THE EFFECTS OF EXPERIENTIAL THERAPY ON COMPULSIVE OVEREATING

by

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ABSTRACT

The struggles and pain of the compulsive overeater are frequently met with traditional advice and direction for the control of eating behaviors. As has been documented in the literature, these traditional methods have limited success and appear to leave the individual with repeated failures and further emotional pain. This project is a study of a pilot experiential therapy group that deals with compulsive overeating. The purpose of this project is to explore if this form of therapy can produce positive change in depression and compulsive eating behaviors among its participants. The use of a non-diet approach and the exploration of the underlying issues that facilitate the continuation of the behaviors in this disorder are the foundation of the group's work. This study examines the effects of experiential group therapy on depression and eating behaviors among the group's participants. This was accomplished by the use of surveys which examined eating disorder thinking and behavior by interviews with the members of the group and its therapist, and a pretest and posttest administration of the Beck Depression Inventory. This data indicates that this form of therapy may be helpful for those with a compulsive overeating disorder.
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CHAPTER 1

THE PROBLEM

Introduction

Today, the push to be thin and have the perfect body is the climate in which obese compulsive overeaters live. Society, family and friends observe compulsive behaviors and make rash judgments about weakness of character, lack of will power, and laziness. Obese compulsive overeaters experience their body size and eating behaviors in an entirely different way. They see their eating behavior as failure (again and again), which results in self loathing, and an inability to control their lives. Roth (1991) expresses this by saying that compulsive behavior "at its most fundamental, is a lack of self-love; it is an expression of a belief that we are not good enough" (p. 19). Society, advertising, and diet programs feed on these emotions by promising magical and sure fire results. This leads to further failure, and self damaging and demoralizing feelings. Maine and Johnson (1991) in Father Hunger Fathers, Daughters and Food, state how these cultural factors contribute to eating disorders:

Body-image dissatisfaction, problems with food and eating disorders can be logical responses to these cultural and familial conflicts. . . . historically, women have been indoctrinated to concentrate on appearance and alter themselves to please other people. . . . Western culture places a high value on appearance, and thinness is equated with femininity and beauty. (p. 9)

This research project explored the issues that precipitate the emotional experiences for a small pilot group therapy program.
As stated earlier, many believe compulsive overeaters can choose to stop their behavior. Rader (1991) states that compulsive overeating "is the strong compulsion to eat . . . that is counter to the conscious will and control over the consumption of food" (p.18). Often compulsive overeaters describe their relationship with food as binge eating.

Binge eating is defined in the DSM-IV as:

> Recurrent episodes of eating in a discrete period of time (usually less than two hours). . . an amount of food that is definitely larger than most individuals would eat under similar circumstances . . . (p. 545)

Besides evaluating the group participants perceptions of the program effectiveness, this project also to explored the compulsive overeating/binge behaviors as they relate to the psychological issues that activate these behaviors.

**Development of the Problem**

For 30 years, this researcher has struggled with the disorder of compulsive overeating. During these years of dieting, binge eating, exercise, behavior modification programs, and surgical procedures this researcher had met with one failure after another. Each failure had been followed by continued feelings of worthlessness, depression, and withdrawal. Approximately a year ago, this researcher became involved in a therapy group that confronts the issue of compulsive overeating from a different approach. This group explores the thoughts and moods associated with compulsive overeating and uses an experiential non-diet, healthy well being approach.

The focus of the therapy group studied, is a non-diet approach. It follows the ideals presented in Geneen Roth's (1991) book *When Food is Love*. The author writes about the feelings of pain, the
struggles, the loneliness, the abandonment, and the emotions behind compulsive overeating. Roth (1991) looks at the needs of the compulsive overeater, the feelings of fear of being in touch with emotions such as loneliness and abandonment.

No amount of love in the present, not a single person, not ten thousand people can make up for or take away the pain of the betrayals of the past, just as bingeing today for deprivations in the past or for deprivations to come does not make up for the many times we said to ourselves "you can't have that, you're fat and you're ugly." The only insurance against repeating the pain in the past is to allow ourselves to feel it fully and release it in the present. (p. 50-51)

Roth (1991) also believes that the reasons for this compulsive disorder must be faced:

Curing compulsive eating is the easy part. Take the obsession away and you are still left with the wounds it was designed to blot out. Take the obsessions away and you are left feeling as trapped as a child in a family where there is no one to turn to and nowhere to go but off a bridge. An obsession freezes your feelings in time when you transfer the pain of being alive to the pain of being fat... (p. 130)

The project's group members understand about the emotional drive of their compulsive disorder. The approach of this group does not use the cognitive method. It follows Roth's (1991) approach for change, which she addresses in two steps: The first step is the acknowledgment of the desperation:

We become compulsive about food because we have something to hide. Something we believe is worse then being fat or eating compulsively. The process of breaking free from compulsive eating is of keeping steady with food so that we can discover what we are hiding. (p. 176)

In this first step, food stops being the enemy. The person is given permission to stop being desperate about eating so their feelings can be experienced. The second step is learning to be loving with
the self. Roth (1991) states, "learning how to be infinitely tender with every single part of you that you detest— including your fat" (p. 181).

The literature on the disorder of compulsive overeating addresses traditional methods of food choices in relation to restricting calories, exercising and cognitive/behavioral therapies. These therapies have proven, over time, to have limited effectiveness for those suffering with the compulsive disorder associated with food. The Consumer Reports (1993), reported on the scientific literature and consumer survey stated that "medical researchers have suspected for years that most diets end in failure; studies done at weight-loss clinics and in medical centers showed that people almost always regained the weight they lost" (p. 347). These facts have also been addressed by J. P. Foreyt in an article by Bower (1994), stated that on going studies, by his group, reflected outcomes that demonstrated that "moderate weight loss dieting and exercise is less effective than exercise alone in terms of weight loss maintenance at two-year follow up" (p. 376). Not only are dieting and exercise ineffective in maintaining weight loss, but cognitive/behavioral approaches also have proven to be ineffective over time.

As researchers explore this problem, the notion that weight loss is no longer an appropriate goal... that our best efforts in helping clients achieve cognitive/behavioral changes are moot if we do not address the rampant "sizism" in our culture. (Bower 1994, p. 376)

The emotional impact on the obese compulsive overeater is usually the lowest priority in most treatment plans. Begley (1991) elaborates on this by stating "evidence suggests that the majority of obese persons
who need weight control services suffer from symptoms of eating disorders, which many dietary programs do not adequately address" (p. 1257). Frequently used treatment plans incorporate restrictive calorie diets, exercise programs, and behavioral modification modalities that work to change behaviors and thoughts. These methods use rewards or negative reinforcement to produce results. Dr. Rader (1981) and others document the extent of the problem in treating the compulsive overeater by stating: "... dieting is mostly unsuccessfully, at least part of the time. Yet only 6 percent of the chronic dieters among us manage to keep their lost pounds off permanently" (p. 15-16). These methods do provide some early success. Storlie and Jordan (1984) further expand on obesity treatment:

To date treatment results have been poor and frustrating for both patient and therapist. Using diets, starvation, drugs, psychotherapy, self-help groups, exercise programs and hormones, many patients are unable to lose weight, and of those who do lose weight, few sustain the loss for more than a year. (p. 3)

As the program progresses, and the participant becomes less and less successful, feelings of failure and discouragement cloud the success. Goodrick (1991), in an article on the high cost of obesity management, states:

... patients in very low-calorie diet programs overestimate the overall success rate of the program. They believe the therapy to be effective and blame themselves for failure. Usually no one is able to help such patients manage the impact of the failure. Too ashamed to return to the therapist, patient struggle alone with their sense of worthlessness and hopelessness. (As cited in Wooley and Garner, 1991, p. 1249)

Dr. Rader (1981) in No-diet Program for Permanent Weight Loss, defines the compulsive overeater as one who has no control over the
food (amount or type) consumed. These individuals are emotionally wounded, and continue to be so by their efforts and failures at weight control.

Compulsive overeaters . . . are compelled to eat by a strong, irresistible impulse that often runs counter to their conscious will and desire. They eat excessively, often inexplicably and irrationally eating when they're full, eating "forbidden" foods . . . bingeing in private. . . . Literally lost control over their consumption of food. (p. 18)

To continue to promote programs that further emotionally impact the compulsive overeater is harmful to the overall well being of the individual. Foreyt and Goodrick (1993) explain:

The psychological mechanisms involved in the maintenance of dieting behavior are particularly insidious. . . . Dieting takes its toll and the caloric restrictions leads to uncontrollable cravings . . . Relapses are often characterized by reports of inability to control behavior or to think logically about food. . . . Binges are often precipitated by negative emotions, while the act of overeating seems to relieve the emotional symptoms. (p. 5)

The current literature appears to state that, overall, non-diet and moderate exercise approaches are healthier. Foreyt and Goodrick (1993) support this premise: "The maintenance techniques showing the most promise are extended therapist contact, peer groups and aerobic exercise. The psychological dynamics of these methods parallel those found in the non-dieting approach" (p. 9). The limited exploration of the emotional foundation for compulsive overeating allows for continued failures and more emotional trauma.

Overall, the method of restriction of calories, exercise and cognitive/behavioral modification promoted by the medical and psychological communities have been effective for limited periods of time, with only a very small percentage of compulsive overeaters
attaining long term success. Van Itallie et al. (1993) point out that the theory of "behavior therapy should be very effective in the long-term management of obesity, in practice, it has been disappointing as a therapeutic modality" (p. 34). Cognitive/behavioral approaches to therapy tend to be the psychological community's prominent approach. This researcher will identify an alternative approach. This alternative promotes behavior changes that free the individual from the pain which causes the compulsive disorder.

Purpose of the Study

The purpose of this study is to assess the use of experiential group therapy for compulsive overeating. This will be accomplished by assessing how the participants in a pilot experiential group therapy program for compulsive overeaters rate changes in their feelings of depression, and how their eating patterns have been affected by participation in the group over a six month period.

The group's work is based on a premise that the eating behaviors are the results of inner emotions and past experiences that have not been dealt with consciously. The facilitator of this group uses an experiential approach to explore the issues that may contribute to compulsive eating behaviors. These issues may include, but certainly are not limited to such experiences as sexual abuse, physical or emotional abuse, abandonment, self esteem, loss and grief, and unexpressed anger.

A non-diet approach, along with participation in weekly group therapy sessions are the techniques this study examined. The participants were asked to report their perceived success in managing
compulsive eating with reference to their group participation. The report does not address weight loss in pounds, but identifies the psychological issues associated with their compulsive behaviors.

Research Question

Is the use of experiential group therapy effective for managing a compulsive overeating disorder?

Need for the Study

Most individuals with a compulsive overeating disorder typically have tried a multitude of programs, diets, books, exercises, groups and procedures. In the attempt to find success at getting their bodies to a socially acceptable place, they have been met with repeated failures. For these individuals, learning that there is another approach may lead them to a more positive and healthier lifestyle. This information can be the final step for the compulsive overeater in finding peace, and freedom from their pain. As Bower (1994) states:

The public has learned "dieting doesn't work," but the average dieter has little idea of, or access to, the effective alternatives. The postdieting "vacuum" must be filled by well-integrated professional programs that emphasize replacement of the dieting/compulsive eating cycle with a long-range program of fitness, wellness, and personal growth. (p. 375)

For the mental health professionals who find themselves frustrated by working with clients with a compulsive overeating disorder, they may find this information as a helpful alternative treatment for their clients. These professionals can explore previously unexplored, tangible alternatives with their clients. Understanding this information, and implementing these methods will provide a healthier approach to living with compulsive overeating. As stated by Bower
(1994): "A healthy relationship with one's body and with food becomes, like happiness, not the goal, but the fruit of a life well lived" (p.377).

Definitions

Anorexia Nervosa: characterized by a refusal to maintain a minimally normal body weight (DSM-IV, p. 539).

Behavior Modification: a group of techniques based on objective scientific analysis that consist of a set of procedures employed to change observable behaviors by manipulation of the behaviors (Altschul, 1987, p. 132).

Binge: unrestrained indulgence (Fairburn and Wilson, 1993, p. 3).

Binge Eating: recurrent episodes of unrestrained indulgence in food characterized by (1) eating in a discrete period of time within any 2 hour period, an amount of food that is definitely larger than most people would eat during a similar period of time, (2) a sense of lack of control over eating during the episode, a feeling that one cannot stop eating or control what or how much one is eating (Fairburn and Wilson, 1993 p. 4).

