Why I Do Not Use The 12 Step Approach In My Treatment Of Eating Disorders

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Addiction/Twelve-Step Model

The addiction model of treatment for eating disorders was originally taken from the disease model of alcoholism. Alcoholism is considered an addiction, and alcoholics are considered powerless over drinking because they have a disease that causes their bodies to react in an abnormal and addictive way to the consumption of alcohol. The Twelve-Step program of Alcoholics Anonymous (AA) was designed to treat alcoholism based on this principle. When this model was applied to eating disorders, and Overeaters Anonymous (OA) was originated, the word - food substituted for the word alcohol in the Twelve-Step OA literature and at OA meetings.

The basic OA text explains, "The OA recovery program is identical with that of Alcoholics Anonymous. We use AA's twelve steps and twelve traditions, changing only the words 'alcohol' and 'alcoholic' to food and compulsive overeater" (Overeaters Anonymous 1980). In this model, food is often referred to as a drug over which those with eating disorders are powerless.

The Twelve-Step program of Overeaters Anonymous was originally designed to help people who felt out of control with their overconsumption of food: "The major objective of the program is to achieve abstinence, defined as freedom from compulsive overeating" (Malenbaum et al. 1988). The original treatment approach involved abstaining from certain foods that were considered addictive or binge foods, namely

sugar and white flour, and following the Twelve Steps adapted for OA.

Twelve Steps of OA

Step I: We admitted we were powerless over food–that our lives had become unmanageable.

Step II: Came to believe that a Power greater than ourselves could restore us to sanity.

Step III: Made a decision to turn our will and our lives over to the care of God as we understood Him.

Step IV: Made a searching and fearless moral inventory of ourselves.

Step V: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

Step VI: Were entirely ready to have God remove all these defects of character.

Step VII: Humbly asked Him to remove our shortcomings.

Step VIII: Made a list of all persons we had harmed, and became willing to make amends to them all.

Step IX: Made direct amends to such people wherever possible, except when to do so would injure them or others.

Step X: Continued to take personal inventory and when we were wrong, promptly admitted it.

Step XI: Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

Step XII: Having had a spiritual awakening as the result of these steps, we tried to carry this message to compulsive overeaters and to practice these principles in all our affairs.

The addiction analogy and abstinence approach make some sense in relation to their original application to compulsive overeating. It was reasoned that if addiction to alcohol causes binge drinking, then addiction to certain foods could cause binge eating; therefore, abstinence from those foods should be the goal. This analogy and supposition is debatable. To date there has been no scientific proof that being addicted to a certain food causes an eating disorder (much less masses of people being addicted to the same food). Nor has there been research demonstrating that the Twelve-Step approach is successful in treating eating disorders.

In an effort to find a way to treat the growing number and severity of eating disorder cases, the OA approach began to be applied loosely to all forms of eating disorders. The theory that compulsive overeating was fundamentally the same illness as bulimia and anorexia--and thus all were addictions--was a leap based on faith, hope, or desperation. Nevertheless, the use of the addiction model was readily adopted due to the lack of guidelines for treatment and the similarities that eating disorder symptoms seemed to have with other addictions (Hatsukami et al. 1982). Twelve-Step recovery programs

sprang up everywhere as a model that could be adapted immediately for use with eating disorder "addictions." This occurred even though one of OA's own pamphlets, containing questions and answers about the program, tried to clarify that "OA publishes literature about its program and compulsive overeating, not about specific eating disorders such as bulimia and anorexia" (Overeaters Anonymous 1979).

Criticisms of the Twelve-Step Model

The American Psychiatric Association (APA) recognized a problem with Twelve-Step treatment for anorexia nervosa and bulimia nervosa in its February 1993 treatment guidelines. In summary, the APA's position stated that Twelve-Step{-}based programs are not recommended as the sole treatment approach for anorexia nervosa or the initial sole approach for bulimia nervosa. The guidelines suggested that for bulimia nervosa, Twelve-Step programs such as OA may be helpful as an adjunct to other treatment and for subsequent relapse prevention. In determining these guidelines the members of the APA expressed concerns that due to "…the great variability of knowledge, attitudes, beliefs, and practices from chapter to chapter and from sponsor to sponsor regarding eating disorders and their medical and psychotherapeutic treatment and because of the great variability of patients' personality structures, clinical conditions, and susceptibility to potentially counter therapeutic practices, clinicians should carefully monitor patients' experiences with Twelve Step programs." (American Psychiatric Association 1993)

One of the criticisms of the addiction model is the idea that people can never be recovered. Eating disorders are thought to be lifelong diseases that can be controlled into

a state of remission by working through the Twelve Steps and maintaining abstinence on a daily basis. According to this viewpoint, eating disorder individuals can be "in recovery" or "recovering" but never "recovered." If the symptoms go away, the person is only in abstinence or remission but still has the disease. A "recovering" bulimic (12 Step terms not mine) still refers to herself as a bulimic and continues attending Twelve-Step meetings with the goal of remaining abstinent from sugar, flour, other binge foods, as in the original OA, or in the behavior of bingeing and purging. - Most readers will be reminded of the man in an AA meeting who says, "Hi, I'm John, and I'm an - alcoholic," even though he may not have had a drink for 10 years. he can refer to himself as a “recovering alcoholic” but still he is an alcoholic. Labeling eating disorders as addictions may not only be a diagnostic trap, but also a self-fulfilling prophecy.

