Regarding this violation of the relationship, I would like to say to this person ________________________________

(Use the above format and clear up all relationships. Use another sheet of paper).
HOW IS THE WAY I AM EATING OR NOT EATING AFFECTING THE NEXT GENERATION?

Even if you are not a parent, chances are that children, youth and teens that you are influential with have seen your eating behaviors.

A child in whose life I play a significant role (or played a significant role if that child is now an adult) is _______________________

Do/did I ever binge in the presence of this child? ____yes ____no

Do/did I allow this child to participate in unhealthy eating habits? ____yes ____no

If so, what?

Have I ever lashed out at this child when I was, in fact, frustrated with the issues and dysfunctions in my own life? If so, mention a specific or representative incident.

Have I ever been distracted or depressed with my food addictions in such a way that it caused me to be negligent in meeting any of this child's needs? If so, what needs and how did they go unmet?

In what ways had this child modeled any part of my life (such as in areas of personality, career choices, values, communication, people skills, habits)?

When I think of the possibility of this child's mimicking my addictions to food or the other agents at any point in the future, I feel

In response to any wrongs I may have inflicted on this relationship, I would like to say to this child:

Use the above format and extra paper to do all the names you need to cover.

This exercise is not to drive you to guilt and shame, but to become a role model. REMEMBER! We can do the best we can - YOU CANNOT MODEL PERFECTION!!!
BODY IMAGE

YOUR PATH TO recovery must include the process of saying good-bye to the distorted body image standing between you and freedom from your food compulsion. This can mean several different things.

If you have been chronically obese, you may have come to a point of resignation, throwing your hands in the air and accepting the unnecessary statement that you will always look this way and can never really improve your appearance. If this is the case, then you have locked yourself into an image that is a distortion of the truth. The truth is you may look this way today; the truth is also that you can look a great deal different this same time next week, next month, or next year. A distorted body image that limits you to your present size can become a self-fulfilling prophecy. To continue in recovery, you need to say good-bye to that distorted image and begin to nurture a new image of the way you want to look.

On the other end of the spectrum, if you are bulimic or anorexic you may- no matter how trim or fit you get- see fat or obesity that is not there. To progress into full recovery you, too, must say good-bye to that distorted body image and work on a new view of yourself that reflects reality.

The third possibility is that you are a compulsive overater who may be in denial about his or her obesity. An example is the client who was approaching 400 pounds; he looked one of our counselors straight in the eye and admitted that he knew he needed to lose 40 or 50 pounds. He actually needed to lose several hundred pounds but honestly couldn’t see that.

Take a moment and record your perception of your body image; What do you look like? What words would you use to describe your shape?

Now ask two people to describe you:
1.

2.

Were the two people fairly consistent? Do they think you need to lose weight? If so, how much? Is it consistent with what you think? Do the two people's opinions differ greatly from yours?
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SUCCESSFUL GRIEVING

The positive steps you have been taking in recovering from food addiction represents a major loss in your life. You are giving up old coping mechanisms. IT'S LIKE LOSING AN OLD FRIEND!!

This week you will deal more with the concept of saying "hello" and good-bye to pain.

Become familiar with the dynamics of grief; if you don't complete the cycle you will remain under the influence of that loss. YOUR future depends upon the grief process. GRIEF must be done in three realms.

1. It's important to grieve alone. It's important but cannot complete the process.
   What loss or pain have you allowed yourself to grieve alone only?

2. The process also involves grieving with other human beings. Therapy or support groups are important.

3. Vicarious grieving is a third key. As other people share their pain, it triggers your losses and personal grief.
   Where do you allow yourself to be exposed to other's pain?

Can you describe empathy vs carrying that pain for another person?
STEP NINE: WE MADE DIRECT AMENDS TO SUCH PEOPLE WHEREVER POSSIBLE, EXCEPT WHEN TO DO SO WOULD INJURE THEM OR OTHERS.

This is the time you take the list compiled in Step 8 and begin the process of amends. IT IS NOT EASY. But you need to do so to continue your recovery. Amends are:

1. Sincere efforts to offer apology for past harm and hurt.
2. Wonderful bridge-builders for more positive future relationships.
3. Effective tools in removing that tremendous weight of guilt, shame, and remorse.

Amends are NOT:

1. Installment payments on guilt and shame. Do not do so as it will injure others.
2. Do not make an amends IF it will injure another. (Example is telling your best friend that you have had an affair with his/her spouse).

Who are the people on whom you have inflicted the most obvious pain?
Name:
Nature of how relationship was hurt:

Verbal amend:

Do you need to do more?

Commit yourself to a time and place to do so.

Use the above format for all the people on step 8 list.
The first two stages of grief: shock and denial.

Denial is lying to yourself about the gravity or severity of a problem. Shock is a delayed reaction to the severity of a problem. Shock creates an emotional time bomb. Food may be a way of medicating the shock or denial. Think about and list the traumas in your life.

Make a list of compulsive or destructive behaviors.
Examine the list of people whom amends are not due. You can use the following questions to examine that list.