Bulimia Nervosa: characterized by repeated episodes in binge eating followed by inappropriate compensatory behaviors such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting or excessive exercise (DSM-IV, p. 539).

Chronic Dieting Syndrome: a progressive pattern of frequent weight loss attempts followed by periods of discouragement and compulsive overeating. Characterized by mild to moderate depression, body dysmophia, weight and food obsession, distorted/magical thinking and
metabolic adaptation to periodic caloric deficits (Bower, 1994, p. 375).

**Compulsion:** the hallmark is the inability to know when we've had enough, the hardest part is that when the behavior ends, the emptiness does not (Roth, 1991, p. 199).

**Compulsive Overeating:** the strong compulsion to eat, an irresistible impulse to consume "forbidden foods" that is counter to conscious will and control over the consumption of food (Radar, 1991, p. 18).

**Compulsive Overeater:** one who is compelled by a strong irresistible impulse to eat that is counter to conscious will or desire and eats excessively ... literally with loss of control over the consumption of food (Radar, 1991, p. 18).

**Depression:** a low, sad state in which life seems bleak and its challenges overwhelming (Comer, 1992, p. G-4).

**Dieting:** restraining from food intake in order to achieve the goal of weight loss and a thinner physique (Fairburn and Wilson, 1993, p. 194-195).

**DSM-IV:** Diagnostic and Statistical Manual of Mental Disorders, 1995.

**Experiential Therapy:** a process that considers feeling-expression to be the medium of shared experience and the means to personal and family fulfillment. Draws heavily from Gestalt therapy and encounter groups (Nichols and Schwartz, 1995, p. 288).

**Fattism:** similar to racism in that it is based on prejudice; prejudice toward obese persons (Foreyt and Goodrick, 1993, p. 5).
Food Preoccupation: thinking about food, eating or calories that interferes with the ability to concentrate; spends time between meals thinking about food, eating or calories (Fairburn and Wilson, 1993, p. 338).

Group Therapy: therapy process where the exchanges among the members of the therapy group are viewed as instrumental in bringing about change (Corey and Corey, 1992, p. 10).

Magical Thinking: magic or magical as defined by Webster; to do things by supernatural powers or by knowledge of natures secrets; thoughts that hold belief of supernatural powers or powers of natures secrets (p. 299).

Non-diet Approach: a weight management approach that involves five components; (1) therapist and peer support, (2) cessation of dieting and normalization of eating patterns, (3) gradual increase in exercise, (4) gradual re-education in fat in eating, (5) acceptance of whatever weight is achieved with prudent eating and exercise habits (Foreyt and Goodrick, 1993, p. 5-6).

Nonpurging Bulimia: experienced by about 50% of obese persons undergoing treatment. Includes binge eating two or more times per week, and persistent concern with body shape and weight. Experiences repeated cycles of dieting and regaining weight that may lead to food dependence (Goodrick and Foreyt, 1991, p. 1245).

Obesity: In general terms obesity exists when a person is 20% or more above ideal body weight based on Metropolitan Life Insurance Company's height (in shoes), frame (small, medium, or large) (Overson, 1995, p. 7).
Polymorphism: (poly- many; morph = size) describes a group of symptoms characteristic of the chronic dieter; fluctuating weight and shape of the person who has struggled unsuccessfully with diets much of their life (Rader, 1991, p. 18).

Successful Weight Control: Weight loss per se is no longer considered an appropriate goal. The weight loss success is challenged to define fitness, wellness and personal growth as an appropriate goals (Bower, 1994, p. 377).

Weight Dissatisfaction: a feeling in those individuals who choose to diet, who generally have low self esteem and are dissatisfied with their bodies and are using dieting to improve themselves (Fairburn and Wilson, 1993, p. 194).

Weight Reduction: A method to control weight through periodic food restriction to achieve ideal weight (Pace et al., 1991, pp. 1258-259).

Assumptions and Limitations of the Study

It is assumed that the participants responded honestly to the surveys and interviews. This project was intended to provide honest and factual information.

A significant limitation to this project was the small number of participants. This limited the generalization of the results. Another limitation was the possibility that the participants could leave the group before the project's completion. These factors did further effect the final results. The group's final participants were reduced to three (3) by the completion of the six (6) month period. Also, this group shared intimate personal issues and had significant concern about confidentiality of the study. This concern was addressed
by reaffirming that the confidentiality and anonymity of all individual participants would be maintained.

This researcher, a member of the project group, also had to consider that this factor might have an affect the participants responses. This researcher also had a strong bias regarding the failure of the medical community in truly and effectively addressing and providing adequate care to the compulsive overeater. This researcher's bias comes from years of experience with the attitudes and prejudices of the medical community in judging the compulsive overeater as weak and not willing to "stick to a diet." This researcher has been frustrated by insurance programs that cover mental health issues, but ignore those dealing specifically with compulsive overeating. This frustration has been heightened by the realization that individuals diagnosed with anorexia and bulimia are assisted with insurance benefits for these specific diagnosis.

Organization of the Remainder of the Study

The remainder of the study examines the effectiveness of the experiential group therapy approach in managing compulsive overeating behavior. This is addressed in the literature review in Chapter 2. The review examines what has been proven effective in managing a compulsive eating disorder. Information also is presented on the approaches of non-diet and experiential therapy in facilitating a healthful and healing approach to compulsive overeating management.

In Chapter 3, the methodology for this project is identified and described.
Chapter 4 presents the findings of the study. Chapter 5 presents a summary, conclusions and recommendations. The appendix includes all instruments used in the study.
CHAPTER 2

LITERATURE REVIEW

Introduction

The popular media abound with suggestions on how to lose weight, how to have "buns of steel" and how to have the shape you want in 30 days. For the obese compulsive overeaters these magical, hope laden methods hold false promises of fixing their problems. The obese compulsive overeaters return to previous behaviors and blame themselves for their failures. Pace et al. (1991) expands on such obesity treatment:

The treatment of obesity is a multibillion dollar business in the United States, yet an estimated 90% of all dieters who lose 25 lbs. or more in a diet program regain that weight within 2 years. The costs are not only monetary, but psychological and physical as well. Repeated failures to control weight through periodic food restriction are self-defeating because chronic dieting may exacerbate low self-esteem and make obesity more refractory. (p. 1258)

In reviewing the literature for treatment of compulsive overeating, there is no limit to the information available promoting weight reduction, and new body image. Anyone can find information for the most commonly prescribed practices in this area. Restriction of calories, exercises and cognitive/behavioral methods are the standard practices in treatment. The reviews on these methods are not encouraging and promise little hope to the compulsive overeater. Storlie and Jordan (1984) elaborate on these modes of treatment:

A nutritionally balanced, calorie restricted diet may be important for the treatment of obesity, but the success rate of
even medically sound dieting is low. It is apparent at this time that a variety of factors can lead to improper eating habits, food selection, and depressed levels of physical activity. Treatment must reflect individual differences with respect to these factors as well as the person's attitudes, interpersonal relationships, and the quality of their lives. (p.15)

This review presents an explanation of these methods, and how they have not worked for the majority suffering with obesity, and compulsive overeating. This review also examines the reason for the behaviors by examining the psychological aspect of a compulsive eating disorder. An explanation of the non-diet and experiential approaches in dealing with an overeating disorder is also presented.

**Traditional Approaches in Treatment**

There are three common threads that run through this information. These threads include the use of restricting calories, increasing exercise and methods in cognitive/behavioral therapy to practice in an effort to change eating behaviors.

Restricting calories and exercises promote a change in body energy balance. The idea that the obese compulsive overeater must "eat less and exercise more" (Altschul, 1987, p. 5) is promoted. The energy balance issue emphasizes limiting food intake. Certain foods become "bad" or forbidden." For the compulsive overeater this issue takes on extreme importance. Storlie and Jordan (1984) cite "the idea that obesity is the result of ingestion of more calories than expended, has become socially accepted, and often are medically reinforced truism" (p. 71). This statement reinforces the idea that the obese individual eats too much and doesn't stick to reducing calories to get into the ideal "body image." Not only is this socially believed but the belief is supported and reinforced by the medical community. So when the
compulsive overeater is unable to continue the deprivation of calories a pattern of cycling begins. The cycle begins with the deprivation of calories, moves to the inability to maintain the calorie restriction, is followed by the development of food cravings which leads to feelings of failure and guilt. The pattern of binge eating starts again with the consumption of excessive calories which further increases feelings of failure and guilt. The individual begins the restricting cycle again thinking that "maybe this time I can do it." These failures only add to the problems, creating more distress and the development of a chronic dieting syndrome. Altschul (1987) explains how these practices interfere with treatment and success:

Panaceas exacerbate, an already serious situation, obesity, perhaps more than any other disease generates quick-cure schemes, denial of the fundamentals of energy balance . . . , dangerous ways of losing weight rapidly, and quackery. These false solutions all have in common that they fail right from the start or that any weight loss achieved is temporary. Aside from direct harm, the cyclic lose and regain of weight . . . seem to make subsequent weight loss more difficult. (p. 5)

Because these frequently promoted methods of weight loss and the mania surrounding this issue, that compulsive overeater continues to be confronted with chronic dieting patterns, restricted calories, and injury to health such as cardiac problems, hypertension and emotions problems such as depression and anxiety. Restricting calories is only one thread in this method of treatment and the literature indicates this method is not successful over the long term.

Energy balance is also affected by exercise or the amount of energy expended. As Altschul (1987) states "obese humans . . . tend as a group to lead a sedentary existence: they are less active physically
than their lean counterparts" (p. 22). Goodrick and Foreyt (1991) emphasize "considering the importance of exercise in treatment success, adherence to exercise among the obese is an important area for research" (p. 1244). Goodrick and Foreyt (1991) also express the concern that "relapse to former exercise habits has not been carefully studied in the obese" (p. 1244). So the matter of exercise as an important component in weight reduction is promoted, but for the obese its importance has limited review. Foreyt, as cited by Bower (1994), examines this issue; "moderate weight loss dieting and exercise combined is less effective then exercise alone in terms of weight loss maintenance at two-year follow-up" (p. 376).

At present, the literature indicates the most common recommendations of restricting calories and exercise have only been successful for small numbers of individuals. Altschul (1987) documents:

The literature abounds with data to show that the cure rate of those who seek treatment is abysmally low. Two years after treatment only 2 out of 100 obese patients managed to retain a weight loss of 20 pounds ... There has been little improvement in the clinical effectiveness of weight reduction therapy. (p. 60)

The third thread of these methods for weight reduction is a cognitive/behavioral approach. Cognitive/behavioral modification are techniques used by the individuals to manipulate, and to change their behavior. It has been the premise of this methodology that eating is a learned behavior, therefore the individual can learn different behaviors associated with eating. The literature indicates the outcomes of these methods are not any better than restriction of calories and exercise. Goodrick and Foreyt (1991) do not provide encouraging
Most people trained in behavioral self management of obesity experience relapse to old behavior and former weight. Only about 5% show significant and lasting weight loss. Long term success of very low-calorie diets with behavioral training is about 10%. . . . Very little progress has been made in behavioral treatment in the last 24 years . . . (p. 1243)

Foreyt and Goodrick (1993) and Fairburn (1993) indicate that these modalities are not the processes to follow for weight reduction and control. Physicians, dietitians, and commercial programs such as Weight Watchers and Jenny Craig use these modalities to encourage the obese compulsive overeater in the magical thinking that by using their programs, their problems will be solved and the weight lost forever. The reality is, there is no magic in any weight reduction program. The results are short lived, and the obese compulsive overeaters usually return to their cyclic chronic dieting behavior (Bowers, 1994, p. 377).

The ultimate goal, of weight reduction programs, self help books, and advice givers for weight loss programs, is to reduce the total body weight measured by the number of pounds on the scale. These methods, though well intended, ultimately produce failure for the obese compulsive overeater. This is elaborated on by Jordan (1984) in his citation of the American Dietetic Associations recommendations "that weight loss be achieved through dieting modification, alterations in eating behaviors and regular aerobic physical activity" (p. 4). He further comments on the realities of these recommendations, they "constitute an excellent and time-honored prescription of weight reduction, but achieving these goals has been at best difficult for everyone and, in fact, impossible for most obese persons" (Jordan, 1984, p. 4).
Psychological Issues

Traditionally, the primary goal in treating the obese compulsive overeater focused on restricting calories, increasing exercise and using behavioral modalities; it did not focus on the underlying causes for the behavior. Since the focus today in mental health has become brief therapy with the limiting of service, the disorder of compulsive overeating is virtually ignored. The exception is when the client carries the financial burden alone.

