“Feed Your Faith”: Disease and Spiritual Healing in Overeaters

Anonymous

Sarah Katherine Brewer
Division III Project
Dr. Alan H. Goodman, Committee Chair
Dr. Pamela K. Stone, Committee Member
Hampshire College
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To Mom,
For instilling in me a curiosity about others’ experiences,
and to Dad,
for teaching me integrity and patience.
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Introduction

I originally formulated my project in the spring of 2013 by asking how individuals came to identify as compulsive overeaters, and how this identity connected with their other identities including gender, race, class, religion, and health status. For example, I wondered what it meant to be a female overeater as opposed to a male overeater; what were the associated feelings, the impression of cultural norms, and individual understandings of how these two identities might intersect and affect daily life?

I had just spent two years studying topics in medical anthropology, and had garnered a special interest in the cultural interpretations of fat, specifically relating to employment discrimination of overweight and obese persons on the basis of weight. Simultaneously, I had explored the health effects of under eating on maternal and child nutrition. I had questions about what it meant to be a compulsive overeater in a culture that shames obesity. In particular, I wondered if the different identities of compulsive overeaters intersected to create different understandings of what compulsive overeating is and who compulsively overeats.

In this Division III project I conducted two months of field research in which I talked to people who were participating in Overeaters Anonymous (OA) about two topics that serve as the basis for my ethnography: disease and spiritual recovery. I began to wonder how OA members construct and use an illness narrative around the idea that compulsive overeating is a disease. Furthermore, what do these narratives look like when intersected with an individual’s life history and experiences? I wanted to know how individuals understood and addressed their compulsive overeating prior to coming to OA, how they applied the disease narrative, told throughout the OA program, to their own lived experiences and what effects, if any, this identification with the disease narrative had on their recovery. In other words, what narrative did participants use?
My second area of inquiry involved unpacking the various ways that OA members talk about and conceptualize the Higher Powers framed by the OA program, and what they believed these Higher Powers do for their recovery. While OA, like other anonymous programs, is rife with suggestions to turn one’s will over to a Judeo-Christian God, the OA program is careful to suggest that a “Higher Power” does not need to be this Western, patriarchal version of a God. With this in mind, I was curious about how OA members engaged in rituals and established patterns of eating and behavior (e.g. strict food plans) and what purposes these rituals served in an individual’s recovery. This part of my research was also informed by published scholarship on the intersections of religion, ritual and eating. This literature allowed me to situate the OA program within a longer history of spiritually-significant consumption.

While the small sample size I used prevents broad generalizations from being made, the participants responses to interview questions presents modern and unique perspectives on what it means to be a compulsive overeater in a largely biomedical and secular culture. The data were fraught with contradictions and areas of tension that speak both to the flexibility of the OA program and to the diversity of participants’ interpretations about what the program is and what it does for them. Interestingly the OA program was never described in the same way by any of the participants and often appeared simultaneously rigid in some aspects and fluid in others when practiced by the same individual. The flexibility of OA certainly allowed participants to self-diagnose and self-prescribe in ways that could be viewed as empowering and disempowering. In addition, the flexible nature of OA created tensions around appropriate action within the program and appropriate circulation of the program on local and global levels. A large part of my ethnographic work was to tease out these contradictions and tensions in order to better understand where OA as a program struggles and where these struggles are felt by individual
participants in their practice of recovery. In sum, this project ties together questions of self, consumption, and group identity, relating these findings to larger discourses concerning Western body politics and cultural values.

THE PROJECT AND PERMISSIONS

Beginning in May of 2013, with approval from Hampshire College’s IRB (Appendix A; Appendix B) and the participating OA groups (Appendix C), I began observing two to three meetings of Overeater’s Anonymous in Massachusetts on a weekly basis (two of the meetings were in the same location and were usually attended by the same individuals). I observed group meetings and engaged in informal conversation with participants after the meetings. After three months, I began formal interviews with willing participants, asking them about their experiences with the disease of compulsive overeating and their time in OA (see attached questionnaire, Appendix D).

Both OA meetings I observed are located in Massachusetts. To keep the anonymity of the meeting sites I will employ pseudonyms: Franklin and Bridgeton. The meeting site in Franklin was in a church with an average of eight participants at each meeting. The Bridgeton site was located in a local building available for community-organized events. The Bridgeton meeting averaged 7.4 attendees each week, with two to three of those individuals also being a part of the Franklin group on a near-weekly basis.

For the seven months of my fieldwork I was able to work closely with a few individuals from each group. Different themes and social and cultural dynamics emerged across two groups and from interview to interview. The close proximity and overlap of the two groups in a narrow geography allowed a better understanding of the roles of class and race among the people who
participated in this study. Nearly all participants were white, and most (but not all) came from the lower to middle class households; most were middle aged or elderly, although two young adults occasionally appeared at meetings.

It is important to frame these interviews and observations into the larger literature that explores medical and feminist understandings of body image and eating; the popularization of methods of coping with compulsive overeating, including the diet and exercise industry; the history of 12-step programs in the US and, of course, Overeater’s Anonymous. An analysis of the ethnographic data collected in my project is presented in Chapters 3 through 9. Chapter 3 presents the major themes for analysis in this ethnography: medicalization, religion and spirituality, and diversity. Chapter 4 details the two field sites where research was conducted and outlines my role as a researcher in those spaces. Chapter 5 describes the structure of the OA program, how it introduces participants to its values and what participants say they feel about the effects of compulsive overeating on their bodies and lives. Chapter 6 includes an analysis of what participants say they felt to be the origin and manifestation of the disease. Chapter 7 examines the use of spiritual practice in the program and suggest that ritual is a core component of what makes the program successful for these participants. Chapter 8 explores the narratives of a select few participants in relation to their experiences with trauma, abuse and addiction as connected to their development of compulsive overeating. Chapter 9 focuses on participant and organizational viewpoints on how the program should circulate among local and global, youth, and anorexic and bulimic populations; this chapter also examines women’s perspectives regarding empowerment/disempowerment within the program. I conclude this work by suggesting that OA’s unique flexibility and ability to foster community may be its saving grace in future generations.
Chapter I

Historical and Modern Perspectives on Eating, Body Size, and Development of the 12-Step Program

“Communities take shape, or not, through patterns by which food is shared, or not.”

Dorothy Bass, Eating (2012)

Food is an intrinsic part of how humans engage with themselves, as well as with others. We arrange our daily lives around food and eating, and so it follows that foods, along with the other various edible and inedible substances that we consume, come to shape and define our own identities and sense of belonging. The extent to which communities cement their identities around what kinds of food they eat, the preparation or consumption of specific dishes, and the manner in which they engage in eating (i.e., fasting or binging at specific times) is documented in the literature. Dorothy Bass (2012) points out in her essay Eating, the food is the most fundamental aspect of an individual’s and community’s way of life. Food situates humans within a web of complexities surrounding production, consumption and social and economic relations. In addition, food represents humans’ vulnerable need for subsistence, and the act of eating is a significant marker of cultural and personal identity.

What is of interest here is how groups form identities around food, and the various cultural meanings of the over-consumption of food and its relation to Western frameworks of addiction and recovery. This literature review traces the development and growth of various discourses surrounding food and bodies, which, I argue, give way to the development of the self-help recovery movement, including, but not limited to, Overeater’s Anonymous. This review explores the historical-cultural discourses that overlay the framework for treating compulsive overeating as a disease.
The term ‘compulsive overeating’ is used by most OA groups to reference the eating behavior of someone who wants to stop eating compulsively, including those individuals who struggle with obsessive thoughts about food but are underweight or maintain a ‘healthy’ weight. I use the term in that sense but also focus on the medicalization of overeating in the sense of compulsive overeating without purging. I am specifically interested in the treatment of fat and fat human bodies throughout Western history in order to understand the stigma associated with fatness and possible resultant cultural phenomena, including social movements, discrimination and popular media discourses. I address the history of thinness within American culture in order to demonstrate the various meanings given to fat and thin bodies throughout the last two centuries, including the discourses surrounding bodies that eat and those that do not eat. By tracing the religious, medical and cultural meanings of thin and fat bodies, I find that certain discourses within American society led to various understandings of what it means to be fat or thin, which in turn has created a plethora of social solutions, medical remedies, and activist backlash regarding eating behaviors.

A history of the American mealtime and the social meaning of taking food, from colonial times forward sets the foundation for this review. Historical conceptualizations of food addiction, restrictive diets and compulsive overeating, considering religious, medical and feminist viewpoints, set the stage for a brief history of the self-help and recovery movement in the United States. By presenting the roles of religious, medical and feminist discourses, I suggest that the medicalization and stigmatization of fat bodies and exorbitant food intake has led, in part, to the creation and popularization of OA among other cultural ‘fads,’ including the diet/exercise industry and feminist fat acceptance movements. The relation between the abuse of alcohol and the abuse of food is addressed in this chapter, as the stigmatization and
medicalization of both behaviors follow a similar trajectory with the concept of compulsive overeating growing out of a different cultural era, a point that is pertinent to both my historical review and the lived experiences of participants. This chapter concludes with a brief examination of the original 12-step program, Alcoholics Anonymous, and the subsequent development of other Anonymous programs. The formation of AA is understood not only to be a founding circumstance within the self-help movement in America, but is also the program upon which OA is heavily based (Travis 2009).

**Mealtime in America**

Europeans, Africans and Indigenous Americans of colonial America all shared a similar belief that the human body had to exist in balance with the various elements of its environment, including weather, food and emotions; part of this belief also involved the idea that health and disease were often dictated by spiritual elements (Tannenbaum 2012). Disease was an indicator of the body’s imbalance with the environment, but especially for the pious Calvinists of early America, disease was a punishment from God (Bowker 1997; Tannenbaum 2012). Prayer was used as a method of healing (Tannenbaum 2012). In this way, illness gave meaning both to individual suffering and to the collective construction of society, and it was used as a sign of both sin and social inferiority (Bowker 1997).

In the late 18th century, the colonial family structure slowly became that which is today considered the modern family (Cinotto 2006). Whereas prior to this, men and women worked in the home, now men increasingly worked outside of the home for wealth, while women worked at home, primarily around food and housekeeping. Cinotto (2006) links this change in family structure to an increasingly emphasis on family rituals, including the family meal as social event,
across a century. Into the Victorian era, how and when meals were eaten were tied to social status and gender roles; for example, children started their transition into adulthood when they were allowed at the table (Cinotto 2006). Women’s cookbooks and classes became popularized among working class wives and daughters towards the end of the Victorian era, and the image of the homemaker grew culturally popular. Women’s Temperance Unions towards the end of the 19th century also advocated for women to make the family meals, as they often believed that poor diets led men to overeat and develop alcoholism (Sack 2000). In addition, at the beginning of the 1910s, Americans developed a richer diet as food became more plentiful (Sacks 2000). The ways in which food was to be eaten or conserved also served as markers of citizenship, as children of immigrant parents often chose to reject their parents’ food, and as conservation of foods during WWII in support of the war effort was associated with patriotism (Cinotto 2006). As one source notes, “eating like a Christian meant eating like a middle- or upper-class Anglo-American,” (Sack 2000: 197) thus tying religious values to food consumption, social status and citizenship.

The 1950s continued to emphasize the importance of family mealtime as a daily ritual, along with the gendered expectations of women to cook healthful meals in a time where canned and frozen goods, and later fast food, became increasingly popular (Cinotto 2006; Young and Young 2004). Cinotto (2006) suggests that the American family mealtime has been a cultural ideal emphasized in times of national crisis and change, despite not actually being an accurate portrayal of how Americans eat.