Name:
How have I been responsible for any portion of the hurt?

How has this other person been responsible for any portion of the hurt?

Does either one of us carry a vast majority of responsibility for the problems in our relationship? If so, who?

If I carry a small portion of the responsibility - for example 10 percent compared to the other person's 90 percent - how realistic are my feelings of guilt and shame?

I do or do not have a responsibility to apologize for this damaged relationship. Circle one.

Use the above format for all people you are not sure you owe amends to. If you are still not sure, discuss it with a therapist, your sponsor and in your support groups.
The third stage of grief is anger. Anger is multi-leveled. There may be a felling of depression - anger turned inward. Often we project anger toward a person that doesn't reflect the true source of anger.

There is true anger and beneath it lies a fear on insecurity. This is the foundations for all anger and resentments.

**I am depressed by:**  **I am angry about:**  **I am afraid of:**

Grief is to get in touch with your feelings and when we stuff our feelings, addictions surface.

Grief is painful, but it is healthy pain and keep in mind that your pain is giving birth to life, not death.

**IT IS ALSO TIME TO MAKE AMENDS TO YOURSELF.** Besides making verbal amends to yourself, you will most likely need to set limits and boundaries so that you will not be a victim again.

I need to make amends to myself for:

I pledge to myself that:

Use the above format and make a list.
The fourth stage of grief is true grief or sadness. So many people don't reach this stage and get hung up in earlier stages for weeks, months, or decades.

The grief or sadness the previous lessons have brought forth may take a period of time to overcome. Use your support group or peers for a "shoulder to cry on."

If grief or sadness comes upon you, break away for time to feel the feelings - journal, cry, etc. Explore the feelings.

The stages of grief do not necessarily go in a linear fashion.

ALSO, THERE ARE PEOPLE WHO SHOULD NOT BE CONTACTED!!
Use this format to examine those people's names.

In my relationship with ____________, I was responsible for _______________ and in many respects should make an effort to express my remorse and clear the air. Yet due to circumstances surrounding ________________, contacting this person might result in more damage than good. The kind of damage or pain that might result from person-to-person contact includes: ________________

Go over this list with your sponsor and/or therapist.
The fifth stage of grief is resolution, acceptance, and/or forgiveness. This does not mean that you agree with what happened - instead you simply are saying that you have gotten to the place where you can accept that it happened and forgive.

You cannot jump directly to this stage by bypassing the other stages. Ungrieved anger and sadness will demand indirect expression as well as something to push you back down and when the feelings begin to surface, addictions are likely to surface.

List your losses or hurts. Who have you held responsible?

Take time to picture these losses and people. Get in touch with your body signals. If feelings or bitterness or fear arise, you must go back and finish the grief process; that means go back and work through previous stages. Do not be hard on yourself. IT TAKES A LONG TIME!!

Some people cannot be contacted, for whatever reasons. Try one of these techniques. You may need the help of a therapist.

1. Empty-chair technique. Imagine the person is there. Express your feelings and imagine the response.
2. Write a letter even though it cannot be mailed.

If I could speak with ______________, I would express my remorse and regrets regarding ___________________________.

Unfortunately, I no longer have access to this relationship due to ________________________________.

As a means of addressing my personal need for some resolve to the pain in our relationship I will adopt the previously described method of:

   empty chair
   writing a letter
   gave-site visit
## WEEKLY FOOD AND EXERCISE JOURNAL

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STEP TEN: WE CONTINUED TO TAKE PERSONAL INVENTORY AND WHEN WE WERE WRONG, PROMPTLY ADMITTED IT.

Ask yourself the following questions every day as you continue your recovery process:

What are my needs, including basic needs such as love, acceptance, and security?

Can I acknowledge the legitimate place of these needs in my life? __yes __no

Are these needs being met in a legitimate fashion? __yes __no

If not, what changes can I make to encourage the healthy, appropriate fulfillment of these needs?

Were your parents overweight? Both or just one?

What about your grandparents, aunts, and uncles?

What about your brothers and sisters?

Were the above-named people overweight because of their eating habits or because of their genetic makeup?

Do you feel that they were overweight because of a combination of these two factors?

How do you feel about the reasons for your own problems with weight? What factors figure in?
What are the "bogus" methods you use to try to satisfy yourself and your needs?

I deserve to look good.  ____yes ____no

Am I overcontrolling others?  ____yes ____no

I deserve to be healthy.  

What would be a better approach to meeting that need? ___________

By body is a gift from God.  

Am I being perfectionistic or compulsive with myself or others?  ____yes ____no

I deserve to feel good.  

What would be a better approach to meeting that need? ___________

Am I attempting to win acceptance by playing the martyr or the victim role in relationships?  ____yes ____no

If so why? ____________________________

Am I attempting to win acceptance by playing the martyr or the victim role in relationships?  ____yes ____no

If so, why? ____________________________

What would be a better approach to meeting that need? ___________
LET'S CHANGE THE MESSAGES!!!