The American Psychiatric Association (1995) in the Diagnostic and Statistical Manual of Mental Disorders (DSM), addresses compulsive overeating under the category of Eating Disorders Not Otherwise Specified (307.50). Item number six (6) of this category: "Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristics of Bulimia Nervosa (p. 254)" is promoted as the diagnostic reference for compulsive overeating. There is no specific category for diagnosing and adequately treating the psychological component of compulsive overeating. Diagnosis is then required under other diagnostic categories, such as depression or anxiety. These categories are given specific DSM-IV codes that may result in a limitation in the number of therapy sessions allowed by an insurer. Anorexia and bulimia require long-term therapy. Long-term treatment is not a consideration for compulsive overeating under the present diagnostic criteria. Researchers tend to place anorexia and bulimia with its variations of starving, purging, bingeing, excessive exercise and preoccupation with body shape on a continuum (see Figure 1). The
present assessment for eating disorders leaves compulsive overeating out of this continuum, and therefore diminishes the focus for treatment.

FIGURE 1
ANOREXIA, BULIMIA CONTINUUM

<stare> <binge> <purge> <exercise>

ANOREXIA

BULIMIA

(Anorexia nervosa and bulimia appear to be syndromes that exist on a continuum (Altschul, 1987, p. 100).

This researcher believes the continuum must include compulsive overeating (see Figure 2). The idea of a more comprehensive continuum allows for a broadening of the eating disorder category.

FIGURE 2
ANOREXIA, BULIMIA, COMPULSIVE OVEREATING CONTINUUM

<starve> <binge> <purge> <exercise> <nonpurge>

ANOREXIA

BULIMIA

COMPULSIVE

OVEREATING

(The continuum as interpreted by this researcher)

This restatement of the continuum will allow for the adequate diagnosis and treatment of the disorder. It is known that the anorexic and bulimic suffer from psychological issues of low self esteem, perfectionism, fear of psychological growth and the need for nurturance. Altschul (1987) discusses:

The anorexic is more successful in appearing disciplined, the bulimic patient is often overtly chaotic. . . . show marked fluctuations in mood with frequent depression, despair, and sometimes, suicidal behavior. . . . bulimics often steal . . . the origins of this behavior tap into the psychologic roots of the disorder, involving fears of starvation and impoverishment,
feelings of entitlement, displaced erotic excitement and an unconscious need for punishment. (p. 100)

The compulsive overeater experiences much the same psychological dysfunctions as the anorectic and bulimic. Figure 2 place the three disorders on the same continuum and allows for greater understanding of all three disorders, and their psychological needs in reference to treatment.

The three eating disorders all exhibit behaviors of starvation, bingeing, use of exercise to excess, and purging. Each of these behaviors (in greater or lesser severity) are present at different times in the life experiences of the eating disordered person. Understanding these factors, makes it easier to understand the need for providing long term adequate care for the compulsive overeater.

Roth (1992) in When Food is Love expresses the fact that a compulsive eating disorder is there because "something is wrong and we are using food to express it" (p. 103). It is quite important to realized that the compulsive eating behavior is driven more from the emotional being and not just the desire for food. As Goodrick and Foreyt (1991) state, binge eating and compulsive eating are associated with:

... patient experiences less self-control over eating in that repeated cycles of dieting and regaining weight may have led to food dependency. Dependence has been defined as the failure to stop using a substance that is deleterious to health where use results in short term mood alteration. ... Relapse processes and relapse rates after behavioral treatments of obesity parallel those of addictive behaviors. (p. 12)

Telch et al. (1990) cite study results that indicate:

Binge eaters appear to experience more psychological distress
than do their non-binge-eating counterparts. The results indicated that as binge severity increased, so did the degree of depression, somatic preoccupation, anger, impulsivity, hypersensitivity, anxiety, alienation, and social withdrawal. Obese-bulimic subjects demonstrated a significantly higher lifetime prevalence of major affective disorder. Compulsive binge eaters may be at high risk for evidencing additional psychological problems. (p. 629)

Therefore it is necessary to explore the problems of depression, feelings of low self concept, worthlessness, and patterns of addictive behavior when formulating a treatment plan for the compulsive overeater. It is also important to address the common personality issues of perfectionism and dependency on food in relation to the compulsive overeating disorder. When treating and working with the compulsive overeater there is no simple formula, no pat program of restricting calories, increasing exercise, or behavior modification activities that can fix the problem over the long term. Nor can this disorder be fixed in ten short therapy sessions. Treatment requires long term, if not life long psychological and personal support.

Compulsive Overeating and Depression

Persons struggling with a compulsive overeating disorder experience an array of psychological sequelae. Depression being just one symptom of the disorder. Comer (1992) elaborates on what McCarthy and Jenserson state about depression and eating disorders:

... although the notion that depression helps cause eating disorders, alternative explanations are also possible. Sociocultural, familial and biological factors that contribute to disordered eating patterns may likely help cause depression, this accounting for the appearance of both eating and mood disorders in many individuals. It is also possible that the pressure and pain of having an eating disorder help cause the mood disorder. (p. 415 - 416)
Comer (1992) goes on to say that no matter how depression originates, either being caused or resulting from the eating disorder, the "person grappling with eating disorders also suffers from depression and that treatment must address both forms of dysfunction" (p. 416). No matter the origin of the depression, it is common in most of these individuals. Other psychological symptoms are also present, such as low self esteem, self loathing, anger, fear, and anxiety may accompany depression and compulsive overeating. The actions of a compulsive/binge eater are a

... very painful activity. The obsession with food carries with it an enormous amount of self disgust, loathing and shame. These feelings arise from the experience of being out of control around food and compulsive overeaters try numerous ways to discipline themselves. (Orbach, 1985, p. 28 – 29)

Repeated attempts to gain control and to lose weight further lead to failure and add to the emotional dissatisfaction with self. This further contributes to depression.

Information on depression and the neurotransmitter serotonin, indicates that in depression, serotonin levels in the brain are decreased. When an individual is dieting, and not taking in adequate nutrients, especially carbohydrates, serotonin levels in the brain are further decreased. The compulsive overeater feels tired, lethargic and depressed, contributing to an increasing negative feeling about herself. Thoughts of feeling like a failure, as thought "I can't do it right," "I'm not good enough," or "something must be wrong with me" flood the individual. This negative self thinking adds to further frustration with the process and contributes to the feeling of depression. As the depression continues and worsens, serotonin levels
decrease further, deepening the depression. The cyclic eating behaviors due to the negative thoughts and feelings about self, as well as the craving for specific foods that are common in the dieting process, further deepen the feelings of depression.

There are also personality traits commonly associated with compulsive overeating. These traits are also commonly associated with depression. Alterations in thought patterns may be seen. Emotional behavior patterns that predominate, such as fears of all forms, shame, guilt, fear of rejection, anger and hostility, withdrawal behaviors, and ease at becoming frustrated are frequent patterns present with compulsive overeating and depression. Other "patterns also include poor self concept, placing high expectations on oneself and compulsive behaviors" (McClernan, 1994, p. 10 - 11).

Understanding the psychological issues associated with compulsive overeating behavior and being aware they play a role in the overall picture of this disorder are necessary to providing adequate and appropriate treatment. Nevertheless, the act of compulsive eating shares the stage with depression and other psychological sequelae. The behaviors in compulsive eating and depression as stated by Roth (1991); "Compulsive behavior at its most fundamental, is a lack of self love, it is an expression of a belief that we are not good enough" (p. 19). In realizing this, the compulsive overeater can not be simply told to "restrict your calories, exercise more and burn more calories, and Oh, think about your behavior and change it." It's not that simple. These individuals must be helped to examine the core beliefs about why they are "not good enough" and create a new belief that they "are
good enough" and worth it. When this is realized, new patterns of behavior with the self and food can be created. For the compulsive overeater food has been associated with comfort, and numbing the pain she wishes not to feel. When the pain, stress, anger, anxiety or depression are too great the compulsive overeater turns to food to replace the missing piece:

In all of our tough experiences, we continue to reach for food. It is always there when we need it. Food never lets us down. It never talks back or acts up. It never questions or challenges us. It never makes us feel as if we are not good enough. It is a steady dependable companion. (Ruggles-Radcliff, 1993, p. 64)

Compulsive eating is not something that can be remedied in a limited number of therapy sessions or using traditional methods previously tried, and failed. An approach that supports personal growth, and healing no matter the time frame, is what needs to be available. For the clients given limited access to therapy, they are often left with the decision to terminate therapy because of the cost or pay for the care out of pocket. Often this is not a realistic option for the average client. Another aspect of this dilemma is the individual already has difficulty believing the she deserves love, intimacy, contentment in life, and the right to healing. She is presented with the question, "am I worth the cost." If the healing process has not yet been established and change initiated, continued treatment for this client may abruptly end without an opportunity for closure.

Compulsive Overeating and Addiction

Another psychological aspect to examine when dealing with the compulsive overeater, is the addictive nature of this disorder. Some
may disagree with the idea that compulsive overeating is an addiction. Understanding the process of addiction can shed some light on why persons struggling with this disorder are so difficult to treat and why it is so important to provide a treatment plan that provides a long term approach for recovery. Seeburger (1993) defines an addiction as "a form of enslavement ... an existential state or condition in which one's very life has ceased being one's own" (p. 41). Being enslaved places the individuals into "subservience to their new master (Seeburger, 1993, p. 40)" ', that master being food. This enslavement results in "loss of freedom or liberty" and restricts "choices and actions" (Seeburger, 1993, p. 41). Food becomes the fixation and the individual's life becomes lost. Understanding:

That addictions of all forms is a complex process of what we call "dis-own-ment" - a process whereby the addicts' very lives are taken away from them, ceasing to be their "own." (Seeburger, 1993, p. xiv)

With this knowledge, understanding how food becomes an addictive substance, like heroin or alcohol, and takes possession of the individual. An understanding of the emotional impact that encompasses the addictive nature over the person's very existence is necessary. Shame, guilt, denial and the tremendous sense of loss of control over themselves is pertinent. Food becomes the comforter, so life can be lived, though painfully. The paradox is the addictive substance, food, is meant to numb the pain, but ultimately adds to it. Why does the addiction to food develop? Ruggles-Radcliff (1993) explores the emotional development associated with this process:

A person is set up to develop an addiction if she has only one way of dealing with the stresses of her life. Over use of any
single coping strategy becomes addictive. (p. 66)

Addictions numb the painful experiences in life. Whether they are past, present or perceived painful experiences, the addiction to food is one way of numbing these experiences. The compulsive overeater will never feel good enough and the repeated failures of the cycle of dieting, regaining weight and the addiction process will continue to control her life. Providing short term brief therapy isn't adequate for this problem. Compulsive overeating and addictions are a process that requires long term treatment and support.

Nontraditional Treatment

The fact that the most commonly used methods for treating compulsive overeating have proven ineffective for the majority of compulsive overeater the question becomes, what will work? Literature is now available that presents ideas on alternative. These alternatives present a more realistic and accepting approach to managing a compulsive overeating disorder. The non-diet, self loving approach takes the focus off body weight and size. The focus becomes the person with an approach of teaching self acceptance and self love. Foreyt and Goodrick (1993) promote the assumption of this approach:

Treatments that have the best potential for healing the emotional damage caused by years of dieting failure, perceived lack of self-control and the social isolation often associated with being overweight ... a conservative approach that could also optimize physical health would include motivational techniques to help the patient develop a regular exercise habit and reduce the amount of fat in foods eaten. ... The non-dieting approach ... involves five components ... 1. Development of therapist and peer support; 2. Cessation of dieting and normalization of eating patterns; 3. Gradual increase in exercise; 4. Gradual reduction of fat in eating; and 5. Acceptance of whatever weight is achieved with prudent eating and exercise habits. (p. 5 - 6)
This alternative approach takes the self demoralization out of the weight management and approaches the individual with acceptance. Acceptance of the idea that "you are acceptable just the way you are," is important to the recovery process. This idea is also liberating. The approach takes the focus off the fear that something is wrong "with me" and allows for the individual to defuse the emotional issues that contribute to the behaviors of this disorder. The non-diet approach emphases is off the numbers on the scale and emphasizes a healthier life style that includes self love and acceptance.