Throughout American history, certain foods have become villainized by being linked to certain habits, bodies or people, thus gaining moral values and often negative religious or spiritual connotations. Sugar has been morally debated since the mid-17th century, after it gained noted popularity in middle Europe around the same time (Mintz 1997). As early as the late
1700s, sugar was portrayed as a sinful luxury, and it was targeted by British abolitionists. During the Industrial Revolution, sugar also became associated with individual “choice” and obesity; particularly interesting is the fact that females in particular chose to abstain from sugar, as it became increasingly associated with female sexuality due to the link to obesity (Mintz 1997). We need only think of desserts with names like “Chocolate Sin” to remind ourselves of the kind of moral dilemma certain foods represent in our culture, however playful these names might appear (Sack 2000).

Paul Rozin notes the connection between food and moralization, “disgust evolves in culture and in individual development, from an emotion that deals with potential harm to the body from foods to one that deals with potential harm to the soul.” (1997: 384). Foods often become associated with certain bodies and certain moral and spiritual elements based on who consumes them. Rozin (1997) uses the examples of vegetarianism and smoking to demonstrate how societal views on health influence what is seen as morally acceptable and ‘just.’ He also suggests that the food/morality link in American culture is the product of the Puritan spirit, thus connecting religion and spirituality to the secular morality. He argues that food and bodies are judged morally today, a point I historicize in the next section. The 1970s and 1980s saw a reform both towards vegetarianism and an increased focus on overabundance in America and a lack of food elsewhere in the world, and Christian organizations led the way in creating hunger relief efforts overseas (Sack 2000).

The link between certain foods, morality and the American meal is telling. The ideal of the individual consumer has been pertinent to American culture since the 1950s, following the breakdown on the focus on the American family (Cinotto 2006). Instead, increasingly pressure has been placed on the individual to make his or her own morally-laden food choices (Coveney
Identity itself seems often to be produced by the combination of diet and moral values, especially when food becomes an indicator of class, nationality, gender, or social worth.

**Morally Righteous Diets and Women**

Judaism, Christianity, and Islam all include traditions of fasting, particularly to symbolize purity. It follows that overeating has historically represented evil and contamination, and gluttony has been defined as a sin by many religions. The historical connection between religion, diets and body weight, even when limited to American culture, is expansive. Patel (2008) traces the roots of dietary popularization in America to Presbyterian minister Sylvester Graham, who advocated William Metcalf’s strict vegetarian diet for spiritual purity in the 1830s and 1840s, especially in relation to ridding oneself of lustful thoughts and desires (Patel 2008). In addition, Graham expressed special interest in having women and mothers participate in his dietary reform that extended to physical and spiritual health (Boero 2012). Of particular interest here is Patel’s (2008) analysis of spiritual reasoning for a particular diet. A key message of the Overeater’s Anonymous program emphasizes a relationship between God and oneself in order to stop compulsive overeating and other addictions. Some groups within the Overeaters Anonymous program suggest a diet which is intended to lead to addiction recovery and, by extension, spiritual practice and purity. In this way, the program suggests using spirituality in order to gain recovery, a suggestion not far off from 19th century movements connecting bland diets to increased religiosity and spirituality.

Dietary reforms and restrictions connected to cultural or religious moral values have also proved to have extreme negative consequences for bodies, particularly female bodies, throughout history. Perlick and Silverstein (1994) note that women have reportedly experienced what they
refer to as “gender ambivalence” dating back as far as the 4th B.C.E. in Greece. The common symptoms of “gender ambivalence” included disordered eating, depression, anxiety, and somatic symptoms. Together these symptoms were termed “chlorosis” in the 17th thru 19th centuries, “hysteria” in the 19th thru early 20th centuries, and, more recently, “anorexia” (Perlick and Silverstein 1994). Perlick and Silverstein (1994) argue that while symptoms may have changed slightly over the centuries, key to these disorders is their common popularization among females. They are gendered diseases that arise from cultural inequalities and conditions (Perlick and Silverstein 1994). Particularly within the last century, disorders seen most frequently in females have been those centered on eating. According to Joan Jacobs Brumberg (2000), anorexia nervosa (AN) emerged in the 1870s when anorexic patients typically believed their food to be poisoned, claimed poor appetites, or engaged in “religious monomania.” Brumberg (2000) also notes that while treatment of AN was originally reserved for asylum patients, throughout the 1920s and 1930s anorexia nervosa was increasingly understood to be a curable disease and taken outside of the asylum due to the work of Sir William Gull. Of interest here is the fact that during the 1920s and 1930s, American doctors used the terms “hysterical anorexia” and “anorexia nervosa” for the disorder, thus demonstrating the link between the “hysteria” and associated irrationality of women and their sexual ‘appetites’ of the earlier generation with the proliferation of this new disease (Brumberg 2000).

Gull (2012) observed that anorexia was popularized within the bourgeois society of the late 19th and early 20th centuries. Within Victorian popular culture, appetite and eating represented both a display of sexuality and a lack of willpower on the part of the consumer. Food was also connected to lower- and middle-class women’s demands in the kitchen, and thus eating itself was strongly associated with class identity. Eating, and female appetites in particular, were
intricately connected to moral status, class, and standards of beauty in ways that meant thin bodies were bodies of affluence (Brumberg 2000). Researchers have also connected the rise of eating disorders and their subsequent transfer into the realm of disease medicine to the suffrage of women in the 1920s (Brumberg 2000; Wolf 1991), arguing that cultural fixation on the need for women to be thin is not an obsession with thinness, but instead about female obedience and submission despite gains in autonomy and freedom (Wolf 1991).

Similarly, anorexia became increasingly commonplace beginning in the 1920s, specifically among college-aged women who were the first to widely compete with male peers in collegiate institutions (Perlick and Silverstein, 1994). Furthermore, throughout the last century rates of anorexia have risen in populations who received a higher level of education than their mothers, demonstrating that gains in the social ladder have put increased pressure on females to conform to specific cultural norms (Perlick and Silverstein, 1994). While anorexia and later, bulimia nervosa (BN), were first recognized as upper-class diseases in America, they later “spread eastward and down the social ladder” (Wolf, 1991: 183). In addition, caloric restrictions have been shown to create personalities that are passive, anxious and emotional (Polivy and Herman, as cited in Wolf, 1991), thus reinforcing traits stereotypically associated with femininity and consequently ‘proving’ women to have weak and irrational natures despite their supposed equal places in professional and academic environments.

Brumberg (2000) estimates that by the late 1980s as many as five to ten percent of all American women and girls had one of these eating disorders. According to the National Institute for Mental Health, drawing on Hudson et al. (2007): 0.6% of the U.S. adult population will have anorexia at some point during their lives (NIMH 2007a); 0.6% will have bulimia at some point in their lives (NIMH 2007b); and an estimated 1.2% will have binge-eating disorder (NIMH
In addition, for all three conditions combined, an estimated 2.7% of 13 to 18 year olds will be affected (NIMH, 2010 from Merikangsas et al. 2013). While these statistics vary significantly across sources (Brumberg 2000; Hudson et al. 2007; NIMH 2010), it is evident that eating disorders have been driven by distinct cultural and religious pressures to be thin and to stay thin.

That food and eating often connect to faith is reflected broadly in the literature. For example, Bass (2012) identifies food as a keystone for individuals who practice the Christian faith; she explicates how specific foods are not only symbolically used to represent Jesus Christ and the guiding principles of the Christian faith, but also how certain foods are meant to link Jesus to the follower. She concludes that fasting is used to demonstrate control of the bodily urge of hunger in order to make the follower more physically open to the words of God. Bass’s essay is an excellent demonstration of the historical and modern intimate ties between faith and food. By underlining the importance of the connections between faith, food and weight, the profound cultural impact of ideas concerning all three subjects becomes evident. An historical understanding of fat and fatness as defined above helps illuminate the shame associated with fat in the context of the holy, Puritanical counterpart of thinness.

**Historical Understandings of Fat**

The history of dietary reform and the idealization of the thin female body has developed in conjunction with powerful cultural narratives opposing fat and fat bodies (Farrell 2011). This history is less often explored and less understood to exist outside the obesity epidemic of the 21st century. Reviewing the history of fat bodies within the history of overeating is not meant to conflate the two or to indicate that one is always the result of another. Instead, I argue that
historically, fat people have been labeled as those who overindulge in food, whether or not this is the actual case. Furthermore, as we have entered the 21st century, thin people that eat as much as their fat counterparts are not problematized or stigmatized (LeBesco, 2010). Finally, the history of fat, like the history of thinness, is also largely about dietary reform, medicalization, morality, and sexuality (Farrell 2011). As sociologist Boero (2012) points out, the ways in which fatness has been discussed in any given era demonstrates the social, moral and economic fears of that time period. Throughout time fatness has often been criticized in culturally and historically specific ways. For example, by the early 19th century, cartoon portrayals of fat individuals demonstrated that fat represented a threat to the United States, whether in the form of “monopolies, unbridled capitalism, child labor, [or] political corruption link[ed] to business interests” (Farrell, 2011: 31).

During the 19th century, for middle and lower class individuals, the balanced body, which was neither excessively fat nor emaciated, was held as the ideal (Farrell 2011). Scientists theorized that fatness, like certain races, indicated “natural” inferiority and primate qualities, specifically in women (Levy-Navarro, 2011: 64). In addition, physical markers were thought to indicate a person’s character, specifically equating fatness with immorality (Levy-Navarro, 2011). With such cultural stigmas in place, it is not surprising that anthropologists like Italian Cesare Lombroso were able to garner popularity within the field by suggesting that women were inherently “childlike” and inferior to men due to their “greater wealth of connective and fatty tissue” (Lombroso and Gugliemo, 2004; Farrell, 2011: 68). By the end of the 19th century, fat bodies were not just those of affluent matrons and politicians in political cartoons, but also middle-class workers and families, particularly within portrayals meant to critique a supposed loss of frugality in these individuals (Farrell 2011). By the end of the 1800s, Protestant “dieting
gurus” advocated for an increase in restraint and control, which Gorn and Goldstein (1993) connect to the creation and popularization of the YMCA, an organization that connected morality, religion and exercise (also see Farrell, 2011).

According to Farrell (2011), in the beginning of the 20th century, white women were expected to be neither too thin nor too fat, thus neither denying nor displaying their sex and sexuality. Postcards portrayed fat female bodies as deserving of ridicule, with targeted criticism of fat bodies as being overtly sexual (Farrell 2011). At this time, fatness was also increasingly associated with Jewish women, thus demonstrating that the fat body was projected onto populations considered inferior as a method of validation of cultural values and biological reasoning (Farrell 2011). Strikingly, images of fat women were used by both pro- and anti-suffrage women’s groups from the mid-19th to early 20th centuries (Farrell 2011). Anti-suffrage activists portrayed suffragists as having out-of-control female bodies and similarly, first-wave feminist groups portrayed anti-suffragists as matronly old-timers resistant to change. Both groups depicted their opponents as fat in order to communicate these messages. However, both groups also portrayed themselves as thin and white within these portrayals. Thus, as Farrell (2011) points out, thinness was used to indicate a right to citizenship, as opposed to the primitive and evil desires associated with fatness.