I deserve to look good.
I can reach the top.
I deserve to be healthy.
My body is my friend.
My body is a gift from God.
My body is something I have control over.
I am happy to be the gender God created me to be.
I enjoy feeling good.
I enjoy looking good.

What are some of the negative messages you repeat to yourself?

Sometimes I look in the mirror and think

I seem to be always berating myself for

Even when other people give me compliments, I may discount their comments and think, instead

I most often think negative thoughts about myself in the area of
You cannot prevent obesity from affecting your life at this point. BUT YOU CAN PREVENT IT FROM RECURRING.

1. Every time you try to lose weight again after losing and regaining, it is metabolically more difficult.

2. Make permanent changes and continue the same routine you have begun in this program.

3. Keep up your exercise.

NEW MESSAGES ABOUT RELATIONSHIPS!!

I want people in my life.
I can enjoy healthy relationships.
I can enjoy intimacy in my relationships.
I deserve to be sexual.
I have permission to ask people to help meet my needs.
I can love and be loved.
My spouse is my best friend.

You have a right to ask spouse, friend, colleague and family to meet your legitimate needs so you don't meet them with food!

I give myself permission to ask that my need for _____________ be met through the dynamic of relationship. In the past, I have sought to meet this need through the means of _____________

______________________________

I CAN GIVE AS WELL AS RECEIVE! I NEED TO CHANGE _____________(behavior) in my relationship with _____________(name).
Instead, I choose to ____________________________.

With the above model, consider family, boss, co-workers, etc.
NEW MESSAGES ABOUT YOUR VALUE

I deserve to live.
I deserve to succeed in my career.
God loves me.'
God forgives me.
I accept forgiveness.
God guides me.
God gives me strength to enact my new decisions.

WRITE NEW, POSITIVE MESSAGES ABOUT YOUR RIGHT TO EXIST!!

WRITE NEW MESSAGES ABOUT YOUR RIGHT TO HAVE THOUGHTS AND FEELINGS!!

WRITE NEW MESSAGES ABOUT YOUR RIGHT TO HAPPINESS!!

Each day ask yourself the following questions about possibly violating others' boundaries.

Am I aware of instances in which I have violated my own boundaries or the boundaries of others?

If so, what were the personal boundaries that I allowed others to cross?

How did I feel when my boundaries were not respected?

What were the boundaries belonging to others that I allowed myself to cross?

How did violating those boundaries make me feel?

How can I reset and reestablish new, proper boundaries?

How can I make amends to those who have been harmed?

What were the needs driving me to the violation?

How can I meet my needs in other ways?
NEW MESSAGES ABOUT FOOD!!

I give my body the most nutritious food I can.  
I stop eating when I am satisfied.  
I never eat in secret.  
My diet is a gift I'm giving myself.

Make food your friend, not your enemy!

Food is not and cannot serve in foles for which it was not created. Food is for physical nourishment. What have you used food for in your life?

I have tried to elevate food to be a tranquilizer for my pain. From now on, I will allow myself to feel the pain, say good-bye to the pain and grieve past the pain.

From now on, I will ____________________________

Use this format and write down all the things you have tried to have food do for you but it could not.
In order to recover from food addiction, you will need to set new boundaries.

SOCIAL AND RELATIONSHIP ISSUES

The first step toward establishing a boundary with __________
I will need to ________________________________
This boundary is important because ________________________________

SEXUAL ISSUES

The first step toward establishing a boundary is to __________
This boundary is important because ________________________________
I would like to say 'no' to ________________________________
I would like to say 'yes' to ________________________________

FINANCIAL ISSUES

The first step toward establishing this boundary is to __________
This boundary is important because ________________________________
I will take care of myself financially by ________________________________

HEALTH AND PHYSICAL ISSUES

The first step toward establishing this boundary is to __________
This boundary is important because ________________________________
I will take care of myself and my body by ________________________________

FOOD ISSUES

The first step toward establishing this boundary is to __________
This boundary is important because ________________________________
I will make appropriate food choices by ________________________________
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STEP ELEVEN: WE SOUGHT THROUGH PRAYER AND MEDITATION TO IMPROVE OUR CONSCIOUS CONTACT WITH GOD, PRAYING ONLY FOR KNOWLEDGE OF HIS WILL FOR US AND THE POWER TO CARRY THAT OUT.

Is there a special time of day when you might carve out a niche of time in which to spend time alone with God? Is so, that time might be when? 

What can you do to protect that time from being crowded out by the hustle and bustle of your many responsibilities?

Is there a special place you would like to spend these moments in prayer? Is so, describe that place.

Are you willing to make the commitment to begin today spending daily time alone with God in prayer? ___yes ___no

If you have a schedule that, at times, takes away your time with God, don't let shame and guilt set in. Re-establish your routine and set limits!!

Use this format to begin a simple prayer to God.