Food for the compulsive overeater has been the enemy, the sources of great concern, struggle, shame and guilt. The non-diet approach allows the individual's to develop a relationship with food that is a much healthier association. In *When Food is Love* (1992), Roth states that food had become love for the individual, and became something in their way of living life. "When love is love there is nothing standing between you and your breaking heart" (Roth, 1992, p. 205). When the relationship with food is changed, the person's life and belief systems are changed, food no longer is the focal point.

The non-diet approach de-emphasizes weight loss, dieting and eliminates the element of failure. The individual learns self love and acceptance. With gentleness and compassion for oneself, the individual learns to stay in the reality of now and relate to food in a different way, this diminishes the need for the compulsive behavior. At the same time the emotional distress associated with the compulsive behavior is changed and the individual experiences life and food in a healthier way (Foreyt, 1993, p. 56).
Learning to handle life and stress differently changes one's life. Developing new coping styles through therapy that addresses the eating disorder at its origin and the mechanisms that produce the compulsive eating behaviors initiates healing. The nontraditional approach to treatment for compulsive overeating allows for the learning of new life style activities around food, exercise, family and the management of painful life experiences.

Experiential Therapy

This researcher believes strongly that the mental health process is extremely important in the management of a compulsive overeating disorder. This project is focusing on the use of an experiential therapeutic process as an avenue in producing healing for the compulsive overeater. At present the use of restricting calories, exercise, and the therapeutic use of cognitive/behavioral methods to control compulsive overeating behavior have not been shown to have long term success. Compulsive overeating is more than the willful intake of large amounts of food. The therapist working with the compulsive overeater is wise to focus on the underlying issues. Seeburger (1993) in Addiction and Responsibility an Inquiry into the Addictive Mind elaborates on the cyclic thinking and emotional degradation of the problem:

The more the compulsive overeater eats, the fatter they grow; the fatter they grow, the more disgusting they find themselves to be, the more they turn to food in search of comfort in the face of the self disgust... find themselves caught in the circle of their own thoughts. (p. 20 - 21)

Behind these degrading thoughts are the feelings of worthlessness, loneliness, depression, and "not being good enough." This is the place
where the therapist needs to begin the focus of the therapeutic process. The therapeutic process requires experiencing difficult and painful issues. The experiential method approaches the individual to "find her own way in life and accept personal responsibility if they hope to achieve maturity" (Corey, 1991, p. 231). The idea therefore in focusing on the experiential group therapy approach is to allow the compulsive overeater to find the emotional messages, the questions behind her behavior, and to support her development into a healthier lifestyle.

Walsh (1993) in *Normal Family Process* states that experiential approach to therapy is:

... aimed beyond symptom reduction to the individual and family growth, attending to shared affective experience and the totality of ... interactive self maintaining system. Regardless of awareness or intent, or pains are propagated and intensified by current interactions around them. To explain and change behavior, key elements ... process other mutual influences are addressed. All are believed to be changeable and correctable. These growth-oriented approaches promote fuller awareness and appreciation of oneself in relation to other throughs and intense, affective experiences in open communication of feelings and differences. ... experiential exercises such as sculpting and role play facilitate this process. (p. 43)

Expressing unexpressed feelings such as resentment, rage, hatred, pain, anxiety, grief, and guilt by the use of a powerful activities in the therapeutic process is promoted. These activities include techniques such as psychodrama, role playing, and Gestalt methods. These methods have a powerful impact on the individual. The experiencing of feelings and past events allows for resolution which affords changes in thoughts and feelings about experiences and about self. These changes in old self destructive behaviors are believed to produce healthier behaviors
that promote healing. Social group therapy approach has on the

Having an understanding of the problems in treating the individual
with a compulsive overeating disorder, as well as the failures of the
present treatment philosophy, is necessary to the understanding of
this project's objectives. Answering the question, "Is the use of
experiential group therapy for compulsive overeating able to produce
a positive approach to managing a compulsive overeating disorder?"
is presented in the findings and conclusions of this project.

Summary

Becoming more familiar with the psychological workings of
compulsive overeating promotes a change in the belief system about
the magnitude of this problem. Simply telling the compulsive overeater
to eat fewer calories, to exercise more, and to think about how you
behave and change, just isn't enough. Understanding that the
traditional treatments are proving to set the compulsive overeater
up for failure and further emotional pain is important to those involved
in treating compulsive overeating. Therefore it becomes an important
factor to explore the underlying psychological issues that contribute
to the behavior of overeating. Examining issues of depression, low
self concept, the concept of addiction in relation to food, and eating
behaviors is important when working with these clients.

The fact that the traditional methods have limited effectiveness
with compulsive overeating encourages the possibility that a
non-traditional approach to treatment may prove more successful.
Taking the focus off food and onto the individual's experiences is
the objective of experiential therapy. This project investigates the
impact that the experiential group therapy approach has on the compulsive overeater in changing the way the individual experiences self, develops control over her life, and increases feelings of success.
CHAPTER 3

METHODOLOGY

Introduction

The purpose of this study was to assess the perceptions of the participants of a pilot experiential group therapy program for compulsive overeaters. This was accomplished through the participants' reporting changes in both feelings of depression and patterns of eating over a six month period.

Identification of Research Methodology Used

The descriptive methodology has been chosen for this research project. According to Merriam and Simpson (1995):

The central focus of the descriptive research is to examine facts about people, their opinions and attitudes. Its purpose is not to give value to sets of relationships between events, but simply to draw attention to the degree two events or phenomena are related ... Its purpose is to systematically describe the facts and characteristics of a given phenomenon, population or area of interest. (p. 61)

The strengths and limitations of the descriptive research method include the fact that this method is easy to use, especially in asking the question "what are" the effects on this group? This method also provides the researcher with an opportunity to "study the relationships or events as they happen in the human life situation" (Merriam and Simpson, 1995, p. 71). A third strength of this method involves the exploratory nature of the design. This nature allows for the study of "not only variables being studied that indicate probable cause, but additional variables that may be discovered that
shed new light on the research question" (Merriam and Simpson, 1995, p. 71). The limitations of the descriptive method include first its lack of predicting outcomes. Also the use of statistical terms may cause confusion, frustration and discourage the researcher and the reader of the study from finding the correlation to the research question. These factors "challenge the researcher's ethical responsibilities in reporting the findings of the study" (Merriam and Simpson, 1995, p. 72). Examining the surveys and personal interviews and being able to explore the different aspects of study and the group's experiences provides valuable information on the use of the experiential model of therapy for compulsive overeaters. This examination of data is an appropriate use of the descriptive model of research. The limitations of this design of study were factored into the reporting of this project. The ability to generalize the results were limited by the small sample size.

Description of the Methodology

The project evaluated the self reported perceptions of the group participants related to the effectiveness of the therapy program in helping them manage their compulsive overeating. Measuring the perceptions of the participants was conducted in a two phase fashion. In the first phase, after obtaining consent in writing for participation in the study, each participant completed two instruments. The first was the "Readers Survey" from the book *Enlightened Eating Understanding and Changing Your Relationship with Food* by Rebecca Ruggles-Radcliffe (1993). The survey provided information on demographics, food and diet behaviors, and personal histories. The second instrument was
the Beck Depression Inventory (1961). It assessed the participant's depression levels at the beginning of the study and again upon the study's completion. The reason for the use of the Beck Depression Inventory (1961) in the project was the researcher's belief that compulsive overeating and depression are closely related and that a reduction in levels of depression would validate the effectiveness of participation in such a group. Storlie and Jordan (1984) support this idea:

> Depression and anxiety may be somewhat less common when comparing broad groups of obese and nonobese segments of the population. However, within the diverse group of the obese, there are segments, particularly young women, for whom anxiety and depression may be more prevalent. (p. 86)

The second phase of the project was completed after a six (6) month period of participation in the pilot experiential group. Phase two included a repeat administration of the Beck Depression Inventory (1961) to evaluate changes in the level of depression and included personal interviews with each participant and the therapist of this group. The interviews questioned the participant's perceptions of their involvement with the group and how group participation affected (either positively or negatively) the participant's relationship with food, compulsive eating behaviors, and their relationship with themselves. The final activity was an interview with the therapist which gathered historical data about the group's development, therapy techniques believed to be most effective in changing eating behaviors, and information on how other therapists might apply the data in working with their own compulsive overeating clients.
Source of the Data

The source of the data for this project was a group of women who meet weekly to confront their compulsive eating behaviors. Though, at the time of this study the group consisted of only women, participation in the group was not restricted to women only. The group members joined the group after an interview with the therapist who determined their suitability for the group. The group consisted of six (6) members at the beginning of this project. One participant, the researcher, was excluded from the project. A total of five (5) participants agreed to be evaluated in this study.

Instrumentation

The instruments used in this project included the Beck Depression Inventory (1961) (see Appendix 1), the Enlightened Eating Readers Survey (1993) (not included because permission to print this survey was denied by the author), and interview questions for the participants (see Appendix 3) and therapist of the group (see Appendix 4).

The Beck Depression Inventory (1961) was developed by psychiatrist Aaron T. Beck in the 1950's, and revised in 1961 and again in 1971, for use in measuring depression in his clinical and research programs with adolescents and adults. This inventory is a "well-researched assessment tool with substantial support for its reliability, and validity" (Conoley, 1992, p. 79). The scoring guidelines indicate scores from 0 - 9 as being of normal range, scores from 10 - 18 indicate mild to moderate depression, scores from 19 - 29 indicate moderate to severe depression, and scores 30 and above indicate extremely severe depression (Conoley, 1992, p. 80). This scale was used in the
evaluation of the first and second administrations of the depression inventory.

The evaluations of the Beck Depression Inventory (1961) for test-retest validity, concurrent and construct validity as described in the Eleventh Mental Measurement Yearbook (1992) by J. J. Kramer and J. C. Conoley are reported to be moderate to high in comparison to other inventories of a similar nature. Repeated studies have shown this instrument to be valid and internally consistent over time (Comer, p. 307). The results of this inventory provide important clinical data on how depressed an individual is.

This twenty one (21) question inventory has been widely used to evaluate clinical depression. The items "used a set of questions answered on 0 - 3 scale for severity of the problem" (Conoley, 1992, p. 79). This inventory is easily administered and is a self report that takes 5 - 15 minutes to complete. The limitation of the inventory is the ease of ability for the testee's to "fake good" or "fake bad," if they wish to over or under self report the severity of their depression. Even with this weakness, the inventory has proven to be a useful tool in the clinical setting.

The second instrument used in the project was a "Readers Survey" from the book, Enlightened Eating Understanding and Changing Your Relationship with Food, by Rebecca Ruggles-Radcliffe (1993). The stated purpose of this survey by the author is:

... believe women of all ages share concerns about their bodies and weight which are never voiced aloud. To normalize this concern, ... to help identify issues which have been a part of your life. ... Answers will be pooled ... used to build awareness and educate the public about body image, food and weight. (p. 160)
This survey consist of 39 questions of yes/no and multiple selection. There is a set of questions requiring fill in data of optional demographic information. Generally the questions elicit information on eating patterns, exercise habits, family patterns associated with obesity and eating behaviors and finally the individual's dieting methods previously used. This information was used for background data, to ascertain if there was any significant correlation in the responses among the participants. This researcher believed this instrument would provide significant information about life and emotional experiences of the group participants that would shed light on the underlying issues that contribute to their eating disorder. This researcher also believed that there may be similar experiences among the group members that contributed to their eating behavior and that data from the use of this instrument might indicate such a correlation.

After a phone conversation with Ms. Ruggles-Radcliffe, permission to print this survey in this research report was denied. The decision was made to summarize the researcher's thoughts regarding the significance in the interpretation of this survey and to report this summary.