By 1912, weight loss remedies were already being advertised and sold across the U.S. Dieting advice could be frequently found in popular women’s magazines, and the flapper of the 1920s represented the thin ideal (Boero, 2012). After World War II, obesity became widely medicalized and was eventually termed a disease, deemed deserving of medical intervention (Boero, 2012). Eating habits beyond restrictive diets also became a central focus of medicine, including the definition of binge-eating disorder (BED) formed by Albert Stunkard in 1959 and
BED’s inclusion in the DSM-IV, which was published in 1994 (Anderson, 2008a). BED symptoms include recurrent episodes of binge eating, marked distress concerning binge eating, binging at least two times a week for at least a six month period, and binging not associated with unhealthy compensatory behaviors, including purging and over-exercising (DSM-IV, APA 1994, in Anderson, 2008a). Treatments for BED include cognitive behavioral therapy, group therapy and drug treatment, along with OA and other eating-related support groups (Anderson 2008a).

Anorexia also received increased interest after the publication of Hilde Bruch’s “Eating Disorders” (1973) which explored mental issues and family problems, with a focus on mother-child relations, in anorexic patients (in Bordo, 1993). Bruch, before studying anorexia in the 1960s and 1970s, focused much of her research on obesity and theorized that fatness was not a sign of an inferior body, but instead a product of being born into an inferior culture (Bordo 1993).

In the second half of the 20th century, eating disorders began to be viewed as physical signs of cultural anxieties, especially as binge-eating became more widely accepted as a legitimate eating disorder (Anderson, 2008a). Yet, researchers were slow to apply this theory to either anorexia or bulimia (Pope and Hudson 1984; Bordo 1993). Biological reasoning also consistently took new forms as scientific technologies developed, but again more research emphasized finding a link between binge-eating and genetic/biological components, as opposed to trying to find biological reasons for anorexia or bulimia (Pope and Hudson 1984; Bordo 1993). This phenomenon could be due to the fact that fatter females who did not keep their weight ‘in-check’ were viewed as out of control, while female anorexic and bulimic bodies met cultural expectations. Throughout the 1960s and 1970s, hunger became increasingly eroticized (Wolf 1991), as models like Twiggy gained world-renown. Subsequently, much of Brumberg’s
(2000) work regarding anorexia focuses specifically on the 1980s, at which time the disease became particularly widespread and common compared to prior decades.

Finally, the body mass index [BMI, or weight in kg/ht squared (m)], developed by Belgian astronomer Adolph Quetlet in the 1830s, became widely-adopted as a method to measure health status in the late 20th century (Boero 2012). However, BMI charts were never intended to be used in this way as Quetlet had no background in medicine and his chart was never intended to measure the health of individuals (Boero, 2012). In this way, a tool to measure large-scale diagnosticks became the go-to reference to deem individuals as fit or unfit (Boero 2012). The popularization of the BMI chart as a method to measure health has allowed individuals to self-diagnose from home.

It is important to note that the BMI tables used today were established using a population of individuals who owned life insurance policies, meaning that the health values placed on certain height and weight combinations are more heavily based on middle- to upper-class Caucasians of northern European descent on the East Coast, according to Rothbblum et al. (1994). I argue that the development and perpetuation of BMI as a way to measure health means that individuals can enter body weight and height into a BMI calculator on the internet, and understand their bodies to be underweight, normal weight, overweight or obese within seconds. I suggest that these diagnoses are assumed to be indicators of health, thereby allowing weight to have a direct impact on who we, as a society, understand to be healthy. While BMI emphasizes a weight to height ratio to determine health status, it does not take into account the tens of other factors that impact an individual’s health and wellbeing.

Today, obesity is understood to be an epidemic necessitating a wide-range of medical interventions, from pills and special diets to surgery (Saul 2005). The history of the treatment of
thin and fat bodies in America demonstrates that the construction of appropriate ways to approach fatness has been decades in the making.

**Modernity, Medicine and the Stigmatization of Fat**

LeBesco (2009a, 2009b, 2010) demonstrates that anorexia and bulimia have not only become normalized identities, but also ones that demonstrate attractiveness and self-sacrifice, while fatness represents resistance and protection from the male gaze. By being fat, one is not only blamed for this condition by the dominant institution of public health, but also receives an inferior moral status as a result. By 1995, obesity was commonly referred to as a “disease” (Fraser, 1997). Levy-Navarro (2011) writes that history has played a pivotal role in casting fat as a failed identity and making thin a normative one; today obesity is still associated with the working class and the poor, both statistically (Rothblum et al. 1994) and in the popular cultural imagination.

In present-day England, stereotypes of fatness have been used against the working class and immigrant populations in order to label people with fat bodies as inherently of an inferior class and, therefore, of a lesser social status (Evans, 2010). As Evans points out, “[w]hen the aristocracy were still a threat to the middle-class supremacy, they were ‘fat,’” yet during the last half of the twentieth century fatness became associated with sloth, poor hygiene and low socioeconomic standing, the last of which was regarded as an indicator of production, and thus value, in modern society (2010: 156). As fatness became a medical and moral issue tied to social understandings, it was increasingly regarded as a method by which to understand a person’s essential *worth* in industrialized societies. Yet, it appears that popular discourses around who is fat are also premised on who represents a threat to the greatest portion of society. Portrayals of
fat cats and fat immigrants or the fat poor, are icons displaying that fat and the stereotypical fat persons, are to be feared. This was also displayed in the earlier discussion of pro-suffrage and anti-suffrage depictions of fat matronly and out-of-control women (Farrell, 2011). In these ways, depictions of fat often aim to create a barrier between bodies who are and who are not deemed worthy of social inclusion.

Fatness is also associated with the spread of modernity. Ironically, where consumer capitalism and industrialization go, so do obesity, anorexia and bulimia (Levy-Navarro, 2011; Brumberg 2000). Obesity is also cast as a cultural product of the additional life stresses faced by the individuals in the modern age, where “eating can perform a kind of irresponsibility that’s mostly not exuberant… but folds a vitalizing pleasure into the spaces of ordinary living” (Berlant 2010: 27). From Berlant’s (2010) perspective, obesity is a product of needing a vacation from exhausting careers, environments and personal lives, but also a form of resistance against the need to conform to societal demands and discipline the self. More often, researchers like Fortuna (2010) are searching for biological triggers for obesity such as addictions to sugar or for specific obesity genes. In addition, Western medicine has managed to pathologize the condition of fatness, while popular media promotes the idealization of slender female bodies. While fat is represented as the “expendable female filth; virtually cancerous matter, an inert or treacherous infiltration into the body of nauseating bulk waste” (Wolf, 1993: 191) within historical cultural discourses, fear of fatness is today expressed as concern for an “obesity epidemic,” and the modern way to communicate moral values is through medical opinion (LeBesco, 2010).

Obesity has been shown to be associated with downward social mobility, suggesting that obesity causes poverty, but the poverty/obesity association is more recently considered to be a cyclical process with harsh economic realities (Rothblum et al. 1994). This social reality is
supported by research demonstrating that it is not atypical for fat people to be denied economic success based on their fatness (Rothblum et al. 1994). The common cultural aversion to fat of the 20th century persists strongly today, as fat has become synonymous with illness and disease (Boero 2012a). Yet, fat people have been shown to diet more than their thin peers, a practice that can lead to a number of health risks, including the development of eating disorders, diabetes, hypertension (Rothblum 1994), and disturbances in the body’s natural metabolism (Kilbourne, 1994). By 1990, the diet industry had gone from a $10 billion industry annually to $33 billion a year within the last decade (Black, 1990, in Kilbourne 1994). Within the last two decades, specific emphasis has been put on fitness, or slim and lean bodies without excessive muscle or strength. Throughout the 1980s and 1990s, food ads stressed the sensuality of certain foods and the cultural demand for women to partake in specific ‘diet’ foods in order to purify their desires. However, these messages have been increasingly criticized over time, particularly by members of the groups they most target, in acts of resistance and activism towards body acceptance and recovery.

**Backlash**

Bordo (1993) advances a feminist cultural model for analyzing why eating disorders only emerge among some women who seemingly have had the same cultural exposures as their peers. She argues that by emphasizing the learned, addictive dimensions of eating disorders, recognizing gender and culture as productive and primary factors rather than contributory ones. By searching for social causes rather than individual dysfunction, researchers can provide a portrait of how the identity of each woman is affected by a unique configuration of culturally significant messages. In addition, Bordo suggests that that women who engage in disordered
eating are not being duped into following “oppressive regimes of beauty” (1993: 30), but instead are engaging in an “institutionalized system of values and practices” (1993: 32) which is the widely accepted path to economic and social success, a success they may not get otherwise.

Similarly, eating disorders start as “sane and mentally healthy responses to an insane social reality” (Wolf, 1991: 198; Orbach, 1978). In the 21st century, the slender body has grown to hold opposing meanings. Thinness is simultaneously weak, frail and submissive as well as being autonomous and in control.

However, empowering representations of fat and fatness have yet to significantly change or present an alternative interpretation to popular cultural discourse surrounding the fat body, despite their growth during the late 20th century. Examples include the founding of the National Association to Aid Fat Americans (later renamed the National Association for the Advancement of Fat Acceptance), a group founded by a male admirer of fat women, in 1969 (www.naafaonline.com); the founding of the Fat Underground in 1973 in the San Francisco Bay Area, poignantly nicknamed the F.U. (Resenbrink 2010), a fat feminist group which advocated the idea that fatness was a violation of patriarchal standards of beauty and aimed to form a positive identity around fatness for fat women, particularly fat lesbian women; the Health at Every Size Movement, a movement born in the 1960s which aims to promote respect for body diversity, advocates nutritional balance and satiety over dieting and weight loss, and recommends appropriate physical activity for pleasure (LeBesco, 2009b); the formation of fat women-only aerobics courses in the 1980s (Ellison, 2011); and a more general cultural anti-dieting movement, embodied in groups like Overcoming Overeating, at the end of the 20th century, focused on encouraging ‘healthy women’ (read: women with a ‘healthy’ BMI) to stop obsessing over their weight and weight loss (Burgard and Lyons, 1994; Fraser, 1997). The goals
of these groups varied greatly. While some wished to simply provide a space for fat women to practice self-expression and self-acceptance, other groups asked fat women to actively challenge and fight against what they perceived to be dominant patriarchal discourses that advocated against women who did not fit the idealized slender body portrayed by the popular media, and that indeed only about 5% of women fit today (Kilbourne, 1994). A uniting goal of most of these organizations was to recognize the ways that fatness was socially discriminated against and to bring that discrimination into question (Farrell, 2011).

Such groups receive little attention in popular media today. Yet, individual stories are frequently collected by academics in the field of fat studies. Joannisee and Synnot’s (1999) work demonstrates how size discrimination, in forms including school bullying, romantic relationship struggles, employment discrimination, public harassment, and fat discrimination from health professionals, is still reportedly commonplace today. Their study displays how self-identified fat individuals have also mustered the courage to ‘fight back’ against their perpetrators through verbal assertions, physical aggression, activism, self-acceptance, and through emphasizing their conspicuousness with prideful displays (Joannisee and Synnot 1999). Fat activists, whether in groups or individually, aim to construct a new way to see fat.