Dear God,

Approaching you in prayer makes me feel
One reason for that might be
I'd like to start by saying that I'm really thankful for
I can see how You are involved in this because

One of the concerns I'm facing right now in my life has to do with
I've thought about approaching it by
Another alternative would be to
I would really like to know Your will for me concerning this

Knowing Your will doesn't mean it's easy to find the power to carry it through. For example in the matter of
I know Your will for me in this area would be
It's hard for me because

Give me the strength
Help me to recognize Your answers when they come. Amen
On-going support is critical in the recovery process. Not being involved seems to be the ‘missing’ link in the ‘failure’ chain of continued relapses.

The most obvious resource for support is Overeaters Anonymous. Look in the white pages in the phone book.

There are many different support groups available. Here is a list of several of them.

- **Alcoholics Anonymous**
  P.O. Box 459, Grand Central Station
  New York, NY 10163
  (212) 686-1100

- **Gamblers Anonymous**
  P.O. Box 17173
  Los Angeles, CA 90017
  (213) 386-8789

- **Narcotics Anonymous, World Service Office**
  16155 Wyandotte St.
  Van Nuys, CA 91406
  (818) 780-3951

- **Overeaters Anonymous, World Service Office**
  2190 190th St.
  Torrance, CA 90704
  (213) 542-8363

- **Al-Anon/Alateen Family Group Headquarters Inc.**
  P.O. Box 182, Madison Square Station
  New York, NY 10159
  1-800-356-9966
  (212) 302-7240

- **National Clearinghouse for Alcohol Information**
  P.O. Box 1908
  Rockville, MD 20850

- **Debtors Anonymous**
  314 W. 53rd St.
  New York, NY 10019
  (212) 969-0710

- **National Association for Children of Alcoholics**
  31582 Coast Highway, Suite B
  ‘South Laguna, CA 92677
  (714) 499-3889

- **Overeaters Anonymous, Central Service Board**
  P.O. Box 35623
  Los Angeles, CA 90035
  (213) 464-4423

- **Emotions Anonymous**
  P.O. Box 4245
  St. Paul, MN 55104
  (612) 647-9712
  (international)
  (612) 738-9099
  (Twin Cities)

- **Overcomers Outreach**
  2290 W. Whittier Blvd., Suite D
  La Habra, CA 90631
  (213) 697-3994
  (Alcoholics and Adult Children Claiming Christ’s Promises and Accepting His Healing)

Be advised these organizations exist also. Seek them out locally.

- **Adult Children Anonymous**
- **Al-Anon**
- **Alcoholics Victorious (Christian recovery support group)**
- **Bulimics/Anorexics Anonymous**
- **Child Abusers Anonymous**
- **Codependents of Sex Addicts**
- **Parents Anonymous**
- **Pills Anonymous**
- **Sex Addicts Anonymous**
- **Sexaholics Anonymous**
- **Sex and Love Addicts Anonymous**
- **Shoplifters Anonymous**
- **Smokers Anonymous**
- **Spenders Anonymous**
- ** Victims of Incest Can Emerge**
- **Workaholics Anonymous**
Not linking up to a support or recovery group is denial!!

I haven't linked up with a recovery group because ____________________

Explore your fears!!

If I were active in a recovery group, other people might think ____________________

If I were active in a recovery group, I might have to talk about ____________________

If I were active in a recovery group, I'd have to admit to myself that ____________________

If I were active in a recovery group, people in the group might ____________________

Change those fears to positive affirmations!!
I deserve ____________________
I deserve ____________________
I deserve ____________________
PREVENT DISEASE THROUGH IMPROVED NUTRITION

Prevent strokes and heart attacks
Dietary control of hypertension
Lower your cholesterol by eating light
Prevent osteoporosis - You're never too old for milk

Cancer prevention dietary guidelines:
- avoid obesity
- reduce total fat in your diet
- eat more high fiber foods
- eat more foods rich in vitamins A and C
- eat more cruciferous vegetables such as cabbage, broccoli, and cauliflower
- reduce your consumption of alcohol
- reduce the amounts of salt-cured, smoked and nitrite-cured foods

Take an honest look at your health.

Do you have high blood pressure?
Do any of your close relatives have high blood pressure?
Are you aware that high blood pressure is an inheritable disease?
Would you rather control it by medications or improved health habits?
Does anyone in your family have a curved spine which has occurred with old age?
Have you taken calcium and milk intake seriously as an adult?
Which risk factors for osteoporosis apply to you?
- low calcium intake
- white race and fair skinned
- genetic link to osteoporosis
- inactivity
- smoking
- post-menopausal, not taking estrogen replacement
- alcohol abuse

Are you getting enough calcium now (3 - 4 servings per day) or a supplement?

What immediate changes do I need to make to begin the prevention process of disease through nutrition?
RE_PARENTING plays an important role in the normal course of adult life, especially in recovery!!

The source of re-parenting comes within as you learn to nurture yourself with other than food or compulsive behaviors.