The interview process was completed after a six (6) month period of participation in the group. The interview questions were developed by the researcher and evaluated for content, reliability, validity and appropriateness by the project advisors of Ottawa University. See Appendix 3 and 4, for the list of participant and facilitator questions used in the interview process.
Data Collection Procedures

After all the participants provided signed informed consent to their willingness to participate in the project (see Appendix 2), the first phase of the project was initiated. On Monday, June 26, 1995, at the beginning of a group therapy session, the Beck Depression Inventory (1961) and the Enlightened Eating Readers Survey (1993) were handed out to the individual group members. A stamped self addressed envelope was provided for the return of the surveys to this researcher. The participants were instructed to complete the surveys honestly and as soon as possible and to return them by mail or in person, to this researcher at the next group session. Confidentiality of all information was emphasized. Once the surveys were returned, they were coded to maintain the anonymity and confidentiality of the respondents, yet to provide a means for comparison of the data upon completion of the project.

On the last Monday of January 1996, after six (6) months, the second phase of the project was initiated. The three (3) remaining participants were informed that the Beck Depression Inventory (1961) would be re-administered at the time of the personal interviews. Private interviews were scheduled and conducted with each participant. The Beck Depression Inventory (1961) was administered when the personal interviews were conducted. The participant's responses were recorded on audio tape and later transcribed. An interview with the therapist was also scheduled and conducted in a similar fashion to that of the participant interviews.

On completion of all data collection, the scores from the Beck
Depression Inventory (1961) were compared for individual and group changes in depression levels.

The data from the Enlightened Eating Readers Survey (1993) was evaluated for patterns of behaviors among the members of the group. Due to the limitations placed on the project associated with the printing of this instrument, the researcher evaluated the responses for commonalties. Upon completion of this evaluation, an opinion was formed regarding pertinent behaviors in the participant's relationship with food. A summary of this evaluation is provided in Chapter 4.

The interview data obtained from the therapist focused on the therapist's perceptions of the effectiveness of the experiential group process and the participant change in levels of depression and compulsive eating behaviors.
CHAPTER 4

PRESENTATION AND ANALYSIS OF THE DATA

Introduction

In review, this project consisted of administering the Enlightened Eating Readers Survey from the book *Enlightened Eating Understanding and Changing Your Relationship with Food* by Rebecca Ruggles-Radcliffe (1993). A second survey, the Beck Depression Inventory (1961) was administered at the beginning of the project and again after a six (6) month period for completion of the project. At the end of the project, the consenting members of this group and the therapist were interviewed. Their interviews were conducted for the purpose of learning what their perceptions were regarding the effectiveness of the experiential group therapy process on changing depression and compulsive eating behaviors.

The five (5) members of this pilot group therapy program, were asked about their willingness to participate in this project. The five eligible members agreed and signed an informed consent. Then each member received the Enlightened Eating Readers Survey and the Beck Depression Inventory to complete. One member of the group did not complete nor return the surveys. She was infrequent in her attendance in the group, and left the group three (3) months into the project. Due to these factors, she was eliminated from the list of participants. A second member completed both surveys but left the group at the three (3) month period and was also eliminated as a
participant of this project. The remaining three (3) members of the
group completed the project objectives and their data are presented
here. These remaining participants are referred to as P2, P3 and P4.
The personal data about these three (3) women are: all range in age
from late 30's to late 40's. Two women are divorced and one is married.
All hold a high school education and one has an undergraduate level
degree. All are working full time. These women all related struggles
with weight and problem eating patterns for more than 20 years.

Participant P2 left the group December 1995 because she felt
she no longer needed the group. She believed she had become able to
manage her eating behaviors and had experienced an increased sense
of well being. The decision to keep the data provided by her, as part
of this project, was made because of her longevity with the group,
three (3) years, and her positive state at the time of withdrawing
from the group.

Findings

Survey Findings. Though it is not possible to provide the
questions to the Enlightened Eating Readers Survey, this researcher
believes the ideas and thought accumulated regarding the participant's
responses are important to this project. From this survey, common
responses were found. In responding to specific questions it became
clear the participants all maintained a continued hope of losing weight
and attaining an ideal body weight and image. Other significant
information gleaned came from questions related to when their emotional
eating began and had a positive correlation to parental attitudes about
the participant's weight in childhood and adolescence. This researcher
found that all participants began their present eating behaviors with food in the pre-pubescent and very early adolescent periods. The age ranged from as early as 7 years and as late as age 13 years. When comparing these facts to the questions that related to parental concern over the participant's weight, these factors showed positive correlation. All stated that their compulsive behaviors with food began between ages 7 - 13 years and that their parents made negative statements to them about their weight. Questions related to the parents' concern about weight and early inappropriate or emotional eating behaviors received positive responses by all participants. Also, the participants indicated they had tried multiple avenues in attempting to lose weight, and all noted that they believed these methods did not adequately address the underlying causes for the compulsive eating behavior. This survey points out that the compulsive eating disorder has a long standing nature. It also points out that individuals who began compulsively eating began this behavior early in their development. These traits have a long standing nature and require considerable time to change.

The second survey, the Beck Depression Inventory (1961) was administered at the beginning and again at the completion of this project. This researcher decided to use this inventory for two (2) reasons. The first reason was that it is an easy and quick tool to assess depression. This tool has an excellent history of reliability in clinically assessing depression. The second reason for the use of this tool was the researcher's belief that depression and compulsive overeating are significantly associated. The researcher's
intention was to use a tool that provided a comparison about the participant's level of depression over the six (6) month period of the study.

Figure 3, charts the scores from the Beck Depression Inventory (1961) for the three (3) participants. Based on the scoring scale for this inventory, on the first administration, all three (3) participants scored in the 19 - 29 scoring range indicating moderate to severe depression. On the second administration participants P2 and P3 reported scores in the 0 - 9 scoring range indicating no depression or in the normal range. Participant P4 scored at 19 on the first administration and 22 on the second administration. Both administration scores were in the moderate to severe depression range. The scores indicate that this participant remained clinically depressed.

**FIGURE 3**

**BECK DEPRESSION INVENTORY RESULTS**

<table>
<thead>
<tr>
<th>Participant</th>
<th>First BDI*</th>
<th>Second BDI*</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>P3</td>
<td>22</td>
<td>6</td>
</tr>
<tr>
<td>P4</td>
<td>19</td>
<td>22</td>
</tr>
</tbody>
</table>

*Beck Depression Inventory

A review of P4's interview data, shows that her depression levels worsened. For the other two participants, the change in the depression level downward was reported in relation to a positive sufficient change in attitude about their lifestyle and feelings about themselves. P2, as noted, had left the group feeling emotionally healthy about
herself and her relationship with food. The other participant, P3 indicated she had been taking Prozac for the last two (2) months of the project and verbalized feeling much better about her life. This client reported in her interview that she wasn't sure if the medications alone or the combination of the therapy and medication contributed to her improved sense of well being. Though P3 had a positive change in depression she admitted that her relationship with food had not been changed as of yet. The data obtained from this survey has strongly indicated that the depression levels changed during this participation period.

**Interview Findings.** The personal interviews further provided information about the effectiveness of group participation and changes in levels of depression. Each response to the questions related to changes in perceptions of self and changes in behaviors with food were evaluated for positive or negative responses. These responses were then compared to the length of time each member had participated in the group up to the completion of this project. Participant P2 had the longest participation in the group, three (3) years. This participant reported sufficient positive change in her perceptions of herself, and her attitude and behavior with food. She reported feeling more in control over these aspects of her life and was able to leave the group feeling less depressed and with an improved sense of self. She indicated that the emphasis for her life now had changed to living life and not living for food. This participant also reported that her changed behavior with food, improvement in depression and feeling empowered in her life had resulted from her participation in
the group.

Participant P3 who had been a member of the group the shortest time, eight (8) months, reported a positive change in feelings of depression. She indicated she had been on Prozac for the last two (2) months of the project. Her feeling better about herself was prefaced by a report that her relationship with food "really hadn't" changed. She stated that she had continued to compulsively eat but with much more awareness of her behavior than before her participation in the group. She also prefaced this awareness with a concern that she had not as of yet discovered the underlying causes for her compulsive overeating. She also reported a belief that the therapy process had been a positive, helpful experience for her. It leaves the researcher to contemplate that perhaps the Prozac had contributed to the mood change and that therapy had not yet effectively addressed the underlying triggers for her compulsive eating behavior.

Participant P4 (a member of the group for one (1) year) appeared quite frustrated by her participation in the group. She reported not being aware that her initial depression had been so severe when joining the group. She intuitively self reported that she now believed her depression was much higher. She was concerned and frustrated by this fact. She is aware that this therapy process is what had caused her new experience with depression. She also reported she has been confronted with an awareness of some of the underlying triggers that initiate her compulsive overeating, and expressed frustration about this. She reported being frustrated by the fact because of this increased awareness she had hoped for a change in her weight and
behavior with food, and this had not happened yet. This researcher questions the negative disparity in the participant's depression change, unchanged eating behaviors, and her frustration with her participation in the group. Perhaps this is a crisis point for her and continued participation would result in improvement in her depression and her relationship with self, and food. See Appendix 5 for the transcripts of the three (3) Participant Questionnaire Responses.

The response to the questionnaire by the group therapist added valuable knowledge to the foundation established by the participants' responses. The therapist for this group had been facilitating this particular group for the past three (3) years. She has fifteen (15) years of practice as a Psychologist which includes study in the management and treatment of eating disorders. She provided important information about issues of denial and depression associated with compulsive overeating. This therapist indicated that one of the most difficult issues in dealing with the compulsive overeater was the denial about how much food is consumed. She related that some clients sometimes deny eating, though their body weight indicates differently. In interviews with participants P3 and P4 they affirmed this statement when questioned about conscious realization around food consumption. These participants both affirmed the disparity in their behavior and the amount of food consumed. Both stated that often they had distorted beliefs about the amount of food consumed, and often "did not think they ate that much."

On the matter of depression, this therapist holds the belief that compulsive overeating is a symptom of depression and treatment must
address both issues. Besides the therapeutic approach of group, drug therapy must also be a consideration to facilitate healing.

The therapist explained how her approach for managing compulsive overeating is promoted in When Food is Love (1991) by Geneen Roth. This approach promotes eating until full without depriving oneself of favorite foods and focuses on becoming aware of the emotional components of the eating behavior. This approach encourages empowerment, control, contentment, and happiness with one's life.

This therapist evaluates improvement in her clients by observing for changes in their behaviors with life and food. She observes for reported changes in a relationship with food and feelings of happiness about life. She reports a belief that there is generally a 75% improvement in the behaviors in all her group participants from the time they joined their respective group to this interview. For the transcript of the therapist interview see Appendix 6.

The therapist who facilitates this group reports that she observed a positive change in group members relationship with food over time. Based on the data provided by all individuals who contributed to this project, this researcher has drawn these assumptions. First, compulsive overeating behaviors start early in the person's development. Second, compulsive overeaters are also depressed. Third, each participant experienced this group differently. Fourth, experiential group therapy may be helpful in changing compulsive overeating behaviors. Fifth, experiential group therapy and other interventions such as antidepressant medication, individual counseling and the use of some traditional approaches may produce a positive outcome for the
compulsive overeater. Finally, management for compulsive overeating requires long term treatment and support. Because of this small sample size, this researcher's ability to draw adequate conclusions about this project is limited. The above assumptions provide some basis for the belief that participants in an experiential group therapy process may produce positive results in the management of compulsive overeating behaviors and improvement in depression.

A Compulsive Overeater's Story

Because of the small number of subjects in this study and the difficulty in drawing an adequate conclusion to answer the research question, this researcher has chosen to include the story of a compulsive overeater who was not a part of the pilot project group and who did not respond to the surveys.

This is the story, as shared with this researcher, of a 50 year old woman who has experienced the emotional pain with the struggles related to her obesity and compulsive overeating for more than 30 years. As a child, she recalls being very thin. From a very early age she remembers her mother always "fussing" about how thin she was. She also experienced a childhood full of chaos and abuse. To add to her childhood dysfunction she shared her emotional pain of shame and guilt around being raped by a schoolmate at age 14. She remembers that her binge eating began about that time in her life even though her body weight did not reflect that behavior until years later. She remembers that she ate everyday when she got home from school. She also reports being restless and fearful during this period of her life.