As Goffman (1963) notes in his famous work on stigma and identities, stigmatized individuals often go to extremes to rid themselves of a socially inferior identity, but may eventually choose to form a social movement to empower their identity around their social stigma. However, individuals may also struggle to distance themselves from the stigmatized identity long after they shed the socially inferior trait. For example, respondents in one study (Granby, 2011) claimed that after sustaining significant weight loss, they still felt it took years before they felt they were no longer stigmatized for once having been ‘heavy.’ In sum, fat
backlash, particularly from feminist women-only groups, was only one response to the proliferating cultural messages concerning eating disorders and what bodies were considered healthy. Indeed, this response, in comparison with others, was progressive at the time it was formed, and would be still considered as such by many Americans.

**The Self-Help and Recovery Movement**

A more utilized set of discourses that emerge from the 1960s to modern day is that of the self-help and recovery movement (Starker 1989). The self-help movement arguably operates within specific dominant religious and medical purviews and thus gains more scientific and moral credence than fat acceptance movements. The self-help movement stems from the idea that you can control your life with the right amount of reflection and discipline, a concept originating with religious practices that advocated spiritual salvation only through the denial of earthly temptations (Anderson 2008b). By 2005, the self-help industry generated nearly $2.5 billion a year, mainly in the form of dieting and weight loss products (McGee 2005, *in Anderson 2008b*). Specifically, the main tools used in most self-help solutions are discipline and management of body and bodily desires, tools emphasized in both Western culture and religious doctrines. Many of the products geared towards weight loss and dieting focus on emotional overeating as a key issue, including groups like Jenny Craig, LA Weight Loss, Weight Watchers, Taking Off Pounds Sensibly (TOPS), and Overeaters Anonymous (OA). It is worth mentioning that while none of these programs are associated with any particular religion, they make use of ideas and practices sometimes deeply rooted in religious and/or spiritual values.

This religious/spiritual framework for self-help organizations can be traced to the development of Alcoholics Anonymous literature and its masculine-centered focus, due to the
fact that when AA was first formed it was believed, that women could not be alcoholics (Trysh 2009). During the 1970s and 1980s, there was increased interest in how to present 12-step and other forms of addiction recovery as spiritual recovery to women, along with, to a lesser extent, other demographics populations based on sexuality, race, religion, and other identities (Trysh 2009). This occurrence happened simultaneously with the development of group psychotherapy, consumer rights and new age religion, as Archibald (2008) points out; the continued rise of self-help during the 1980s and 1990s was also likely a product of the rise in identity-based activism, particularly around groups who had historically faced social stigmatization. Other historians have interpreted the movement as gaining popularity in part because of cuts by the Reagan administration to professional services (Reissman 1990).

The budget cuts and the formation of these groups to fit populations whose access to mental health resources had been historically limited is not coincidental. According to a February 5th, 1990 edition of Newsweek, 15 million individuals were in 500,000 self-help groups across the U.S. (Leershen et al. 1990; Reissman 1990). By definition, self-help organizations are non-profit mutual-help organizations that exist outside of therapeutic and academic approaches and that place emphasis on a spiritual approach to ending addiction (Reissman 1990). Self-help groups are formed around every subject possible, as discussed above, and unsurprisingly, groups like Anorexia Aid, which formed in 1974, provided an Alcoholics Anonymous-esque framework for members looking to overcome eating disorders (Hartley 1994). Twelve step groups were not alone in their attempts to address the growing number of individuals affected by anorexia and bulimia. The issue also received attention by way of The Society for Advancement of Research into Anorexia (S.A.R.A.), to raise funds for research into eating disorders, and soon the creation of academic journals would follow, including the *European Eating Disorders Review* by John
Wiley (previously titled the *British Review of Bulimia and Anorexia Nervosa*), which itself was a product of the self-help movement (Hartley 1994).

Self-help organizations have been criticized for acting as a substitute addiction for members, for wrongly positing addictions as lifetime illnesses, for using religious tones that discourage many potential newcomers, for diverting attention that could go to structural or political change towards the individual ‘addict’ instead (Reissman 1990; Kurtz 1997) and for continuing to perpetuate white, patriarchal expectations and norms (van Wormer 1994). Similarly, as Nikolas Rose (1990) writes, the rise of psychology and the adoption of the concept of the self into everyday language during the twentieth century meant the rise of emphasis placed on the individual, where increased self-esteem and sense of self-worth indicated normal healthy behaviors. Thus greater value was placed on the individual as opposed to collective goals and action, and individuals began to increasingly see their problems as personal as opposed to results of larger structural political issues (Rose 1990; Ellison, 2011). While the goal of this project is not to evaluate whether or not 12-step programs are effective, it is important to acknowledge that there are many critics of 12-step programs and the 12-step focus on the spiritual connection between individual and something greater than the self. Yet, if 12-step programs did not have significant meaning in the lives of those seeking recovery, it is unlikely that they would still exist to the extent and variety in which they do today.

In order to unpack the long history of the 12-steps and their significance across different social circles and different addictions, the next section concerns the history of AA and the development of other Anonymous programs that adopted principles and traditions of the original.
Alcoholics Anonymous and the Development of the 12-Steps

According to the timeline of Alcoholics Anonymous provided by the organization’s website (Oct. 2013; http://www.aa.org/aa-timeline/), the AA program rose out of the Oxford Group, a Christian organization begun by American Dr. Frank Buchman in the early 1900s, which became popularized in the U.S. and Europe during the first third of the 20th century (Alcoholics Anonymous World Service Organization, 2013). The Oxford Group’s principles focused on self-improvement by means of taking self-inventories, admitting wrongs, making amends, the use of prayer, and sharing one’s growth with others. In the early 1930s, two men joined the Oxford Group, one of whom shared his experience with a previous drinking buddy, Bill W. Bill, a successful stock broker on Wall Street, struggled with alcoholism and considered his condition “hopeless, progressive and irreversible.”

Bill W. entered the Towns hospital for treatment in December 1934. During his hospitalization, Bill claims that he had a life-changing spiritual experience that prompted him to stop drinking. This experience is today recognized as the foundational moment that prompted the formation of the Alcoholics Anonymous program. After being released from the hospital, Bill, along with his wife Lois, joined the Oxford Group, whose message stresses that members practice the “Four Absolutes”: honesty, purity, unselfishness, and love. After struggling with how to carry the message to other alcoholics, Bill W. sought advice from Dr. William Silkworth of Towns Hospital, who encouraged Bill to understand alcoholism as a disease. Through connections with the Akron, Ohio meeting of the Oxford Group, Bill was also connected to Dr. Bob, and together they concluded that personal communication among recovering alcoholics can foster necessary spiritual support. On June 10, 1935, Dr. Bob had his last drink. Today, this is considered the founding date of Alcoholics Anonymous. In 1938, Bill created the Alcoholics
Anonymous 12-step program, drawing in part from the teachings of the Oxford Group. In addition, in order to preserve AA as an organization unaffiliated with outside groups, Bill created Works Publishing Company to print AA-approved literature and materials.

Towards the end of the 19th century, alcoholism began to be understood as a disease to be addressed by doctors, and during the early 1900s, Evangelical ministers continued to promote abstinence from alcohol, whose use was associated with family men and criminals (Courtwright 1997). There was particular pressure for alcoholism to be addressed because it fed into the desires of alcohol prohibitionists and because alcoholism was often seen as causing criminal or disorderly behavior, a concern not associated with the similar levels of opiate addiction seen among female populations at that time (Courtwright 1997). AA’s adoption of framing alcoholism as a disease speaks to the power and widespread social acceptance of the equation; framed as a disease, alcoholism, although associated with poor moral constitution, seemingly should have a medical solution. Finally, at the time that AA was founded, diseases were beginning to be understood as possibly the result of environment, heredity, or poverty circumstances beyond the control of the diseased individual, an epidemiological perspective that removed total blame from the patient (Brandt 1997).

For the last eighty years, Alcoholics Anonymous has enjoyed significant globalization and growth in both membership and media attention. In 1941, women’s AA groups slowly began to be formed, followed in later decades by a surge of groups specifically for women, youths, the elderly, African Americans, gays and lesbians, professionals, and the deaf. In 1942, the first meeting specifically for prison inmates was held, followed by the meeting of women’s prison groups in 1944. By 1954, AA had 130,000 members in 6,000 groups; in 1970, it was reported that 20,160 members took part in meetings in 742 hospitals, demonstrating the continued
association between medicine and AA. In the 1980s, the Internet and other electronic communications facilitated new ways for alcoholics to connect, hold meetings, and find sponsorship. According to a 2013 survey of membership, there are an estimated 1,295,656 members in 59,321 AA groups in the U.S. Worldwide, there are an estimated 114,642 groups with 2,131,549 members across 170 countries (Alcoholics Anonymous General Service Organization).

Alcoholics Anonymous has also given rise to other 12-step programs, although it is important to note that no 12-step program is affiliated with any other. Nonetheless, without the great success of AA in the 20th century, other Anonymous groups would not have garnered the popularity they have received. Two of these groups are Narcotics Anonymous and Gamblers Anonymous. Narcotics Anonymous meetings started in the early 1950s in the Los Angeles area. By 1983, NA had grown to 2,966 meetings worldwide. According to NA’s 2011 Membership Survey, there are currently an estimated 61,800 weekly meetings in 129 countries (Narcotics Anonymous World Service, Inc.). Interestingly, thirty-two percent of survey respondents also noted that they belonged to other Twelve-Step fellowships.

Gamblers Anonymous began in January of 1957 by two men who, according to the organization’s official website, based the program on “guiding spiritual principles used by thousands in recovery from other compulsive addictions” (Gamblers Anonymous International Service Organization, 2013; http://www.gamblersanonymous.org/ga/content/history). However, less information about membership demographics and globalization of meetings is available for Gamblers Anonymous compared to NA and AA. Nonetheless, the significant impact of these programs is evidenced by their continued popularity throughout time and across geographic
regions, indicating that many individuals believe that these twelve-step programs are necessary to resolve their addictions and achieve recovery.

This impact has not gone unnoticed by a wide range of academics. The amount of academic research conducted on Alcoholics Anonymous is too extensive to be covered in this literature review. However, it is notable that literature reviews of academic work on Alcoholics Anonymous have become extremely specific, including reviews regarding solely the role of women members in AA and other recovery groups (Ullman et al. 2012), the effectiveness of AA (Krenzman 2007) and the spiritual dimensions of the AA program (Bliss 2007). In fact, significant attention has been given in recent years to the intersections between women’s and sexuality studies and recovery groups, covering not only feminism and AA and other 12-step programs (see for example Sanders 2009; Sanders 2011), but also extending to queer individuals in anonymous recovery programs (Kus, 1987; Tallen 1990; Suprina 2005).

While research pertaining to AA members has relied heavily on interviews with its members (for examples, see Zakrzewski & Hector 2004; Weegmann 2009; regarding AA and NA members, Grant 2007), relatively few studies have used multiple ethnographic methods, such as interviews and participant observation, within AA groups (Hoffman 2006; Suprina 2005). A review of the academic work pertaining to Narcotics Anonymous groups demonstrates that although less research has been done on NA compared to AA, some of the research has been more ethnographic in nature. For example, Peyrot (1985) uses interviews, participant observation and a survey of NA literature to outline the history, structure and approach of the organization. Rafalovich (1999) completed a two year ethnographic study of over 150 NA groups in order to posit a common identity for the recovering addict. In 2011, White et al. compiled the academic
history of NA, in order to demonstrate the unique history, challenges and growth of the
organization, and they argue that NA, compared to AA, has its own distinct recovery culture.