1. Extend compassion to the inner child
2. Give your "inner child" assurance that you will never abandon the child or subject the child to further abuse.
3. Give your "child" permission to trust again.
4. Give your "inner child" permission to
   . express anger
   . be vulnerable
   . be relatively happy
   . be creative and productive
   . have and express sexuality
   . have emotionally intimate relationships
   . have and use a chosen support family

It is usually best to look to other persons outside of your immediate family of origin for re-parenting candidates. Consider the following sources:
   . trusted friends
   . support group sponsor
   . pastor
   . spouse
   . support group members
   . therapist
   . mentor

My plan for re-parenting my "inner child" on a daily basis is:
RECOVERY TAKES DAILY MAINTENANCE

Make a 24 hour commitment every morning. Ask God for the strength. Each night take time to reflect and say thanks for the help you had during the day.

Customize the following for your daily maintenance.

What am I feeling? Identify and list feelings without judgment.

What are my needs?

Have I hurt anyone else or been hurt? I may need to set boundaries.

I will implement some daily quiet time and meditate. To implement this I need to

I will pray to God every day. To implement this I need to

I will read something inspirational every day. To implement this I need to

In recovery I need daily contact with people who are special to me. To implement this I need to

I commit to a daily food plan. To implement this I need to
<table>
<thead>
<tr>
<th>Date __________________</th>
<th>WEEKLY FOOD AND EXERCISE JOURNAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (First day of week only) __________________</td>
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</tr>
<tr>
<td>Day One</td>
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<td>Day Two</td>
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<td>Day Six</td>
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<td>Day Seven</td>
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<tr>
<td>Breakfast/ A.M. Snack</td>
<td>Lunch/ R.M. Snack</td>
</tr>
</tbody>
</table>
READ THIS FIRST

If you have not reached your ideal weight yet, we recommend that you save this chapter until you are at that point. If you are working with a group, go ahead and read it. There is nothing here that should alter your progress. If you have the option, however, you might want to save it until your goal is reached so that the information will be fresh on your mind.

Have you lost as much weight as you need to?
Are you now within your ideal bodyweight range?
If not, how many more pounds do you need to lose?
At your current rate of loss, how long do you anticipate it will take you to reach your ideal body weight?
How do you feel about your new weight and yourself?

What has happened in your life that might not have otherwise been possible without the weight loss?

WHAT HAVE YOU LEARNED?

Name five new food products you are using as a result of this program.
1. 
2. 
3. 
4. 
5. 

How much exercise are you doing now that you have reached your weight goal?

Do you realize that you still need about three hours of aerobic exercise per week to not regain weight?

What type of activity do you plan to use to fulfill this need?

List some of the other health benefits you will receive by exercising regularly and eating right. What types of diseases are you preventing?

How has the daily food and exercise log helped you to see what your true habits really are?

Should lapse and relapse ever bother you, can you see the value of beginning a new log? How might this help? Be specific.

Can you see how it is easy to save 300 to 400 calories per day through improved, low-calorie cooking methods without much effort at all?
NUTRITIONAL NEEDS

Let's review what the National Research Council says about good health through better nutrition:

1. Reduce the total fat intake of your diet to less than 30 percent of the total caloric intake. Eat lean meats only with an emphasis on fish.
2. Limit daily cholesterol to 150 mg.
3. Eat a lot of fruits and vegetables - at least three cups per day.
4. Eat six or more servings per day of bread, cereals, and other whole grain products.
5. Get regular physical activity.
6. Alcoholic beverages are not recommended.
7. Limit your daily salt intake to less than four grams per day.
8. Maintain an adequate calcium intake.

PLANNING A MAINTENANCE DIET

1. Determine your daily caloric needs. You will always gain back a few pounds after ending any type of calorie restricted program. DO NOT BE ALARMED!! It takes nearly six months to normalize.

12 x your current weight = initial maintenance calorie level

I should consume _______ calories per day as I begin my new maintenance diet program.

2. Learn your exchanges.

ALLOWANCES

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<tr>
<td>bread/starch</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>9</td>
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<tr>
<td>lean meat</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
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<td>milk products</td>
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</tr>
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<td>4</td>
<td>5</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>vegetables</td>
<td>------</td>
<td>----</td>
<td>----</td>
<td>----</td>
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</tr>
<tr>
<td></td>
<td>-no limit; 2 cups per day minimum</td>
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<td></td>
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<tr>
<td>fats</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

3. Design your own menu using the above exchanges.

Breakfast
Snack
Lunch
Snack
Supper
Snack
STEP TWELVE: HAVING HAD A SPIRITUAL AWAKENING AS THE RESULT OF THESE STEPS, WE TRIED TO CARRY THIS MESSAGE TO OTHERS AND TO PRACTICE THESE PRINCIPLES IN ALL OUR AFFAIRS.

Look back and reflect the way your addiction brought you to crisis and a spiritual turning point in your life. What discoveries have you made about yourself as an indirect result of your food addiction?

My food addiction, through the recovery process, has indirectly prompted my discovery of

Write several examples using the above guide.