She married and began having children by age 18. She said, in
hindsight, she got married to get away from her abusive stepfather. It was during her first pregnancy that she began to "really put on a lot of weight." She described being alone a lot, bored, lonely, frustrated and restless. She was married to a man in the military, who was gone a great deal of the time. She reflects that, in fact, even when he was around, he was gone a lot not only physically but gone emotionally as well. The first few years of the marriage were lived in a foreign country. She had few friends. She didn't know the language well at first, and she felt "so very lonely." That's when her weight problem and the compulsive eating began in earnest. These behavior patterns became very ingrained into her personality and life style. It was also a period of a long and unhappy marriage. It was a time when her needs were not met, when her life was out of control, and her eating and weight problems aggravated every aspect of her being.

Over the 21 years of her marriage, she reports being a very unhappy woman. She weighed 300 lbs. on the day her husband left her. During those years the compulsive eating behaviors became severely out of control. She tells of times when for periods of weeks she would drive to fast food restaurants, sometimes twice a day, and ordered two meals. She then drove home as fast as she could and consumed those meals as fast as she possibly could. She said she thought she would die from the physical pain of being so full. She wished she could die because of the emotional pain and shame she felt over her eating behavior. Her body size kept getting larger. She felt disgusted with herself at not being able to stop the behavior and lose weight. During those
years she tried any number of weight loss programs, diets, starvation, exercise, and therapy. Each attempt only met with failure, feelings of guilt, shame, and more depression.

At 300 lbs., divorced, suicidal, and totally out of control with her eating and her life, she believed this was the end for her. A physician suggested a stomach stapling. She felt so desperate at that time that she agreed to this major surgical procedure and did lose 150 lbs. Reflecting on this time, she stated "I finally felt happy with life and became successful with my career." This "good" time lasted about five (5) years. She somehow managed to keep her weight down during this time. The problem remained; she never learned how to control her binge eating behavior. Though she could not consume large amounts of food at any given time, she learned that eating high fat, high sugar foods, such as chips, ice cream and chocolate was what she craved. These foods became her most frequent choices for meals. The consumption of these foods was done compulsively and often unconsciously. She gradually regained 80 lbs. She continued having no idea why she couldn't stop eating and keep her weight down. So the cycling behavior of dieting, failure, and regaining of the weight began again and seemed to have more distressing consequences for her at age 50.

Fortunately, she met a therapist who conducts group therapy for individuals struggling with the compulsive overeating. She became a member of this group, and initially held the belief that she'd lose weight and get control over her eating and her life. She laughs at that, because to her surprise that hasn't happened in the year
and a half of participating in this group. Her weight has remained relatively constant. She still is unhappy with her body size, but something else has happened to her.

What has happened is that she is more accepting of herself, just the way she is in all areas of her life. She readily admits "I hate the weight I carry around," "I can't believe the emotional struggles, and painful past experiences I've had to face to get to this point in my life." She admits to a new awareness that when she is lonely, bored, restless or afraid, she wants to eat. She admits that sometimes she still eats compulsively. This woman speaks of facing her past demons as a journey that has helped her learn that the past abuses have contributed to her feeling of being out of control. She describes a nearly life long journey with depression as a time of unending darkness when life didn't matter much. The journey has become a time of travel through a void, and coming out into a space full of adventures to experience.

She has learned through the group therapy process about the triggers that sent her life into an out of control eating frenzy. She admits that this process has only just begun to help her in getting control over her life. She admits she continues to struggle with her compulsive eating but has learned to look at what is stimulating that behavior. She now makes different choices. She is now aware of when her compulsive eating behavior starts, and she also feels less depressed with herself. She has also learned to be more forgiving with herself and this results in more control in her life. She has become conscious of when she has lost control with her eating behavior, and she now
is able to stop the behavior before it is totally out of control. This taking control means that she must consciously investigate the emotional triggers that initiate the compulsive eating behaviors. She talked frankly about what is required for her to be conscious about food. She describes this as being "very hard work." This hard work has helped her become healthy, healed and empowered.

This woman's story shares many similarities to those of the participants in this project. This woman's shame, sense of loss of control over eating, food, and life have had a tremendous impact on her life. All of the women who contributed to this project have experienced depression associated with their eating disorder. They are learning what triggers their eating behaviors. They are aware these behaviors have been unconscious acts that are now becoming conscious as a result of their work in this group. These women have taken on a very difficult journey in exploring the emotional causes for their disorder. The exploration of these experiences has taken a great deal of time and personal effort, along with a risk that their body weight may not change, but they might be changed by this journey.
CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

This project is a study of a pilot experiential therapy group that deals with compulsive overeating. The purpose of this project is to explore if this form of therapy can produce positive change in depression and compulsive eating behaviors among its participants. The use of a non-diet approach and the exploration of the underlying issues that facilitate the continuation of the behaviors in this disorder are the foundation of the group's work. This study examines the effects of experiential group therapy on depression and eating behaviors among the group's participants. This was accomplished by the use of surveys which examined eating disorder thinking and behavior by interviews with the members of the group and its therapist, and a pretest and posttest administration of the Beck Depression Inventory.

Conclusions

The question, "Is experiential group therapy effectively able of producing a positive approach to managing compulsive overeating," cannot be answered by a simply stated, Yes. It is important to examine the findings, and realize that all factors are pertinent to the issue of compulsive overeating.

The magnitude of a disorder in compulsive overeating does not allow for a limited focus. This project was restricted to the effectiveness of experiential group therapy on depression and changes
in eating behaviors. The final evaluation of the surveys and interviews conducted, as part of this project, brought out other issues. Issues in denial of food consumption, the exploration of past emotional experiences, self esteem, and the use of medications in treating this disorder expanded on the initial research question.

The participants in this experiential group therapy program provided significant data on depression by their response on the Beck Depression Inventory and from their interviews. Also these women provided important data regarding associated symptoms and behaviors that are a part of their eating disorder. The effects of their experience in the group therapy process related to change in depression as well as their eating behavior changes appeared to be positive.

Self reporting of depression was skewed by one participant's own beliefs that her depression in fact was worse than she initially believed. Also, the use of antidepressant drugs by a second participant affected her depression scores. She reports that her behavior with food has lagged behind her improvement in depression. These factors alone distort the ability to assess how effective the experiential group therapy process has been in changing depression levels in the compulsive overeater. Though two (2) of the participants reported positive improvement in depression, it seems that an assumption might be that if depression for the compulsive overeater improves, therefore the behaviors with food will also be improved. This assumption was validated in only one of the three person assessed. As stated, only one participant had improvement in both depression and eating behaviors and felt healed enough to leave the group. A second participant had
improvement in depression with the use of antidepressants but no
significant change in eating behaviors. The third participant was
more depressed and continued with unchanged eating behaviors but
admitted to an increased awareness regarding her depression and
compulsive eating behaviors. With further assessment of the data,
it was evaluated that one participant reported a positive change in
both depression and relationship with food. So therefore, this
researcher questions if it can be assumed that the effectiveness of
experiential group process on depression and eating behaviors be changed
after significant longevity in this type of group process (3 years
in this instance).

The data provided by the Enlightened Eating Readers Survey as
well as the participant and therapist interviews point out the issues
related to the underlying emotional experiences associated with
compulsive overeating. Each participant related on how she has become
more aware of feelings and upsets that trigger her eating behavior.
This researcher assumes that once the individual becomes aware of
the emotional behaviors associated with food, then choices can be made
to change eating behavior. The issue is that first the emotional
trigger must become conscious. The techniques for this experiential
group therapy program uses many active approaches to bring into
awareness of past experiences and emotional triggers that propagate
the continuation of the compulsive eating behaviors.

From the limited data gathered, the researcher has drawn
conclusions on what was learned from this project. The data lead
to the conclusions that compulsive eating behaviors are initiated at
an early developmental stage. Compulsive overeaters also experience depression associated with their eating disorder. The researcher has made the conclusion that each person who contributed to this project has experienced their participation within the experiential process differently. From the professional's perspective, this researcher assumes that the experiential group therapy process may be helpful in treating compulsive overeating. Yet the assumption is also present that experiential group therapy in combination with other traditional and nontraditional modalities may produce a positive outcome for these clients. The final conclusion, related to management of compulsive overeating, is that because of its long standing nature and the need to explore the underlying emotional triggers, therapeutic support will need to be provided longer than the brief therapy model provides for at present. Based on these conclusions about the management of compulsive overeating the following recommendations are presented.

**Recommendations**

Treatment for compulsive overeating must explore multiple aspects of this disorder. When treating individuals with a compulsive overeating disorder, the therapist is required to give attention to many factors in the complexity of the compulsive overeating disorder.

Considering the possibility that depression is caused by compulsive overeating or that compulsive overeating is caused by depression, treatment requires a focus on both disorders. It must not be neglected or forgotten that a compulsive overeater has emotional triggers that result in their eating behaviors. The compulsive overeater can receive assignment of benefits for a diagnosis of depression or anxiety but
not for the disorder of compulsive overeating. Yet the anorexic or bulimic receives appropriate diagnostic assignment to their disorder, and insurance benefits are reflective of that. This is an injustice to the compulsive overeater, and to the needs of that individual. The physical, psychological, financial, personal and social consequences of this injustice are not adequately taken into consideration.

This researcher has a twofold recommendation for the mental health profession concerning treatment of compulsive overeating. The first recommendation is that the experiential group therapy approach should be considered and recommended to these clients. This alternative needs not only to be available but affordable due to the inadequacies of the system at the present time. The second recommendation is that this disorder deserves at least the same recognition as the eating disorders of anorexia and bulimia. The person struggling with compulsive overeating has the right to effective, adequate and affordable treatment that provides education, support and exploration of all underlying issues, and presenting symptoms in order to promote healing in mind, body, and spirit. Therefore this researcher recommends to the mental health profession the development of a separate and distinct DSM-IV category for Eating Disorder: Compulsive Overeating.

More investigation and support is required to validate the effectiveness of the experiential group therapy method in managing persons with a compulsive overeating disorder. This project can not adequately generalize the effectiveness of such an alternative nontraditional treatment of compulsive overeating. The challenge for the medical and psychological communities lies in expanding the scope
of knowledge, treatment methods, and acceptance of individuals presenting with the disorder of compulsive overeating.


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APPENDIX 1

BECK DEPRESSION INVENTORY
REX DEPRESSION INVENTORY

by Aaron T. Beck

Read over the statements grouped with each letter, A through U. Pick out the statement within each group that best describes the way you feel today, that is, right at this moment. Circle the number next to the statement that you have chosen in each group. If two or more statements in a group describes the way you feel equally well, circle each one. Be sure to read over all of the statements in each group before you decide on one.

A. (Sadness)
0 I do not feel sad.
1 I feel blue or sad.
2a I am blue or sad all the time and I can't snap out of it.
2b I am so sad or unhappy that it is quite painful.
3 I am so sad or unhappy that I can't stand it.

B. (Pessimism)
0 I am not particularly pessimistic or discouraged about the future.
1 I feel discouraged about the future.
2a I feel I have nothing to look forward to.
2b I feel that I won't ever get over my troubles.
3 I feel that the future is hopeless and that things cannot improve.

C. (Sense of failure)
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2a I feel I have accomplished very little that is worthwhile or that means anything.
2b As I look back on my life all I can see is a lot of failures.
3 I feel I am a complete failure as a person (parent, husband, wife).

D. (Dissatisfaction)
0 I am not particularly dissatisfied.
1a I feel bored most of the time.
1b I don't enjoy things the way I used to.
2 I don't get satisfaction out of anything anymore.
3 I am dissatisfied with everything.

E. (Guilt)
0  I don't feel particularly guilty.
1  I feel bad or unworthy a good part of the time.
2a I feel quite guilty.
2b I feel bad or unworthy practically all the time now.
3  I feel as though I am very bad or worthless.

F. (Expectation of punishment)
0  I don't feel I am being punished.
1  I have a feeling that something bad may happen to me.
2  I feel I am being punished or will be punished.
3a I feel I deserve to be punished.
3b I want to be punished.

G. (Self-dislike)
0  I don't feel disappointed in myself.
1a I am disappointed in myself.
1b I don't like myself.
2  I am disgusted with myself.
3  I hate myself.

H. (Self-accusations)
0  I don't feel I am any worse than anybody else.
1  I am critical of myself for my weaknesses or mistakes.
2  I blame myself for my faults.
3  I blame myself for everything bad that happens.

I. (Suicidal ideas)
0  I don't have any thoughts of harming myself.
1  I have thoughts of harming myself but I would not carry them out.
2a I feel I would be better off dead.
2b I feel my family would be better off if I were dead.
3a I have definite plans about committing suicide.
3b I would kill myself if I could.