Compared to the two prior groups, Gamblers Anonymous has garnered significantly less
attention from academia, followed by OA. In an academic search for the utilization of
ethnographic methods within Overeaters Anonymous settings, bulimia nervosa was the focus of
the majority of studies (Hertz et al. 2012; Wasson and Jackson 2004; Rorty et al. 1993; Wasson
2003). Martin (2002) was the only ethnographic work that addressed various forms of disordered
eating or dieting patterns, and only by researching group frameworks by interviewing leaders and
participants of Weight Watchers, Overeaters Anonymous and the National Association for the
Advancement for Fat Acceptance (NAAFA).

The increas e in popularity of anonymous groups over the last few decades is astonishing.
Rapping (1990) quotes Robin Norwood, author of Women Who Love Too Much, a bestseller self-
help book published in 1985 concerning obsessive and abusive relationships, as saying, “there
are over one hundred varieties of Anonymous Programs that exist today,” and Norwood has
“never yet encountered a troubled individual who didn’t qualify” for at least one anonymous
group (316). Here, Rapping (1990) uses Norwood to suggest a prescription of 12-steps for
everybody, and therefore medicalizes the 12-steps as a legitimate form of treatment for a wide
array of problems. Such an approach to Twelve Step programs gives added weight to what it
means to have an addiction, and whether or not a given addiction can be understood as a disease
by a wider medical community, such as is the case with alcoholism, and with food in the case of
Overeater’s Anonymous.

Overeaters Anonymous is an organization that retained AA’s 12-steps and 12 traditions
nearly word-for-word. In addition, OA kept intact AA’s emphasis on spirituality, sponsorship
model, decentralized organizational structure, and self-supporting financial system (Trysh, 2009). Overeater’s Anonymous, along with other less-popular 12-step groups addressing eating disorders, arose out of specific historical social and cultural circumstances, including, but not limited to, medical understandings of what qualifies as eating disorders, understandings of addiction recovery, the oppression of women throughout American history, and the rise of a demand for spirituality and dietary reform.

The ideas and perceptions surrounding body size and the need to measure, regulate and manage body size is the culmination of decades of discourse across a wide range of fields. The cultural phenomena that we see and experience in our daily lives, from SlimFast ads, to body acceptance community workshops, to depictions of concerns about under or over eating as diseased behaviors, are viewpoints that arise out of specific cultural circumstances. The Twelve Step program is one example of such discourse, but individuals living the Twelve Step program have daily interactions with other visions of how to be and how to embody themselves. Their experiences with their eating patterns and their bodies are deeply rooted not only in their relationships with themselves and others, but also in social, cultural and political trajectories whose meanings are often seemingly contradictory or intricately related.

The next chapter details the history of Overeater’s Anonymous, and concludes with a review of primarily ethnographic literature pertaining to the collected experiences of individuals in OA and other similar self-help groups.
Chapter II

Overeaters Anonymous: History and Review of Ethnographic Literature

Of particular interest in this literature review are ways that in research on OA it has been closely connected to weight-loss programs like Weight Watchers. While researchers (Boero 2012; Damon 2012; Martin 2002; Weiner 1998) recognize the programs’ vastly different approaches to body size and weight loss, participants from both groups are often used to inform research concerned with women trying to lose weight. This suggests that for many individuals, OA may be considered the ‘dieting and calories club’ that it explicitly states it is not. This repeated association between the two groups is a weakness of the research because it ignores how Overeaters Anonymous members experience their food behavior as explicitly addiction and disease, not just behavioral patterns that lead to weight problems. My ethnographic research is designed to shed light on some of the experiences that make participation in OA unique. This research focuses on the accounts of OA members only, in part to avoid the repeated comparison between Weight Watchers and OA participants that risks labelling OA as “like Weight Watchers, but…”. While these two international weight loss group programs were created at almost the same point in history, the goal of this project is to examine the impact of OA’s unique ideology and how it interacts and changes participants’ beliefs about their bodies and selves. While Weight Watchers is about the counting points and practicing new behaviors, OA focuses on reasonable satiety, spiritual healing and finding peace with one’s food and body.

I also address criticisms lodged against OA by academia, particularly critiques by Lester (1999), who uses Foucault’s technologies of the self to demonstrate how the organizational structure and language of the OA program can be read as anti-feminist. Again, while it is not my
intention to pass judgment on the OA program, it is essential to recognize political discourses surrounding and influencing OA (Lester 1999) and other anonymous programs (Sanders 2009). Such literature provides not only a sense of the academic critique of OA, but also identifies themes that are reflected in my fieldwork and interview data. It is not only academics who are concerned about the constructions of gender and gender roles in OA; the participants I worked with also conveyed concerns of these same issues.

Disease and spirituality are emphasized in OA. However, scholars have not questioned the disease-framework of compulsive overeating and what having a “Higher Power” does for OA participants to help influence their compulsive overeating, relationships with self and others, and daily lives. This gap in the literature has helped to frame my research questions. This literature review thus explores the key themes highlighted in my research: the roles of gender and gendered participation in OA groups from the founding of OA to the ways in which group members operate and behave today; the place of spiritual and psychological understandings of compulsive overeating as key foundational points in the program of recovery; and the academic reliance on examining OA in comparison to organizations with other messages concerning bodies, namely Weight Watchers. These themes reflect the historical and political movements in which the founding of OA is embedded, at a time when revolutionary gains were being made in the feminist movement and in understanding the psychology and mental health issues of eating disorders. OA was born at nearly the same moment Weight Watchers was created, demonstrating the demand for self-help solutions to weight and eating troubles that were developing in the 1960s.

In *Beyond Our Wildest Dreams* (1996), one of the founding members of the OA program, Rozanne, details the beginnings of the organization. In 1959, Rozanne attended a Gambler’s
Anonymous meeting in support of a friend, but what she heard at the meeting was a description of how she felt about her compulsive overeating. Gambling was framed as a disease. The Gamblers Anonymous meeting that Rozanne attended had been started by the founder of GA, a man named Jim W., in Los Angeles. In her story, Rozanne recounts approaching Jim, hopeful that a group could exist to help with her compulsive overeating.

“Trembling, I asked, “Jim, do you think an organization like yours could work for compulsive overeaters like me?” He smiled down at me gently. “I don’t see why not. I was in Alcoholics Anonymous before I ever started GA. Tell me what you have in mind.”


In this way, OA grew out of inspiration and a feeling of “what I needed- except that it was the wrong compulsion” (Overeaters Anonymous, Inc., 1996: 8). However, what is particularly special to the OA program is that it was founded by a woman, unlike AA or GA before it (Overeaters Anonymous, Inc., 1996).

Rozanne, in January of 1960, after hitting rock bottom during the holidays of 1959, founded a group for compulsive eaters with only the support of Jim W., her neighbor Jo, and Bernice, the wife of a GA member. The first meeting of OA was held on January 19, 1960 in Rozanne’s home in west Los Angeles. Over the course of less than a year, OA, which was limited to women, was structured on using a psychological basis to understand compulsive overeating. Rozanne wanted to deemphasize the spiritual aspects of the 12-steps as written by AA. Thus, the beginnings of OA reflected the values of 1960s America: women fighting to be
equal to their male counterparts. In addition, medicine, at this point was dominated by psychological understandings of behavior. Medicine was not only an authority, but a moral authority. OA’s foundations existed in a historically-situated web of interconnected ideas regarding what feminism, disease and recovery meant, which frequently left the group in turmoil (Overeaters Anonymous, Inc., 1996).

At this time, some new OA groups wanted to keep the spiritual focus of the original 12-steps. But this generated much friction among groups in different geographic regions as some women who came to OA in its first years, were or had, family in the AA program, and they demanded that OA adopt AA’s 12-steps nearly word for word. But Rozanne had originally rewritten the 12-steps of AA to focus on the psychological aspects of overeating, taking out references to spiritual recovery. She then took on Thelma S. as her sponsor, a woman whose husband had been in AA for 16 years, and soon after that Rozanne had a “spiritual rebirth” (Overeaters Anonymous, Inc., 1996: 70) and she was willing to add the spiritual elements of the AA program into the OA literature. However, this change created friction across the handful of OA groups that had sprung up in Los Angeles and the San Fernando Valley.

Strong debates regarding what kind of effects “God-talk” would have on the membership occurred between groups in Los Angeles, who preferred a psychological approach, and groups in the San Fernando Valley, who advocated the change to the AA steps (Overeaters Anonymous, Inc., 1996). While some members feared that a spiritual approach would deter newcomers, the opposing side believed true recovery could not be achieved without a spiritual awakening. Groups in the San Fernando Valley threatened to form their own organization and look to AA for mentorship. Finally, it was decided that OA would adopt the 12-steps of AA, changing only the
Words “alcohol” to “food,” and “alcoholic” to “compulsive overeater.” From there, individual groups could interpret the steps as they wished.

In addition, OA struggled early on with whether or not the program should be centered on a particular diet for recovery (Overeaters Anonymous, Inc., 1996). Many OA members advocated a diet that made foods with flours and sugars off-limits to those members who were seeking to achieve abstinence. These members believed that foods with flour or sugar in them led to binge eating and were addictive substances (Overeaters Anonymous, Inc., 1996). Furthermore, some of members believed that this reaction to such foods must be true for all compulsive overeaters, and therefore OA members who didn’t follow this diet were not actually maintaining abstinence (Overeaters Anonymous, Inc., 1996).

Recall also that OA had voted in its formation to make OA a women-only fellowship. In 1961 the group was contacted by a man by the name of A.G. A.G. founded Gluttons Anonymous in Texas, an organization comprised of five groups of men and women who also used the 12-steps to address their overeating (Overeaters Anonymous, Inc., 1996). Rozanne admits that A.G. posed a problem for the original OA groups because of his gender and his request to attend the first OA national conference with other members of Gluttons Anonymous, some of whom were male. However, she explains that because most of the individuals who requested the groups be women-only had left OA by that time, the proposal from A.G. was accepted by the OA conference committee (Overeaters Anonymous, Inc., 1996).

A.G. and other Gluttons Anonymous members attended the first OA national conference in 1961, and it became apparent that they held some hope that OA could be absorbed into Gluttons Anonymous (Overeaters Anonymous, Inc., 1996). Eventually the Gluttons Anonymous groups were absorbed into the OA groups, although this occurred after some debate and a
member vote. Rozanne notes that with this collaboration she found A.G. to be a helpful businessman and that he was able to solve key problems concerning the organization of OA. For example, it was A.G. who suggested a Board of Trustees be formed.

During the first National Convention, the program adopted the Twelve Steps and Twelve Traditions, thereby accepting the original spiritual focus of 12-step programs (Overeaters Anonymous, Inc., 1996). It was accepted that the spiritual component of the 12-step program was not only helpful but essential to successful completion of the 12-steps for many OA members. A second monumental decision at the convention was to make the only requirement for membership the “desire to stop eating compulsively,” not the desire to stop “overeating compulsively” (Overeaters Anonymous, Inc., 1996). This opened the doors for OA to include individuals struggling with anorexia and bulimia, although the great significance of this decision could not have been realized in 1961.

OA has remained open to individuals struggling with anorexia or bulimia. However, according to OA’s 2010 Membership Survey, 16% of members surveyed identify their problem with food as bulimia, and 9% indicated they struggle with anorexia (Overeaters Anonymous World Service Organization). Survey participants could choose multiple answers, and 95% indicated compulsive (over)eater, possibly meaning that these individuals’ eating patterns change or they see key symptoms of two or more disorders.