There are other problems with applying the abstinence model to individuals who have anorexia or bulimia. Even though the idea of restricting sugar and white flour is fading in OA groups and individuals are allowed to choose their own form of abstinence, these groups can still present problems with their absolute standards and black-and-white thinking. Individuals with bulimia or binge eating who abstain from sugar, white flour, and other "binge foods," often end up bingeing on other foods. Additionally, labeling a food as a "binge food" can be a self-fulfilling prophecy- and is counterproductive to the cognitive behavioral approach of restructuring dichotomous (black-and-white) thinking.

Individuals with anorexia are already masters at abstinence. They need help knowing it's okay to eat any food, particularly "scary" foods, which often contain sugar and white flour--the very ones that were originally forbidden in OA. To resolve this issue

it Twelve Step proponents have argued that these individuals can use "abstinence from abstinence" as a goal, but this is extremely vague. All of this adjusting just tends to water down the Twelve-Step program as it was originally conceived and used.

Furthermore, behavior abstinence, such as refraining from binge eating, is different from substance abstinence. When does eating become overeating and overeating become binge eating? Who decides? The line is fuzzy and unclear. One would not say to an alcoholic, "You can drink, but you must learn how to control it; in other words, you must not binge drink." Drug addicts and alcoholics don't have to learn how to control the consumption of drugs or alcohol. Abstinence from these substances can be a black-and-white issue and, in fact, is supposed to be. Addicts and alcoholics give up drugs and alcohol completely and forever. A person with an eating disorder has to deal with food every day. Hopefully, full recovery for a person with an eating disorder is the ability to deal with food in a normal, healthy way.

Furthermore, if a Twelve-Step approach is used it must be done with caution and adapted to the uniqueness of eating disorders. Craig Johnson has discussed this adaptation in his 1993 article "Integrating the Twelve Step Approach." The article suggests how an adapted version of the Twelve-Step approach can be useful with a certain population of clients and discusses criteria that can be used to identify these clients.

Twelve-Step Approach as a Means of Support

Many with eating disorders have found support with the Twelve-Step approach and are in recovery. I encourage certain clients to attend Twelve-Step meetings when appropriate. I

love that these groups are free and offered all over the world and that there is a mission for those recovering to give back. There are many incredibly useful aspects to the Twelve-Step philosophy, such as personal inventories, making amends, and the use of recovering sponsors to help those still not abstinent. I am moved by the devotion, dedication, and support that I have seen in those who give so much to anyone who wants help For example, I am especially grateful to sponsors, - when they respond to my clients' calls at 3:00 A.M. .. I have also been concerned on many occasions where I have seen "the blind leading the blind."

Based on my experiences and those of my recovered clients, I urge clinicians who use the Twelve-Step approach with eating disordered clients to do the following:

Adapt the approach for the uniqueness of eating disorders and of each individual.
Monitor clients' experiences closely.
Allow that every client has the potential to become recovered.

The belief that one will not have a disease called an eating disorder for life but can be "recovered" is a very important issue. How a treating professional views the illness and the treatment will not only affect the nature of the treatment but also the actual outcome itself. Consider the message that clients get from the following quote taken from Overeaters Anonymous: "It is that first bite that gets us into trouble. The first bite may be as 'harmless' as a piece of lettuce, but when eaten between meals and not as part of our daily plan, it invariably leads to another bite. And another, and another. And we have lost control. And there is no stopping" (Overeaters Anonymous 1979). I think most clinicians

will find these statements troubling. Whatever the original intention, such statements can set a person up for relapse and creating a self-fulfilling prophecy of failure and doom. If clients believe they can be more powerful than food and can be recovered, they have a better chance of fulfilling this. I believe all clients and clinicians will benefit if they begin and involve themselves in treatment with that end in mind.

Professionals with Personal Recovery

Although not a treatment model per se, the concept of clinicians with a history of personal recovery from an eating disorder is an important topic that is receiving increased attention. In this regard, the Twelve-Step model has a lot to teach the eating disorder field. We are lagging behind in the open use of people who have previously suffered, gotten well, and want to help others. The whole Twelve-Step philosophy and concept of sponsors is based on the "been there, done that" approach.