J. (Crying)
0  I don't cry any more than usual.
1  I cry more now than I used to.
2  I cry all the time now. I can't stop it.
3  I used to be able to cry but now I can't cry at all even though I want to.

K. (Irritability)
0  I am no more irritated now than I ever am.
1  I get annoyed or irritated more easily than I used to.
2  I feel irritated all the time.
3  I don't get irritated at all at the things that used to irritate me.
L. (Social withdrawal)
0  I have not lost interest in other people.
1  I am less interested in other people now than I used to be.
2  I have lost most of my interest in other people.
3  I have lost all my interest in other people and don't care about them at all.

M. (Indecisiveness)
0  I make decisions about as well as ever.
1  I try to put off making decisions.
2  I have great difficulty in making decisions.
3  I can't make decisions at all anymore.

N. (Body image change)
0  I don't feel I look any worse than I used to.
1  I am worried that I am looking old or unattractive.
2  I feel that there are permanent changes in my appearance and they make me look unattractive.
3  I feel that I am ugly or repulsive-looking.

O. (Work retardation)
0  I can work about as well as before.
1a It takes extra effort to get started at doing.
1b I don't work as well as I used to.
2  I have to push myself very hard to do anything.
3  I can't do any work at all.

P. (Insomnia)
0  I can sleep as well as usual.
1  I wake up more tired in the morning than I used to.
2  I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3  I wake up early every day and can't get more than 5 hours sleep.

Q. (Fatigability)
0  I don't get any more tired than usual.
1  I get tired more easily than I used to.
2  I get tired from doing anything.
3  I get too tired to do anything.

R. (Anorexia)
0  My appetite is no worse than usual.
1  My appetite is not as good as it used to be.
2  My appetite is much worse now.
3  I have no appetite at all anymore.

S. (Weight loss)
0  I haven't lost much weight, if any, lately.
1  I have lost more than 5 pounds.
2  I have lost more than 10 pounds.
3  I have lost more than 15 pounds.
T. (Somatic preoccupation)
0   I am no more concerned about my health than usual.
1   I am concerned about aches and pains or upset stomach or constipation.
2   I am so concerned with how I feel or what I feel that it's hard to think of much else.
3   I am completely absorbed in what I feel.

U. (Loss of libido)
0   I have not noticed any recent change in my interest in sex.
1   I am less interested in sex than I used to be.
2   I am much less interested in sex now.
3   I have lost interest in sex completely.

SCORING THE INVENTORY

Your score for each item is the highest number that you've circled for any of the statements within that group. That is, if you circle 1 for group "A. (Sadness)," your score for A would be 1 point. If you circled more than one statement in a group, your score for that item would be only the highest number you circled. For example, if for "B. (Pessimism)" you circled both statements 1 and 2b, you score for item B would be two points. To get your total score for the test, add up points for each item. Thus you total score is made up of 21 individual item scores and can range from zero to 63 points. Write you score in the box below.

__________________

High Scores (15 and Above)

If you scored 15 or more, you probably have a serious depressed mood. Often depressed people feel guilty about having these feelings as a possibly pleasant level of depression. So don't be surprised if you scored very well. Ask someone who knows you what they think you would score if you took the test now.
Low Scores (0-5).

If you scored in this range you probably took this test for fun. Your answers indicate that you are showing almost no signs of feeling depressed. Hopefully, your score also means that you're feeling quite good about yourself and the world around you. If, however, things don't seem as right with your life as this low score suggests, depression may not be the best label for what you are experiencing. You may pick up on your problem area better by taking some of the tests in the other chapters of The Mind Test. Keep in mind also that this test asks for how you are feeling right this minute. If today just happens to be a great day, you may find it helpful to take this test again at another time.

Medium Scorers (6-14).

Scores in this range usually indicate a mild to moderate level of depression. You may feel "down" often enough to make life less enjoyable than it could be but not enough to have your generally feeling bad. This level of depression also suggests that there may be times when it's hard for you to find enough energy it through the day. This is a common problem for many of us since almost everyone shows mild levels of depression at one time or another. That knowledge may not, however, make you feel any better. To help you understand you own level of depression, look over those items that produced your score with particular attention to any on which you scored 2 or 3. Think about how these symptoms relate to the way your life is going, and see if you can identify particular parts of your life that have you down. If you scored at the high end of this range, it's likely that there are important areas in your life causing you serious concern. Many of the professionally written self-help programs are designed to provide you with techniques for understanding and changing some of these problem areas. If you cannot identify the problems or if they seem overwhelming to you, you may gain the most benefit from professional help. It is likely you are feeling bad enough to have to acknowledge you pain, but you probably also have enough energy to make treatment productive.

High Scorers (15 and above).

If you scored 15 or higher, you did not need this test to describe your current feelings as a possibly severe level of depression. You no doubt were well aware of how down you felt before you answered any of the questions. In fact, it's a positive sign that you were interested enough in self-understanding and had enough energy to take this test. If you scored fairly high, you probably see most things in your life as a waste of time or just too much trouble. And the future doesn't look very bright. Since you've taken this one important step toward understanding your problems, continue that self-help direction by getting in touch with your physician or a psychologist or other mental health professional; depression at this level does not often go away without help.
ABOUT THE INVENTORY

The Beck Depression Inventory is an example of how tests can be developed directly from a psychiatrist's or psychologist's clinical experiences. During the early 1950's, psychiatrist Aaron T. Beck became interested in measuring depression. As part of a combination research and clinical treatment program, Dr. Beck worked with five soldiers who had become psychotically depressed after having accidentally killed a comrade. His evaluation of their concerns and emotional problems convinced him of the need for more accurate ways to assess depression than were available at that time.

As Dr. Beck continued his work with people being seen clinically for depression, he began developing specific test items to measure the kinds of feelings and behaviors that psychiatrists and psychologists observed during clinical interviews. You will notice as you look over the twenty-one items that each of them has a label that represents a symptom of depression. An important part of your own test score interpretation will be an examination of those symptoms for which you scored the highest. Dr. Beck's research has established how each symptom is related to overall levels of depression. Sore - sadness, pessimism, and dissatisfaction, for example - have a high relationship to overall levels of depression. Others, such as irritability and weight loss, are meaningful but less related specifically to depression. Ones such as suicidal thoughts are correlated with depression levels but also extremely significant in their own right.

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APPENDIX 2

PARTICIPANT INFORMED CONSENT
To Thesis Project Participants

I, Patricia Birmingham, as a graduate student at Ottawa University, am conducting a research project to gather data for my Master's Thesis. The purpose of the project is to determine the perceived effectiveness in your group therapy experience in influencing your control over compulsive overeating behavior. This project will also assess eating behavior history, patterns of dieting history and perceived level of depression related to compulsive eating behaviors.

Your participation in this project will be held in absolute confidence. Your name will not be associated in anyway with the results of this study. Surveys will be coded to aid follow up.

Your participation in this project will require the completion of two (2) surveys at the beginning of this project and again in six (6) months the completion of one (1) survey and a personal interview to evaluate if there is change in your perception of the effects of the therapy process and you eating habits. Your participation and willingness to provide this information for this project is appreciated. When completing the surveys, please take your time and answer all questions honestly.

If you have any questions regarding the project, please feel free to ask. If you are interested in the results of this project they will be available after May 1996.

In an effort to maintain an ethical standard for this project, I am requesting your signed consent to use the data provide for this project.

I, ________________________________, consent to participation in the Master's Thesis project being conducted by Patricia Birmingham. Ms. Birmingham has my consent to use the data provided by me for this project.

Signature of Participant ________________________________
Date ____________________
APPENDIX 3

PARTICIPANT INTERVIEW QUESTIONS
PARTICIPANT QUESTIONS

1. How long have you been a member of this group?

2. What was your initial reason for joining this group?
   a) Has the group met your expectations for changing your weight?

3. Have you felt that your participation in the group has changed your life?
   a) How has it positively changed your life?
   b) Has there been any negative consequences to your group participation?

4. Is there an issue in your life that you have become aware of since you began participating in this group, that is a factor in your eating behavior, that you were unaware of before you joined this group?

5. Has becoming aware of this issue changed the way you behave with food?
   How?
   Why?

6. Do you believe that your participation in this group has changed your feelings about the way you perceive yourself?

7. Do you feel/believe the counselor understands your needs and directs the group based on those needs? Why or Why not.

8. Did you have feelings of depression when you began your participation in this group? If so, how much on a scale of 1 to 10, 1 being no depression and 10 being very depressed.

9. Has that sense of depression changed, since you began participating in this group, and how has it changed?
APPENDIX 4

FACILITATOR INTERVIEW QUESTIONS
FACILITATOR QUESTIONS

1. What is your level of training, academic degrees and experience?

2. How long have you been facilitating this group?

3. Do you have specific training or credentials in working with clients with eating disorders and specifically compulsive overeating?

4. What are the common psychological issues that you have identified with the clients in your group? Explain.

5. Do you believe that depression is an associated factor with obesity and compulsive overeating? Why or Why not.

6. What are the criteria you use to measure the effectiveness of your work with the clients in this group?

7. What specific technique have you found most helpful for your clients, in changing their eating behaviors?
APPENDIX 5

PARTICIPANT QUESTIONNAIRE RESPONSES
PARTICIPANT #2 QUESTIONNAIRE RESPONSES

Q. How long have you been a member of this group?
A. Would have been 3 years, left the group in November.

Q. What was your initial reason for joining this group?
A. To lose 20 lbs.

Q. Has the group met your expectations for changing your weight?
A. It did, but my expectations changed.

Q. Have you felt that your participation in the group has changed your life?
A. Yes.

Q. How has it positively changed your life?
A. It was a tool in helping me achieve self love.

Q. Has there been any negative consequences to your group participation?
A. No.

Q. Is there an issue in your life that you have become aware of since you began participating in this group, that is a factor in your eating behavior, that you were unaware of before you joined this group?
A. Yes, I was more aware of why I ate. Out of emotional reasons. Loneliness mainly.

Q. Has becoming aware of this issue changed the way you behave with food? How and Why?
A. Yes, I don't use food to take care of my loneliness. I use food to eat when I'm hungry.

Q. Do you believe that your participation in this group has changed your feelings about the way you perceive yourself?
A. Yes, definitely.

Q. Do you feel/believe the counselor understands your needs and directs
the group based on those needs? Why or Why not.

A. Yes, gosh, she would model for me ways to love myself. She would show me, because I'm a kinetic learner, she would model that for me. She did that with role plays and things like that.

Q. How long have you been a member of this group?

Q. Did you have feelings of depression when you began your participation in this group? If so, how much on a scale of 1 to 10, 1 being no depression and 10 being very depressed.

A. When I began the group? Ya, a 7. On leaving the group 1 or 2.

Q. Has that sense of depression changed, since you began participating in this group, and how has it changed?

Q. Has the group met your expectations for changing your weight?

A. Yes, what the group did for me was help become able to find out how I felt, was able to be put me in touch with those feelings, were that was, maybe were the depression was covering up.
PARTICIPANT #3 QUESTIONNAIRE RESPONSES

Q. How long have you been a member of this group?
A. It hasn't been a year, I know I was in it when I went back home and that was in September, so it's been 7 or 8 months.

Q. What was your initial reason for joining this group?
A. My doctor suggested because of my eating.

Q. Has the group met your expectations for changing your weight?
A. I thought, because I'd been in therapy before, I thought they would deal with why I was eating. So in that way, Yes, they met my expectations, but I did go in thinking a weight loss thing.

Q. Have you felt that your participation in the group has changed your life?
A. Yes.

Q. How has it positively changed your life?
A. Yes, very much. I've felt more alive than I have in the last 15 years.

Q. Have there been any negative consequences to your group participation?
A. I can't think of any.

Q. Is there an issue in your life that you have become aware of since you began participation in this group, that is a factor in your eating behavior, that you were unaware of before you joined this group?
A. Before I joined the group, I knew I was a compulsive overeater and I was eating my feelings, I knew that before I joined.

Q. Is there something that's come out in your work that says this is one of the triggers that makes me compulsively eat?
A. Not yet. I know when I get upset I immediately start eating.

Q. Were you aware of that before you started in the group, in terms of were you aware of that? Where you aware that you were upset about something, or has your awareness...
A. I think I knew a little bit before that I was eating because I get upset, I think I knew a little bit before.