The history of OA is of particular interest because of the way it is situated in specific cultural moments around addiction and self-help group formations. These factors include the fact that women were only allowed at first, that the group was born out of a member’s experience in GA, the discussion of addiction as a disease by this organization, and that there was a similar group, Gluttons Anonymous, already forming in Texas for both men and women. All of this
demonstrates aspects unique to the moment in time that OA was formed. In addition, new discourses were arising that focused on the medicalization and re-defining of addiction, the need for safe spaces for women, and also men’s concerns for their eating and weight. There was a cultural demand for a method of self-help that recognized struggles with food as a disease. Later, there were demands to make spiritual healing the key remedy to this disease from some OA groups (Overeaters Anonymous Inc., 1996).

OA was not the only group-based solution to weight control that arose out of this climate. Weight Watchers (WW) was founded in 1963, by a woman, Jean Nidetch (Evans 2004). This concurrent beginning may be why many researchers have focused on comparisons between the models of OA and WW and what these two programs do to help or hurt their participants search for weight control (Weiner, 1998; Martin, 2002; Damon, 2012; Boero 2012). As Weiner (1998) observed, where OA emphasizes the psychological and spiritual components of eating and recovery, WW emphasizes the behavioral components. In addition, where OA attempts to foster a sense of community over shared spiritual and religious values, the main concern in WW is group support and weight loss. Finally, WW does not explicitly address anorexia or bulimia. In these ways, WW was not concerned with the changing of entire self or even certain behaviors of selves, but instead on the actions and behaviors of individual overeating. As Darmon (2012) points out, such institutions exist as “people-thinning” institutions, meant to change body shape and size, but not other internal struggles (378). The goals of OA are clearly more complex than weight loss. This is not to suggest that Weight Watchers does not have a variety of consequences and effects on its participants. Yet, it is undeniable that the primary goal of the weight loss program, to lose weight and build life-long good eating patterns, is not the same as the goals set out in OA. Simply put, the focus of OA is not the desire to lose weight, although that is often a
driving factor getting participants to meetings. In OA, members are presented not only with a challenge to find a Higher Power, but also different disease metaphors with which they often reframe their life histories and restructure their relationship with food..

The next series of studies demonstrate the unique role that OA has played in the lives of participants and the unique core tenets of the OA program. As part of a study exploring how leaders in OA, WW, and the National Association to Advance Fat Acceptance (NAAFA; www.naafaonline.org) understand meanings of appearance, participation, and food, Martin (2002) conducted participant observations and subsequently analyzed taped interviews with OA members. Martin had access only to OA open meetings (which are open to the general public and differ from closed meetings that are only open to those who have had experience with compulsive overeating). Therefore, while Martin attended some OA meetings, the majority of his data came from an extensive audiotape archive of recordings of OA members sharing their experiences of compulsive overeating and the OA program; these recordings were collected at OA events and conferences, but not meetings. From this archive, Martin (2002) was able to collect the life stories of OA members which had been solicited by the organization through OA local and national conferences. Martin used a total of 49 interviews from the archives for analysis, from which he claims he was able to get data that gave a number of conceptual categories he could identify from the stories.

Martin (2002) found that members told their stories as testimonials to the program, not only tailoring their life history to the meanings presented in OA literature, but also presenting a selling point for OA by speaking about an old self versus a new self. In this way, members established themselves as credible sources of recovery, while giving credence to the OA program and establishing a “natural etiology of compulsive overeating that is intertwined with their life
experiences” (2002: 189). As a final point, Martin found that men were more likely to stress medical reasons for joining OA, whereas women underlined their desire to change their physical appearance. In my ethnographic work women reported numerous other reasons why they joined OA, although weight loss was a common reason. Stories of self-transformation also marked the speaker meetings, which is when members lecture about time spent in OA and what they have gained from the program. Martin’s (2012) research demonstrates aspects of how individuals talk about and conceive their recovery.

Boero (2012) conducted participant observation and interviews with both WW and OA members, and also collected information from OA list-serve e-mails among members. Her main finding was that the experiences of OA participants were given shape by their personal histories and the program philosophy. However, participants’ experiences were not shaped by the notion that obesity, particularly their obesity, was a moral or social problem. Boero highlights participants’ understanding of obesity as a symptom of a disease and the addict as (spiritually) suffering from this condition, a point of view that is in line with the OA program. In this way, discourses of anti-fatness are not conscious factors driving participation for Boero’s participants. Instead, she finds that participants are motivated by their identities as addicts suffering from a disease, albeit a disease that is historically grounded and culturally-specific.

Boero’s (2012) emphasis is not only on cultural discourses but on a sense of psychological and spiritual health as assessed by participants. The assessments are what qualify participants for membership in OA. Boero’s (2012) research shows how OA participants present their identities, as diseased compulsive overeaters, in OA spaces. Her research also suggests, to a smaller extent, the psychological and spiritual components of these identities, namely that these aspects of individuals that are themselves diseased. Much debate occurred early in the creation of
OA about how to negotiate seemingly contradictory psychological and spiritual understandings of the disease. Boero’s research demonstrates that members of OA still use psychological understanding of themselves to make sense of their experiences with compulsive overeating. In line with this thesis, my research show how participants use psychological analyses of their selves. My participants also turned to genetic and adaptive reasons to explain their disease, demonstrating a shift in the larger scientific understandings that OA members now apply to their lives. Boero’s research also shines light on how it is that individuals understand aspects of their disease within themselves. However, participation in OA also has been shown to have important implications for how individuals relate to others.

Further studies demonstrate that OA members believe the program has positively changed their ability to have meaningful relationships with others. Hertz et al. (2012) relied on interviews with 20 Israeli women members of OA. Participants in this study claimed that OA helped them build positive relationships, particularly with other women who were either peers of the OA group or were OA sponsors. Hertz et al. theorized that these relationships within the recovery group, unlike many relationships outside of such groups, were not only characterized by consistency and continuity, but also by the formation of a new relationship with a divine entity shared among group members. Hertz et al. concluded that OA had positive benefits in changing attachment styles that, for some participants, seemed to have begun in childhood. This conclusion was reflected in many of the OA members I interviewed who have remained in contact with individuals they had met at their first OA meetings, sometimes over the course of decades. As more than one participant reported, “OA’ers are my people” (Tracy and Joyce).

How individuals struggling with bulimia understand OA as a method of recovery from their illness has been addressed in research by Rorty et al. (1993). This topic could only be
addressed since bulimic and anorexic individuals were accepted into OA groups and language. Rorty et al. (1993) conducted forty interviews with bulimics, 38% of who were in OA, and who had not binged and purged for a year or more. Rorty et al. focused specifically on factors these women believed to be related to their recovery. They found that women credited having already hit ‘rock bottom’ to experiencing or fearing negative social, medical or professional consequences of bulimia, newfound self-esteem in some aspect of their lives, and a desire for a better life in their decision to recover. Of those women who were in OA, about 50% were satisfied with the program. However, those that were entirely dissatisfied often cited discomfort with the ideas presented by the program of having powerlessness over food or never being able to fully recover from the disease. Additional studies have examined other factors influencing bulimic women’s experiences in OA, including relapse (Wasson, 2003; Wasson and Jackson, 2004). While few participants in OA identify as having struggled with bulimia, the presence of such research demonstrates the utilization of OA as a program of recovery for these individuals, and it can be used to better understand the various needs and desires of women who seek recovery from disordered eating.

Much of the research on OA has been largely uncritical of OA’s program philosophy, but it is valuable to present criticism of the program to better understand the multiple interpretations of OA and possible meanings of its messages to participants. Lester (1999) perceives what she considers to be the costs of the OA program of recovery for women. Her earlier work (Lester, 1991) suggests that AA and other Anonymous programs change how members understand and experience their life events. Lester (1999) proposes that members reorganize their life histories in order to fit a specific format associated with 12-step transformations. Specifically, members detail how the compulsive overeating began, specific patterns of behavior and responses to their
compulsive overeating, hitting rock bottom, and the discovery of OA and transformation within themselves during their time in program. Lester (1999) demonstrates how the moral and cultural significance placed on a Higher Power within the program places blame on the individual and focuses attention away from societal factors in the development of disordered eating behaviors. Interestingly, she claims that the program echoes ideas of control, individual responsibility and discipline found in American Puritanical tradition citing the use of confessions to “absolve the sinner” and “discern ‘truth’ about self and soul” (Lester 1999:150). She believes that this group structure replicates and relies on cultural practices around gender and power. Lester points to the fact that OA is a project of the self which largely ignores the gendered nature of compulsive eating, evidencing that OA is more frequented by women than men. Furthermore, Lester (1999) suggests that there is a cultural double standard when it comes to eating habits by asserting that compulsive overeating is likely identified as a problem for more women than for men, even when the two engage in similar eating patterns. For Lester, by focusing on spiritual aspects OA ignores not only the bodily aspects of eating disorders but also the gendered nature in which they are identified and addressed. She views admittance of powerlessness over food, a step taken more by women than by men due to the membership composition of OA, as not only turning one’s will over to a God, but to a patriarchal God. The patriarchal nature of the 12-steps did not go unnoticed by participants in my study and this is an intriguing point in the face of the gender and psychological/religious controversies apparent in OA.

In addition to gender, numerous variables such as age, occupation, health, and family status of participants may influence the results of studies of OA groups. Indeed, 87% of OA members are female (2010 Membership Survey, OA World Service Organization). Whether this statistic is the result of more women identifying as overeaters or the result of women being more
likely to join OA or to join any kind of support groups, it is still culturally telling. It suggests that for women, food is either off-limits in the quantities in which they desire it or overconsumption is something that must be addressed and changed. The most common age range for OA members is between 56-65 (29%); 48% of members are married, 20% are retired or semi-retired or hold jobs in the professional/technical fields (11%), and most come to their first OA meeting between the ages of 26-45. An astonishing 93% of the survey respondents were white, and 32% have graduate or post-graduate degrees. Ninety-five percent identify as having struggled with compulsive eating or compulsive overeating, 16% have struggled with bulimia, and 9% with anorexia. The average weight loss of respondents was forty-five pounds. Therefore, while the dimensions of gender are significant within OA discourses and how the OA program is consumed and reproduced through member stories, the roles of cultural variables such as affluence, education, age, and race have on how the philosophies of the OA program perpetuate or resist dominant cultural and moral values.

This review of the fifty-plus year history of the Overeaters Anonymous program and of research on the life experiences of participants in OA reveals that relatively little attention has been paid to the OA program itself. Studies typically focused on experiences of participants in OA, WW, and NAAFA.

Many of the OA participants in my study had participated in one or more other organizations focused on discourses around body and weight before joining OA, including WW, TOPS, and Jenny Craig. My study explores how individuals navigate the complex discourses in and outside of the OA program in order to achieve unique understanding of themselves, their eating, and their relationships with others and, most times, with their Higher Power. Lester (1999) ends her essay by calling for research that explores the complex web of interactions
between spirituality, food addiction, and morality, particularly as situated within American culture; this is what I aim to do.

My goals are to shed light on these intersections that Lester (1999) identifies. My work emerges both as a product of prior work, and also as a reconceptualization of how to interpret others’ scholarly understandings and individuals’ experiences. By utilizing participant observation and narrative interviews with OA participants, I analyze how these overarching structural ideologies play out within the everyday lives of OA members.
Chapter III

Guiding Themes: Medicalization, Religion/Spirituality, and Diversity

The major themes addressed in this ethnographic study of OA are medicalization, ritual, confession, and the roles of women, youth, and other groups who join OA. These themes repeatedly arose in OA meetings and during informant interviews and are contextualized in this chapter historically and culturally to frame the OA program as an organization that reflects and creates wider cultural values and meanings.