The twelve steps are used as a program of attraction, not promotion. Identify people in your life who might respond well to your new way of life. How are they responding in the changes that occurring for you?

Person:
Addiction:
Response to my recovery:
Symptom of his or her own addiction:
Emotion that may be fueling the addiction:
How Twelve step and spiritual renewal could make a difference:
CAUTION! DANGER AHEAD!

It usually takes about six months for a successful dieter's metabolism to pop back up to normal after an extended period of calorie restriction. You are vulnerable. You will need to monitor your weight and food intake carefully for another few months to make sure your weight remains steady. Weigh yourself once or twice a week as a means of determining your maintenance progress.

Metabolism changed? You will probably use somewhere in the neighborhood of twelve calories per pound per day. Take your current weight, multiply it by twelve and you will find an approximation of the number of calories you need to consume each day in order to maintain your weight. If you are exercising more than three hours per week, that amount will be increased.

As you age, your basal metabolic rate decreases. The decrease after age 25 is approximately 2 percent per decade. Lean body mass also declines with advancing age. This gives us all the more reason to keep up exercising and weight training to offset these tendencies.

FAULT FINDING

Are you doing a lot of fault finding with yourself or others?

If so who are you attacking and what surface reasons seem to be prompting your responses?

Thinking about your attitude on a deeper level, what are you feeling inside that is leading you to be more hostile toward yourself or others?

ACTIVITY LEVEL

Have you noticed a dramatic speed up/ slow down in your overall activity level?

Slowdown may mean depression. Speed up may mean overcommitting yourself.

Either extreme may indicate a relapse.

What might you do to return to a balance?
ISOLATION

Isolation is both a cause and effect of food addiction. It may seem circumstantial, but it may be denial. Identify any recent events where circumstances have seemed to prevent you from getting together with important people in your life. Be particularly aware of any instances where you have reduced contact with people from your recovery support network.

I seem to have lost or reduced my contact with

On the surface, the reason we have lost contact is

Another reason for this sudden isolation might be

Is there any shame involved when I think of renewing contact?

If so, what is that shame regarding?

Is there anything I feel I would need to "explain" or justify at the moment of renewed contact? If so, what?

CRavings

Have you experienced an intensification in specific food cravings or obsessions about food? It may be a warning signal of a relapse just ahead.

How much time do you spend each day planning your meals or thinking about "illegal" foods?

Have you experienced any increase in your "thought-life" regarding food?

How has your attitude toward food changed during your recovery?

Have you recently felt your attitude slipping back toward some of your old thoughts and feelings about food? If so, in what ways?

How does this make you feel?

Significant Interruptions of Your Daily Recovery Activities

Consistent Weight Gain and/OR Significant Change in Your Eating Patterns
RELAPSE

You do not program yourself to relapse; it is nothing to be ashamed of. Don't be so traumatized if you do relapse that you cannot get back to food management.

What are the chances of relapse? Think for a moment about the degree of seriousness of your food addiction. Did you catch it in early stages? If so, the battle against relapse may not be great. If not, and you have gained and lost many times and tried many diets, the greater the battle against relapse. Addictions are chronic, progressive, and potentially relapsing.

The fact is, if you are one of the many who have struggled with a serious, engrained addiction, we can almost guarantee periods of temporary relapse. As a word of reassurance, if you find yourself sliding off your long-term food goals and emotional recovery, don't panic. This doesn't mean your recovery hasn't worked. It simply means that you are experiencing what amounts to a predictable and temporary phase of your recovery - relapse.

The chances are that this may be your last diet! Keep in mind the messages that allowed relapse to occur in the first place.

Name some of the events that have triggered past relapse.

What were some of the excuses or rationalizations you told yourself as you approached relapse.

What did you stop or start doing that broke your healthy patterns and allowed food abuse to reenter your life?

After the relapse, what were some of the messages you gave yourself about shame?

The first thing that has to go is the old shame base regarding relapse. For each of the negative shame messages you have given yourself regarding past relapses, write a positive affirmation about yourself and your success on your diet to date.
THE DYNAMICS OF RELAPSE

There are three major, underlying dynamics of relapse. Any time you face the threat or experience of relapse, learn from the relapse by attempting to identify any of the following dynamics that may be going on in your life.

SELF PUNISHMENT THROUGH SELF-SABOTAGE

...you might need to further grieve out the family of origin shame or trauma
...you might need to further affirm your self worth and value.

Could this be one of the factors fueling your relapse?

What negative messages about yourself are replaying over and over in your mind?

Are you punishing yourself with your relapse? If so, why?

RESPONSE TO CONTEMPORARY MAJOR STRESS OR TRAUMA

...you may need to do more daily emotional inventory work as suggested in Steps 10 and 11.
...you may need to have more contact with support persons

Could stress be one of the factors fueling the relapse?

Remember, even happy events are on the stress scale. What is going on in your life now?

What about small, everyday stress?

How do you typically respond to stress?

When under stress, what special efforts do you make to reduce that stress?

A FALSE SENSE OF SAFETY

Is regression a factor fueling your relapse?