Q. Have you been able to identify the thing that you get upset about that triggers your eating?

A. Not yet anyway.

Q. Has becoming aware of this issue changed the way you behave with food? How and Why?

A. Not yet.

Q. Do you believe that your participation in this group has changed your feelings about the way you perceive yourself?

A. Yes.

Q. Do you feel/believe that counselor understands your needs and directs the group based on those needs? Why or Why not.

A. Yes. Just like yesterday she saw something I was doing, I didn't even realize I was doing.

Q. So you see her as being perceptive with what's happening with you?

A. Yes.

Q. Did you have feelings of depression when you began your participation in the group? If so, how much on a scale of 1 to 10, 1 being no depression and 10 being very depressed.

A. Ya. I thought it was like a 5 or 6. Today it's about a 2.

Q. Has that sense of depression changed, since you began participation in this group and how has it changed?

A. It's gone down, ya but, she asked me to go to my doctor and go on Prozac. I reckon I was more depressed than I realized, and she was really able to see it when I came back from my vacation. She asked me to really think about it, and had me go to my doctor and really talk to her about it. When I went to the doctor I just sat there and cried the whole time I was talking to her. She said I might want to try this and I've been on it for, I just got my third prescription, I going to start my third month.

Q. This is helping you?

A. It must be, its either that or the therapy and the medicine, because I feel I do feel a lot better about myself.
Q. There is one question that I did not include in this questionnaire, but something came up recently that triggered, that maybe I should be asking. In terms of your eating pattern, do you ever feel or see yourself as eating less than what you actually may have eaten?

A. It's funny that you would have asked that question today. Because I was thinking about it. See I went to Weight Watchers on Saturday, one of the gals at work asked, Well how are you doing? All I can say is I've not stayed on program. I'm not eating as much as I normally do but I'm not staying on program. That got me thinking, well are you not eating as much as you normally do or do you think you're just not eating as much as you normally do?

Q. That's a good question!

A. So I stopped now, and asked what I've been eat'n the last couple of three days. And today, I would actually say, I'm eating less even though I'm not eating what "I should be," because I've been just taking salads and trying to skip breaks.

Q. My premise for this project, is that diet programs may be helpful but not successful. So in terms of saying "I don't follow program" do you forgive yourself for not following program?

A. Oh ya, what I've come to the realization is the program is trying to teach us, Weight Watchers is a very healthy way of eating, if you can stick with it. They are trying to teach, you good health, I made up my mind that no one can follow it 100%. And with the turmoil my life is in now, there is so much going on right now I didn't want to wait to join. And if you don't lose but 5 or 10 lbs. in the next 2 months, I'm not going to beat myself up over it.

Q. Are you thinking that Weight Watchers can just enhance what you're doing in the group, or are you hoping or thinking it will make things easier for you?

A. I'm hoping that it will, honestly I know how I should be eating, I reckon I need that structure knowing I have to weigh in every week. Which I really don't like but yet it makes me think, well you better really watch what you're doing because you've go to go weight in. I really would like, its a selfish reason but, I really want to loss weight before I go home in July.

Q. I was just going to ask you, What was your motive to joining Weight Watchers?

A. I'd really like to lose weight for myself and be healthy, but when I was last home. I have two sisters who are as big if not bigger than me, I was the one who brought it up, "let's see who can lose
the most weight by the next time we see each other," and who ever loses the most weight, the other two has to buy them an outfit.

Q. What would it take to accept yourself, your body just the way you are right now?

A. Death, how do I want to say, because I know I'm overweight and I don't like the way I look, but It Does Not Stop me from enjoying life.
PARTICIPANT #4 QUESTIONNAIRE RESPONSES

Q. How long have you been a member of this group?
A. One (1) year.

Q. What was your initial reason for joining this group?
A. To get rid of some anger and to help me lose weight.

Q. Has the group met your expectations for changing your weight?
A. No.

Q. Have you felt that your participation in the group has changed your life?
A. Yes.

Q. How has it positively changed your life?
A. Yes, well ah, since I've been a part of the group, one of the biggest positive changes, a lot of anger that I've had. And I found that some major things that I was very angry at and felt guilty over have pretty well gone away. And so that way I felt the group helped me with the anger. And I find I still get upset at some things that I probably shouldn't, but I seem to get rid of it faster and calm down quicker.

Q. Has there been any negative consequences to your group participation?
A. I think as far as the weight issue, in essence its help me feed on my problem. And I think it's been more of a detriment than.

Q. Has your weight gone up at all?
A. I'm about the same. I go up and down about 5 lbs., since I've been in the group. And I don't think I've added weight, but it definitely hasn't helped.

Q. Do you think if you stay with the group long enough that it will have more positive effects on you?
A. No.

Q. Is there an issue in your life that you have become aware of since you began participating in this group, that is a factor in your
eating behavior, that you were unaware of before you joined this
A. group?

Q. Has becoming aware of this issue changed the way you behave with
A. food?

Q. Do you believe that your participation in this group has changed
A. your feelings about the way you perceive yourself?

A. In essence, I'm more aware when I am doing it and I stop sooner,
then I did. But it has not stopped the initial behavior.

Q. Do you feel/believe the counselor understands you needs and directs
A. the group based on those needs? Why or Why not.

Q. Why?

A. I think she is intuitive and kind of knows who needs what. The
problem with the group is we have so many directions we go in a
short period of time, that I think one or two people get short
changed in the group. So unless you jump in and say "I've got
a real problem today I have to work on." But if I can't identify
it and she doesn't recognize it, then nothing may get done for
me or whoever.

Q. So, do you think its easy to hide-out?

A. Yes, I do think its easy.

Q. Did you have feelings of depression when you began your
A. participation in this group? If so, how much on a scale of 1 to
10, 1 being not depression and 10 being very depressed.

A. Not that I was aware of. When I became aware of it I would say probably about a 5.

Q. Has that sense of depression changed, since you began participating in this group, and how has it changed?

A. Well, in some ways I'd have to say my depression is in the 8 or 9 range.

Q. How do you think its changed?

A. Because I think I am more aware of identifying why I feel like I feel. Why I'm doing nothing and in other ways, Like OK my weight is up, it has not changed, I still don't feel that great about it, but I made a move to by a new wardrobe, change how I dress at work. That makes me feel better every day because I dress nicer at work. I feel perkier. I feel better in that way, but I think that's all surface.

Q. Since your depression level is higher, do you think it could be because of the fact that you are actually doing work, or focusing on the things that are producing the eating and causing stress?

A. I think part of it, again is an awareness level. I'm even more aware, a lot of what I'm doing or not doing, is covering more depression than I wanted to admit to. I don't think I'm wallowing in the depths of despair but I think I'm finally recognizing that what I am or am not doing for myself is some form of depression that I just have not paid attention too.

Q. I have one question that I did not include in this questionnaire that something came up recently and triggered this question. In terms of your eating pattern, do you ever feel or see yourself as eating less than what you actually may have eaten?

A. I think there are time when I deny the amount of food more so than seeing less. I know exactly what I eat, I just don't always want to own up to it. I try to use that old justification game, I skip breakfast. I skip lunch so having a chocolate bar is no big deal. Or my blood sugar is dropping and I have to have this honey bun right now. There are ways to work around it so I think I have a tendency to do that. Still.
APPENDIX 6

FACILITATOR QUESTIONNAIRE RESPONSES
FACILITATOR QUESTIONNAIRE RESPONSES

Q. What is your level of training, academic degrees and experience?

A. I have a Ph. D., and have been a practicing Psychologist for about 15 years.

Q. Do you have specific training or credentials in working with clients with eating disorders and specifically compulsive overeating?

A. Attending conferences. Have passed the eating disorders exam and have decided it wasn't worth the money to be certified. I passed the exam, and don't want to spend any more money.

Q. Do you mean, there is actually a clinical path to that?

A. Yes, there is a clinical path, you can be a eating disorders specialist.

Q. What does that entail?

A. Four hundred (400) hours of supervision, and passing the exam.

Q. So you must find someone who is already certified to do the supervision?

A. Yes. And I toy with that, but if I ever wanted to move out of private practice, if I ever wanted to market the eating disorders in particular, I would want to get certified.

Q. Does that certification cover all aspects of the eating disorders?

A. Yes, anorexia, bulimia and compulsive overeating.

Q. Which do you find the most difficult to work with?

A. Bulimia, by all means. They have very difficult personalities. They are hot and cold the whole time. They warm up, you think they're going somewhere with their therapy. Than they turn on you, they are cold, they are not feeling people. They don't have a feeling in the world. They are not willing to get close to getting anywhere. Whereas the anorextics I work with, even though they don't feel, they either know their problems, from their point of view, are more serious. Are willing to feel, because they have such low resistance to constant working with them. I would much rather work with the anorectic than a bulimic.
Q. So, basically all three parameters of eating disorders have shut off feeling. So are compulsive overeater easier to work with? In terms of getting closer to their feeling.

A. They are slippery. They do a lot of denial and minimizing. Whereas its easier to catch an anorexic, their weight tells me if they are making any progress or not making any progress, be it by a certain weight or they die. The bulimic, usually they don't lie to me about their purging. Usually, it's almost like a metal to them sometimes. But the compulsive eater, they stay in denial, in a place where they're not very much aware of how much food they are consuming.

Q. How long have you been facilitating this group?

A. Three (3) years.

Q. You talked about your training in terms of working with eating disorders, you've said you've taken the test. Is there a specific training program that goes along with it or can you just write the test?

A. There has been a symposium for eating disorders, from Washington D. C., which is the one that does all the certification here and did a workshop, a three (3) day workshop and they were giving the test here. You have to go where they are to take the test. I opted to sit for it. Because I have a Ph. D., I could sit. But even though I took the test, it is not licensing without the certification.

Q. Do you have to be a Ph. D. in order to do this, to do the certification?

A. You don't have to be a Ph. D. in order to do the certification, but I'm not sure to sit for the test without doing the supervision first.

Q. What are the common psychological issues that you have identified with the clients in your group? Explain.

A. Lets here it from your point view first.

(From the interviewer) For me one of the first things I identified is the shutting off of feelings, and depression, abuse, lots of abuse, both physical, sexual, emotional and denial. (these statements acknowledged by the facilitator)

So its real hard, using the Geneen Roth concept, paying attention the your body and eat what you want till your full, and keep asking yourself those questions. (reference to the book When food is love). Until a person really acknowledges that they don't have
control, and give up all the magical approaches, that approach is so foreign. I've got lots of group members right now that, aren't buying the approach. Which is somewhat frustrating. Think the new medication needs to be looked at. I'll look at it, it needs to be examined. I think if we stay in the dark ages that doesn't help us either. From the Marriage and Family prospective, medications were always anti. I was anti-medication until Prozac came out. For lots of reasons I might let clients try it, if I thought there was something other than valium or speed. I have a couple of group members on it ... Dr told her that these drugs work on different parts of the brain. ... She is in a lot of denial about what she eats. Either she's disassociated or she is really not aware of what she eats. Which is common, but it doesn't make for a multiple personality at all. One of the major frustrations, is that eating is a socially acceptable thing to do. So you don't have the leverage you have the alcoholic.

Q. Do you believe that depression is an associated factor with obesity and compulsive overeating? Why or Why not.

A. I think obesity and compulsive overeating is a symptom. The depression, I don't think its a disorder in itself. I thing its mostly a symptom of depression. It can be a symptom of Post Traumatic Stress Disorder, but I think its mostly a symptom of depression. And that's because they have such chemical changes in their body, I think people need to treat their depression, and simply a lot longer.

Q. What are the criteria you use to measure the effectiveness of your work with the clients in this group?

A. We don't do weight loss. That is not the focus of the group. So the focus and scale I use, is there personal growth going on. Are these people grappling with their ideals and becoming happier, feeling more empowered, making food less and emphasis and living more an emphasis. Is that happening for them. Based on that, I think that is probably happening. If I had to scale it, I would say that people are more focused on their own life versus on what they eat, 75% more than when they come in.

Q. What specific techniques have you found most helpful for your clients, in changing their eating behaviors?

A. I use a variety of techniques, like Gestalt, psychodrama and role playing. Use movement activities in group to help people face themselves and the issues that are a block to their eating behavior. I also encourage journaling and letter writing therapy.