Each of these themes was chosen because of their prominence in my data. Participants in this study often noted that they learned through their first meeting in OA that compulsive overeating was a disease. They also reported that after attending a few OA meetings they grasped that ritual and spirituality in are strong aspects of the program. However, embracing rituals within meetings and gaining faith in a Higher Power did take some members years to accept. The impact of gender on participants’ experience in 12-steps is less obvious. I wondered if female members in OA understood the program to empower them. The answers to this question are complicated and multi-faceted and will be addressed further in this chapter. Other demographic factors and the survivability of the OA program will also be addressed.

Medicalization

It takes a certain cultural climate to understand overeating as a disease, let alone allowing eating patterns to be seen as disorders. Many cultures encourage fasting and feasting as part of spiritual or seasonal rituals. I suggest that current Western media representations of eating stress moderation and the consumption of certain foods - at times even certain nutrients - rather than
others. Cultural perceptions about food and consumption become points of social control in the form of healthcare recommendations and, sometimes, religious or governmental personnel, among other authorities and gate-keepers. This culture that expects moderate intake of nutritional foods already sets overeaters up to feel that they are doing something wrong. I was interested to learn how participants approached the idea that their compulsive overeating was a disease, not just a lack of willpower or motivation to eat as others said they should.

When Overeaters Anonymous first began in the 1960s, characterizing overeating as a disease was a relatively unique idea. Since that time there has been increased awareness that overeating is not just a health issue but may be seen as a form of addiction (Fortuna 2012; Marks 1990). While these notions gain popularity in the healthcare field, participants in this study chose OA instead of other diet programs, diet pills, or gastric bypass surgery (the last of which, interestingly, was never mentioned by any of the participants interviewed). Yet while OA participants choose a nonmedical approach to address their compulsive overeating, the program and participants still frame compulsive overeating as both an addiction and a disease. I suggest addiction and disease have become equated in the OA program. What is evident in American culture is a rise in seeing eating disorders as a pathology. Overeating has been adopted by the field of health as not only a public health issue, but an addiction necessitating medical treatment. Medicine has framed compulsive overeating, like alcoholism, as an addiction first, and therefore a disease (Rasmussen 2012). Addiction connotes the idea that an individual has no control over his or her response to a chemical or action. To call that inability to control one’s response a disease, has many implications for recognition and treatment of compulsive overeating.

One important implication of defining compulsive overeating as a disease is the impact this has on those who do eat compulsively. Since the time that compulsive overeating was
conceptualized as a pathology, a variety of biological explanations have been proposed: psychological (Grogan 2013), genetic (Clarke et al. 2010), natural selection, and environmental (see Chapter V of this work). By tracing some of the cultural history that sets overeating on this course, programs like OA can be framed within the historic and cultural contexts in which they were developed.

Irving Zola, medical sociologist and disability scholar at Brandeis University, noted that the “medicalization of daily living...is becoming a major institution of social control, nudging aside if not incorporating the more traditional institutions of religion and law” (1972: 487). Zola sees this medicalization as arising from the development of the psychiatry and public health fields, both of which allowed for the translations of social problems to medical evaluation. Zola argued that doctors were given a new ability to judge what were previously considered deviant behaviors by law and religion, thus giving new power to define acceptable behavior to the medical realm. In this way, behaviors including addiction were made medical issues that fit within and added weight to, no pun intended, the already existing perceptions of acceptable and unacceptable behavior. Zola notes that the extent of medicalization of behaviors is limitless, in that every person’s potential to believe that they are somehow medically faulty is the “most powerful empirical stimulus” for medicalization (Zola 1972: 497).

Zola (1972) was a primary scholar in defining and creating a discourse on medicalization and its power within society, especially shedding light on how it is that medicalization is a continued form of setting societal norms by giving renewed credence to perceptions of right and wrong. This concept relates to OA in that it can be viewed as both a reaction to, acceptance of, and adversary of, the medicalization of eating. The OA program was a product of one woman’s weight and eating troubles, which she had not been able to resolve with medical and socially
popular solutions (*In Memoriam, www.oa.org*). However, the idea that problems of eating patterns and weight need to be resolved is a largely medical perspective. The framing of overeating as addiction accepts this larger medical discourse regarding what is seen as deviant behavior (Kandall 1996). Yet, although the OA program accepts the idea of medicalization of compulsive overeating, it does not support the use of medical and biomedical solutions: there are no diet pills, no bariatric surgery, no search for a fat gene, and no liquid diets. The program points participants to a spiritual practice to address compulsive eating, an approach not generally recommended by Western doctors as a plan of action (Overeaters Anonymous, Inc., 1996).

Another perspective on the medicalization of human behaviors in society is given by Conrad (2007) who defines medicalization as “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders” (2007: 4). Conrad notes that medicalization is a distinct process by which a problem previously labeled as deviant behavior is labeled in medical terms with particular attention to the individual who has the problem, instead of the social environment that may contribute to the problem and/or its formation. Conrad views medicalization as gaining popularity in a time where religion was less popular and rationality, individualism and technology were increasingly valued. In addition, the increase of trust in the medical profession may have escalated the rise of medicalization (Conrad 2007). Throughout the 1980s, patients became more like consumers. Concurrently, doctors were no longer regarded as all-knowing cultural authorities, leading into an age where markets were produced specifically to cater to consumer-patients (Conrad 2007). Recall the persistence and growth of the self-help industry discussed earlier and also the movement towards increased lay knowledge about health, including the publication of *Our Bodies, Ourselves* (1973; www.ourbodiesourselves.org). This patient-as-consumer model has continued to grow in
American popular culture, particularly with the plethora of direct-to-consumer pharmaceutical advertisements and the rise of lay knowledge of genetic, biological, and psychological explanations for illness.

Conrad (2007) writes that while medicalization has helped to reduce personal blame and stigma for certain conditions, including alcoholism, the process has also allowed medicine to define what a “normal” person looks like and does. Conrad asserts that this definition of normality creates social unease and perceptions of illness where there very well may be none. He notes that the “primary engines of medicalization now also include consumers, insurers, and the biotechnological industry” (2007: 156), as more parties believe they have a say in what is a medical condition, and which conditions deserve particular medical solutions.

Conrad (2007) also discusses some resistant movements, such as the National Association for the Advancement of Fat Acceptance, a group which protests medical approaches to fatness; Pro-Ana movements which suggest that anorexia and bulimia are lifestyle choices that individuals have the right to make; and genetic frontiers, sometimes including addiction as a genetic condition that could be addressed by genetic therapies. In addition, some investigators have detailed the rise of biomedicalization, where medicalization has been expanded to include genomic medicine and new technologies (Clarke et al. 2010). Clarke et al. (2010:48) argue that, “health itself and proper management of chronic illnesses are becoming individual moral responsibilities to be fulfilled through improved access to knowledge, self-surveillance, and the consumption of appropriate self-help and biomedical goods and services”. This suggests that biomedicine in part puts increased emphasis on health risk and self-surveillance, so that it is no longer a requirement to feel sick or have symptoms to be considered to be at risk or sick.
These viewpoints (Zola, 1972; Conrad, 2007; Clarke et al., 2010) demonstrate the rise of medicalization and its continuation into realms of biomedicalization, and hint at ways in which participants could conceptualize how they came to experience compulsive overeating, including genetic, endocrinological and psychological explanations. What do OA members think when they ask, “Why me?” of compulsive overeating; how do they conceptualize why they have this disease and where it came from. These questions are particularly compelling in a culture that draws primarily from scientific explanations of disease and addiction, but how do participants answer these in a program that focuses on gaining a Higher Power to achieve recovery? What struck me throughout the individual narratives and in OA group meetings was that the OA program characterizes compulsive overeating as a chronic illness. Kleinman (1998) writes that, “the trajectory of chronic illness assimilates to a life course, contributing so intimately to the development of a particular life that illness becomes inseparable from life history” (8). This statement is emblematic of the exact biological framing through which OA sees compulsive overeating as a disease and how individuals use the disease narrative to newly understand their own life histories with food. However, while OA participants chose to explain their illness through the lens of medicalization, in my interviews it was clear that being a compulsive overeater had become a part of their identity.

When entering the OA program, individuals are asked to do more than identify with the label of compulsive overeater. They are taught that in order to achieve recovery they must “turn [their] will and [their] lives over to the care of God” (www.oa.org, “ Twelve Steps”). In this way, members of OA begin to understand their identity as overeaters as imbued with moral meanings, not entirely unlike the meanings given to fatness by the healthcare industry. In order to heal what they are led to understand as being “defects of character” (www.oa.org, “Twelve Steps”),
individuals work towards having spirituality become a keystone in their lives. Participants are not interested in doctor’s diets or gastric bypass surgery, but instead wish to gain wholeness through spiritual or religious practice. In a world of increasingly medical, technological responses, OA offers a rare spiritual solution.

Numerous medical authorities have used the addiction model to indicate disease, thereby taking blame off of individuals with the addiction while also medicalizing their socially undesirable behavior. In OA meetings, it is typical for individuals to use the terms “disease” and “addiction” interchangeably to indicate their compulsive overeating; always, however, their solution to this problem is to invoke God or a Higher Power. But addiction itself has been largely re-conceptualized over the last few decades by medicine, with spiritual solutions not as popular as scientifically based solutions. In this way, the ability of OA to straddle seemingly opposing understandings of the development and appropriate responses to disease seems extraordinary. Furthermore, the ability of participants to use these two discourses, science and spirituality, to negotiate why they have their disease was also striking. Participants often drew on endocrinological, psychological, and genetic reasons for why they were compulsive overeaters, but some faulted their lack of a spiritual nature as well. In addition, some individuals believed that the environments in which they grew up, or traumatic experiences they had experienced played the foremost role in their development of the disease (see Chapter Six). The hard science arguments have much more detailed histories.

In an analysis of medical journal advertisements from the 1930s to the 1960s, Rasmussen (2012) found that between the world wars scientists’ preferred endocrinological explanations for fatness, thus turning a previous immoral state to one of sickness. In the 1940s, psychological theories suggested that fatness was the result of having a domineering mother and a resultant
need to overfeed and over-nurture oneself, reflecting the idea that fatness was a character defect (Rasmussen 2012). By 1945, obesity was being classified as an addiction, along with alcoholism, in some textbooks, and by the 1950s many psychiatrists advocated the idea that overeaters ate to escape life problems or had psychosexual underdevelopment (Rasmussen 2012). Psychological and psychiatric solutions became more widely accepted with endocrinological solutions often discredited, and weight-loss drug advertisements emphasized underlying neuroses as cause for overeating (Rasmussen 2012). In addition, psychology was reshaped between the 1950s, when the goal was to help individuals fit into the norms of society, and the 1960s, where more humanistic approaches in the field pointed to the flaws in society’s definitions of ‘normal’ and a desire for increased self-awareness of one’s own issues (Grogan 2013). Such shift, along with the cultural authority of psychology, perhaps in part accounts for the original psychological focus of the OA program. By the 1970s, the experience of the patient role was validated as a treatment approach (Pierret 1995). Identity-based groups became common, along with an emphasis on lifestyle and health behaviors in the 1980s, with an eye towards the health effects of inequality (Pierret 1995). For example, activists became concerned with minority groups’ lack of access to medical care, often leading to negative health incomes based on gender, sex, socio-economic status and race.