Are you experiencing negative feelings connected with your diet?

Are you experiencing the sense of a "looming black cloud" of fears, doubts, or anxieties that you can't seem to connect to any specific problem areas in your life?
COPING WITH RELAPSE

1. Dismantle the relapse shame-base.
Forgive yourself for the relapse and do not shame yourself for having experienced this predictable and normal stage of recovery.

I forgive myself for not noticing the warning signals sooner.
I forgive myself for gaining ____ pounds.
I forgive myself for stuffing down my anger with food.

2. Recycle through the grieving process as necessary.
If the shame issues stem from the past, you may need to recycle through the grieving process. Look at Week 9.
Explore the feelings regarding the relapse.
I'm embarrassed that I
My big fear is that
The thing that makes me angry about the whole experience is
I feel that the relapse cost me
I feel sad that my relapse damaged

3. Rechannel your anger.
Do not get angry at yourself or the people around GET ANGRY AT THE RELAPSE ITSELF!!

4. Look for the food messages in the relapse.
Typically a relapse can tell you one of two things - if you are going too fast, or if you are going too slow, with your weight loss. Either scenario can trigger relapse. If you've been losing more than your body can handle, you may find yourself beset with cravings for your trigger foods. If your weight loss is too slow, you may be discouraged.

Is this diet too restrictive or too indulgent. Either extreme can predispose a relapse.

In the past month, I've lost ____ pounds. In terms of the speed of this weight loss, I think

What is my relapse telling me about the variety of foods allowed on my diet?
Do I need to make further restrictions and establish additional boundaries regarding what I eat?

If yes, what boundaries?

Do I need to enlarge my variety of "legal" foods to discourage boredom and enhance nutrition?

If yes, what foods will I be adding to my diet?

5. Quickly recommit to a new food management program. Even if you have come to the conclusion that you need to change your diet or find a new diet, don't stay in relapse while you gear up for this change. Go back to your old diet for a week until you are prepared to launch a new diet.

6. Write out a contract for emotional and spiritual recovery activities.

I HEREBY COMMIT TO THE FOLLOWING IN ORDER TO TAKE CARE OF ME!

...regarding my relationship with food

...regarding my relationship with God

...regarding my relationships with friends and family

...regarding my contact with other recovering persons

...regarding new boundaries I have established for myself

7. Take time to reinventory all of your current MAJOR relationships.

...major relationship
...unmet needs
...step of action
<table>
<thead>
<tr>
<th>Day</th>
<th>Breakfast/ A.M. Snack</th>
<th>Lunch/ P.M. Snack</th>
<th>Dinner/ Nite Snack</th>
<th>Exercise</th>
<th>Feelings and Major Events of the Day</th>
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APPENDIX D
MEMO

To:       Staff
From:     Deanne Penn via Kate Olson

As some of you may or may not know, hopefully in December, 1991, I will be finished with my Master's Degree in Human Resource Management. Part of my thesis is to write an approach to treating eating disorders in the work place, which I have done. To complete the research, I am going to implement the program at TriCity for staff only. It will be in place for 12 weeks.

If you have an unhealthy relationship with food, feel free to join me on Tuesday morning, 7 a.m., September 17, 1991 in room 31 at MEP. This is not for therapists to learn techniques, etc. but for the folks who need help to address the issue which may or may not include therapists.

Feel free to contact me by phone for any questions you may have so that I may have a general idea of the amount of materials needed for the first group, please R.S.V.P. to Genny at MEP.

Thanks!!!!!!! You'll be a part of "science"!!!!!!!
PROGRAM QUESTIONNAIRE
TWELVE WEEK GROUP RESPONDENTS

DATA COLLECTION

1. Do you have an eating disorder?
   yes 8 no 5

2. If so, is self-diagnosed?
   yes 3 no 5

3. I have been aware of the problem for
   2, 1, 30, 35, 2, 20, 12, 15 years
   months 0

4. The eating disorder I have is:
   anorexia/bulimia/compulsive - 1
   bulimia 0
   compulsive eating 5
   bulimia/compulsive eating 1
   anorexia/compulsive 1

5. I am: Male 1 Female 7

6. My age is:
   33y - 1 45y - 1
   40y - 1 49y - 1
   42y - 1 50y - 1
   43y - 1 51y - 1

7. Have you participated in any weight loss/gain program in
   the past 2 years?
   yes 7 no 1

   If so, how many:
   1 program - 5
   2 programs - 1
   5 programs - 1

What would you estimate the total out of pocket expense to you? Include fees, purchase of diet foods, etc.

$20 - 2
$100 - 2
$150 - 1
$800 - 1
$2000 - 1

8. Are you aware of support groups for eating disorders?
   yes 8 no
9. Have you ever attended a support group for eating disorders?
   yes 4   no 4

10. Do you do any form of exercise?
    yes 3   no 5

If so, please state what type:

walking - 2
walk/rowing - 1

How many times per week do you exercise?