Craig Johnson and I wrote an article titled "Been There Done That: The Use of Clinicians with Personal Recovery in the Treatment of Eating Disorders" (2002). We discussed the advantages and disadvantages of clinicians who have suffered from eating disorders being in the field at all and if so whether or not they should disclose their eating disorder history. Craig and I are both supportive of using what he calls "staff with personal recovery" and I insist on calling "recovered staff" For important reasons.

It has been my consistent experience that my private practice clients and those who come to my treatment programs cite their work with a recovered therapist or staff as one of the most important parts of their treatment and recovery. In fact, clients regularly report choosing Monte Nido because we are open about utilizing (we don’t use the staff)

recovered staff.

Over the years, -have told - how much this issue bothers other clinicians (sometimes by the clinicians and sometimes by others who have heard clinicians complaining). I have been told on numerous occasions that it was inappropriate to share with clients, discuss with other professionals, or write in my books and articles that I am recovered. I can only speculate as to why others find this problematic. It seems particularly odd since using people with personal recovery is a cornerstone in alcohol and chemical dependency treatment.

Being recovered does not qualify me to be a good therapist. Neither does my license for that matter. There are good and bad therapists with or without recovery backgrounds. A well-trained eating disorder therapist who is also recovered should not be afraid to disclose his aspect of his or her past. In fact, our field should embrace these individuals and help them learn how best to use their background and avoid the potential pitfalls that could arise.

What Clients Think About Working with Clinicians Who Have Personal Recovery

We need to listen to what clients tell us and stop making decisions for them regarding whether or not working with clinicians who have personal recovery is important or insignificant to them and their treatment outcome. I have been listening for almost 30 years, and they have a lot to say. Here is just- what two clients have said to me but their comments are similar to those I receive on a consistent basis.

My desire to work with recovered staff led me to Monte Nido after living in the confines

of a full-blown eating disorder for over a third of my life. I began seeking help at home, but no matter how much anyone tried to help me, I never believed anyone truly understood what my life was like despite their desperate attempts. Immediately upon talking to the first recovered staff member, I realized there was a degree of understanding I felt that someone who hadn't been through the depths of this would never understand and somehow couldn't. In that moment when I was trying to commit to recovery, I knew I had made the best and hardest decision of my life. Recovery is tough. The absolute hardest; most trying; draining; physically, emotionally, and mentally painful thing I've ever had to do. What keeps me going the most is the people who themselves have battled their own eating disorders and fought for so long and made their way to the other side. In my rough moments, I look to them for a sense of reassurance, almost asking, "Is this okay?" or "Is this normal?" or "Should I be feeling this way?" Hearing recovered staff gives me hope that not only am I not completely crazy, I am definitely not alone.

One of the primary reasons I chose to go to Monte Nido was the recovered staff. I thought that if anyone could help, it would be people who figured out how to untangle themselves from their own eating disorders. I thought they might know things that professionals who had never struggled with an eating disorder could not. And it was true. I never had therapists who were wiser to anorexia's tricks, showed more compassion for my struggle, and who could counteract my eating disorder thoughts and behaviors so well. I have a very difficult time trusting people, especially with my food.

But it really helped knowing that they understood my fears because they had once felt the same way. This allowed me to be more honest, as I didn't fear judgment as much.

I thought that at least one of the staff members had probably done any eating disorder thing I had. This also helps to make the eating disorder feel less mysterious and special. When other doctors saw it as an enigma, for some reason this made me want to keep it. When anorexia lost its mystique, it also lost some of its power. Since they were familiar with the slyness of the eating disorder, the staff members were not pushovers. Since they were strong enough to stand up to their own eating disorders, they were definitely strong enough to battle mine. Most importantly, I think, is that every time I lost hope that I myself could recover, I only had to look around me to remember that people who were just as sick or sicker than me, who once felt as desperate and hopeless, who never thought that they could gain weight, eat healthy, like themselves, recover; they did--fully, utterly, and completely. I cannot overemphasize how important this was to me, as I believe hope is a crucial component of recovery.

Although I recognize the unique contribution of recovered staff in the treatment of eating disorders, I do not promote the notion that the best clinicians are those with personal recovery. I have worked with countless excellent therapists who have no personal eating disorder history. By far the most important thing is to be a well-trained, empathic therapist, period. A former client expressed this eloquently, "Ultimately, it's the potential for and hopeful development of a connection between client and therapist that will provide an impetus for effective treatment, regardless of whether or not the therapist has experienced an eating disorder firsthand."

What I do promote is that if a well-trained therapist is recovered from an eating disorder, he or she should not have to hide it. If you have a tool, you should be able to use it. The combination of good professional training and experience combined with being recovered has been an overwhelmingly successful aspect of my career as a therapist and my treatment programs. I encourage the field to acknowledge this and help recovered professionals use this potential tool appropriately.