5 - 1   1 - 2

How many minutes total per week is spent in exercise?

150 minutes   30 minutes - 2

If you do not currently exercise, have you ever been involved in on-going exercise?

yes 3   no 3

If so, what?

walking - 2
walking/swimming - 1

11. Have you ever participated in any wellness program offered through your employer?
    yes 1   no 7

12. If the employer were to offer on-going support for eating disorders, would you participate?
    yes 7   no 1

If yes, what should the employer consider in setting up the program?

"not sure"
"proper equipment"
"nutrition information"
"don't be punitive"

13. Have you ever missed work related to the eating disorder behavior or taken time off work for doctor or therapy appointments?

   yes 3   no 5
If so, how much time in the past 2 years?
"Zero in past 2 years, but lots in past"
"2 days"
"4 hours"

14. Have you been treated medically or psychologically for problems directly or indirectly related to an eating disorder?
   yes 4  no 4

If yes, did your insurance cover the cost?
   yes 4  no 4

What was your out-of-pocket expense?
   "don't know"
   "$1000"
   "$200"
   "$20"
   "$4000"

15. Have you ever been hospitalized for an eating disorder?
   yes 1  no 7

16. Have you had surgery or your jaws wired shut, etc.?
   yes 1  no 7
   "stomach stapled"

17. I am 7 or am not _ comfortable seeking help for my problem.
    no answer - 1

18. I would 7 or would not _ not talk to an employee assistance program person.
    no answer - 1

*2 drop-outs
APPENDIX F
12 Week Group Participant (6 responses)

The material was presented in an organized manner.

<table>
<thead>
<tr>
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<tbody>
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<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Agree Strongly</td>
</tr>
<tr>
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The presenter appears knowledgeable in this area.

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There was too much information covered in one hour.

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There was too little information covered in one hour.

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<tr>
<td>Strongly</td>
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I want/need more information on this topic.

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</table>

If you agree, tell us what you want.

1 - "To be kept updated on the latest information."
2 - "More! More group interaction. More folks."
3 - "A planned diet schedule."
Comments:

1 - "This class has been a help not only for the learning of how to eat right but also in understanding myself."
2 - "Very helpful, interesting, uplifting! Thank you!"
3 - "Very good class - enjoyed it very much."
4 - "I had a lot of valuable information. I needed to work harder on assignments. Excellent group. Excellent information."
GOALS AND ATTAINMENT 12 WEEK PARTICIPANTS

The goals of each person who completed were:

1. Education on nutrition; make healthier choices

2. Motivation to lose weight, feel feelings, admit I'm powerless over food.

3. Lose 10 lb., get on exercise program.

4. Lose 10 lb., education, change eating habits.

5. To lose at least 10 lb., prefer not to be compulsive dieter.

6. Be aware of what and why I'm eating: become committed to change.

The feedback of goal attainment was presented to each participant as: "Did you reach goal? If not, what was the reason?"

1. "Yes. I gained knowledge and am motivated to a healthier lifestyle."

Comments: "Very good class - enjoyed it very much."

2. "My goal was to get motivated. It pretty much worked."

Comments: "I got a lot of valuable information. I needed to work harder on assignments. Excellent information. Excellent group."

3. "I didn't reach my goal of losing 10 lbs. and exercising regularly. But I learned a lot from the program, about myself and my eating habits. I feel much better about myself and know now that I have the tools to reach the goals."

Comments: "Thank you for all your help. This class has been a help not only for the learning of how to eat right, but also on understanding myself."

4. "I reached half my goal. I became educated the way I wanted to. Part of my goal was to lose 10 lbs. I maintained but that is okay, because of the group I realize I like myself and I am okay."
5. "No. My goal was unrealistic and I quit smoking!"

Comments: "What I'm happiest about is I didn't relapse into anorexia or bulimia on any level. This is a first for me on any diet or food plan. My real goal is to reduce some, but stay healthy mentally, emotionally and physically, as well as spiritually. Thanks. This program has been great in removing some myths; helpful information. Ideas and concepts actually reduced binging (it stopped!)."

6. "Yes". My goal was to become knowledgeable in this area and apply it."

Comments: "Very helpful, interesting, uplifting, informative and useful to a new look at my lifestyle."
Biographical Sketch

Deanne O’Leary was born in Billings, Montana on June 26, 1947. After moving to Pocatello, Idaho in March of 1981, she completed her undergraduate studies at Idaho State University in December, 1982 with a Bachelor of University Studies. Deanne then became employed as a chemical dependency counselor at Road To Road Recovery. She returned to Montana and managed a halfway house for recovering alcoholics for 2-1/2 years. Her next move brought her to Phoenix, Arizona in the spring of 1986 where she became employed by TriCity Behavioral Services and continues to work there in the Addictions/Recovery Program as a chemical dependency counselor. It was Deanne’s desire to attain her graduate degree in the human resources field. She began attending Ottawa University in September, 1989 and her Master of Arts degree in Human Resources with emphasis in training and development was conferred in May, 1992.