Entering Overeaters Anonymous is not a medical event for participants. They are not asked to see a doctor or fill out paperwork about their health histories. Yet, they enter a realm where they address overeating as a disease. They are also free to create their own explanations for their disease in this space. Arguably, group identity, patient-consumerism, and the rise of the technological age, along with other factors, catapulted health care into the genetic sciences. It should be no surprise, then, that genetic explanations for compulsive overeating were some of
the most popular among participants (addressed in Chapter Five). This phenomenon certainly speaks to the popularity and consumer awareness of genetic technologies. Beginning in the 1990s, genetic profiling was used to understand who was predisposed to what illnesses or diseases (Leichter 1997; Alexander 2011), leading to reformist responses from smokers’ rights advocates and fat acceptance groups who saw this kind of testing as a threat (Leichter 1997).

In her study on women with eating disorders, Easter (2012) investigated the impact of genetics on the stigma of having an eating disorder. She found that 50% of the respondents believed that knowledge of a genetic connection would reduce the stigma, while one-third of respondents believed that such data could create additional stigma. While some respondents believed that a genetic reasoning could make the disease seem more real to those who do not have it, others feared that it would mean a medical oversimplification of the disease or discrimination (Easter 2012). While no gene has been found to cause eating disorders, in the 1990s, there was scientific buzz about the supposed discovery of a fat gene, which was later found to be inaccurate, but which still garnered notable media attention (LeBesco 2009a). Interestingly, a few years before there had been much attention on a so called gay gene that was also discredited; LeBesco (2009a) points to these two media hypes to illustrate how popular culture looks to biotechnology as the new solution to moral disorder, distorting the technology to merely perpetuating old eugenics.

In a similar vein, Boero (2010) found gastric bypass patients are often given genetic reasons for obesity to take blame off of those considering the surgery. However, when the surgery goes awry, patients are often labeled as unwilling to change eating and exercise habits and/or as being an “emotional eater” (Boero 2010: 324), harking back to the old discourse of moral failure and arguably evoking the outdated image of the hysterical, hormonally determined,
and out-of-control female. Genetic arguments, Boero (2012) suggests, have been used by doctors and patients alike to both remove blame and to re-inform moral perceptions of deviance regarding eating and body size. What became clear throughout my research is the range of beliefs participants held about the role genetics had, if any, in their development of compulsive overeating.

For all the diversity that OA members I interviewed had in explanations of their compulsive overeating, Overeaters Anonymous urges individuals to also seek out their commonalities. They articulated their shared commitments to gaining a Higher Power (that could be defined in numerous ways), working the Twelve Steps and Twelve Traditions of the program, and using the program’s tools of recovery. In addition, nearly all individuals took part in certain rituals within OA. I had the privilege of beginning my fieldwork at almost the same moment one of the study participants joined OA, and I was able to witness firsthand the process by which she and I began to pick up on the rituals of language and practice within OA meetings. Rituals within OA are points of bonding among individuals in the program and to the program, and act as points where individuals share commonalities that provide a comfort zone to share individual experiences of their newly recognized disease.

**Ritual and Confession**

When I began my research, I was shocked at how many times several participants would say something at the exact same time, in unison. This section discusses the kinds of rituals I encountered in OA, although I focus on only a small portion to illustrate their nature. In the second half of Chapter Five I address ritual in OA further.
Dubisch (2000) argues that the health food movement can be understood as a kind of new religion in America, where health foods are systems of symbols, and their consumption and the practices that surround their preparation are expressions of a particular worldview. Dubisch (2000) suggests that converts “see their health problems and other dissatisfactions with their lives as stemming from improper diets and living in disharmony with nature” (218). Dubisch observed that certain foods are seen as promoting disease prevention while others are taboo. She notes that written testimonials display the movement’s worldview while also aiming to educate and encourage others to take up the lifestyle, and the movement concerns more than the physical body by claiming to address emotional, spiritual and social problems through diet. In some of these same ways, Overeaters Anonymous can be seen as a system of symbols that advocate a specific worldview. The spiritual program is also laden with rituals particular to OA and to 12-step culture.

Some rituals of the OA meeting are obvious to any newcomer, as all regular members partake in certain activities, either by taking turns reciting prayers or saying phrases in unison. The steps of the program are traditionally read at the beginning of meetings, everyone is meant to introduce themselves with their name followed by “I’m a compulsive overeater,” and the meetings are closed with either the Serenity Prayer¹ or Rozanne’s Prayer², which was written by the founder of OA. Some groups recite certain phrases in unison, particularly after the closing prayer, including popular OA phrases, such as “keep coming back,” “give a lot of love,” and “it

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¹ The Serenity Prayer, written by theologian Reinhold Niebuhr, reads, “God grant me the serenity to accept the things I cannot change; courage to change the things I can; and the Wisdom to know the difference” (oadenver.org).
² Rozanne’s prayer reads, “I put my hand in yours, and together we can do what we could never do alone. No longer is there a sense of hopelessness, no longer must we each depend upon our own unsteady willpower. We are all together now, reaching out our hands for power and strength greater than ours, and as we join hands, we find love and understanding beyond our wildest dreams” (oadenver.org).
works if you work it.” Ritualistic sayings and prayers not only give shape to meetings but emphasize certain aspects of the program and its intended meanings for participants.

Interviews with OA participants highlighted the relevance of ritual in regards to food, recovery habits, and weighing. Participants spoke of abandoning or creating new habits with food, avoiding certain foods while carefully monitoring their intake of others and reporting how they were doing with these foods to their OA sponsors. For every supportive ritual that compulsive overeaters used in the OA program, there was another that they admitted to having regarding food before they came to OA. These ranged from stealing food from convenience stores to ridding the house of food and locking it in the car trunk every night. However, the goal of OA is to get individuals to a sane place with food, and at times participants even acknowledged the seeming paradox inherit in what they did with food in the OA program. In one meeting, an OA member shared how she measured out each and every meal as exactly as possible, rhetorically asking, “Isn’t that crazy?” The rituals built into the program were ones that many of participants found to be rehabilitative, but which might not necessarily be considered healthy for others. Yet, their ritualistic nature is what is essential here, as members replaced old rituals with new ones. Stories of daily or hourly weighing of bodies were common in meetings, as well as efforts to change these habits to strictly monthly weigh-ins.

Hillel Schwartz (1986) points out in her book about the history of dieting and fatness in America, the act of weighing oneself in Western culture has become a weighing of the soul and worth, an act that “demonstrates the measurement of the visible by the invisible” (11). I noticed early on that many OA participants strove to dissociate their worth from their weight, while still maintaining ritualistic patterns of weighing themselves to keep apprised of their success. The OA program used rituals in order to encourage participants to develop certain patterns of behaviors,
believing that OA members would fail to appreciate a Higher Power if not for some set of rituals and symbols that upheld the OA world view. For example, recovery habits also became ritual acts, and they often included daily acts committed alone or in special places, such as meditation or yoga. It became obvious that OA’s ritualization extended well beyond food and consumption, into the everyday activities of OA members.

As my fieldwork continued, I became acutely aware of the role of confession in meetings. Both ritual and confession contributed to the redemptive quality of OA; only by practicing the principles of the program could one achieve abstinence and a connection with a Higher Power. Erving Goffman (1963) notes that the stigmatized individual who joins an identity group based on his stigmatized identity is often told that “if he adopts the right line… (which line depending on who is talking), he will have come to terms with himself and be a whole man” (123). Indeed, the OA program offers its participants saner lives and minds by following the Twelve Steps of the program, which in part aims to offer faith as a cure. However, typical OA meetings—although there are some variations—include time for each individual present to reflect on that meeting’s reading selection, making it hard not to speak about one’s thoughts and feelings during a meeting. Considering that it is assumed that everyone present is there to address their compulsive food behaviors, confession is inevitable. In his series of lectures, *Abnormal*, Foucault (2003) details the history of confession, noting that around 1850 there was a “metamorphosis of a quite positive practice of forced and obligatory confession” (169). This was quite different from previous conceptualizations of confession, which had been non-obligatory or did not include the remission of sins (Foucault 2003). I tie the use of confession into the history of confession written by Michel Foucault (2003) because Alcoholics Anonymous, the original 12-step program, grew out of Christian movements in the early 1900s. I
believe it is no coincidence that confession, a tradition whose roots Foucault traces to medieval-era Christianity but which gained much of its centrality within the religion in later centuries, comes to be a vital part of the ebb and flow of particular OA meetings. In a sense, confession itself becomes a ritual in certain meetings at specific times.

As Foucault says of confessions in the Catholic Church in the 16th century, all of a persons’ “life, thought and action must pass through the filter of confession, if not of course as sin, at least as an element relevant for an examination or analysis now demanded by the confession” (2003: 177). Furthermore, in confession the confessor “must recognize in the sin not only the act committed that breaks the law, but also the kind of illness that is the sin’s raison d’être. He must know the ‘spiritual maladies’ and their ‘causes’ and ‘remedies’” (2003: 179).

Since the 16th century, he argues, confession became not just admission of sexual desires but also the thoughts and pleasures of the body itself, thereby making sin centered on the body and not actions (2003: 186-189).

Thoughts and feelings became worthy of confession, and were often confessed in OA meetings, along with the constant confession of being an “overeater” and attesting to what kinds of rituals and behaviors one engaged in as an overeater. By confessing, individuals subjected themselves to both self-examination and group examination, an act Foucault argues is a technique of discipline in that the individual is evaluated by societal and group surveillance (Foucault 2003; Coveney 2000). Via confession, individuals have the ability to reevaluate their inner and outer experiences within the world through the lens of morality and spirituality, to the point where confession itself becomes ritualistic in working the 12-steps. Coveney (2000) posits that through prayer, self-reflection and confession, individuals believed they were enacting techniques of self-discipline that would elicit a good Christian soul, with a good diet also playing
into these values in Christianity from the 16th century onwards. The concerns with diet and health were historically targeted towards the individual, but also reflected a concern with the construction of the self and the finding of truth (Coveney 2000) through self-examination and confession. Certainly Overeaters Anonymous represents a form of this type of promise of self-transformation, utilizing those same tools as previous embodiments of confession.

In exploring how individuals choose to manage their identities and beings, Nikolas Rose writes that in a consumer age each choice becomes an “emblem of our identity” (1990: 227). Today, confession acts as a way to expose oneself to another person who can sympathize, thus “constitut[ing] oneself” and being a “subject for oneself” to evaluate (Rose 1990: 240). This type of self-government, Rose suggests, became a means for individuals to narrate their lives openly, focusing specifically on their life events, emotions, relationships and actions. When participants work the entire 12-steps, they are meant to have examined and confessed to God and to at least one other person their moral faults and mistakes (www.oa.org; “Twelve Steps”). For example, the 12th step of OA encourages recovering compulsive overeaters to share the OA program with other compulsive overeaters, thus in part asking them to be quite open about their own identities as compulsive overeaters. In a small way, these acts are part of embodying the confession.

Rose (1990) hits the nail on the head when he states that the liberated self “is obliged to live its life tied to the project of its own identity” (254). While those who have reached the 12th step may have gained some sanity and perspective, the program views compulsive overeating as a chronic disease, necessitating members to continue to come to meetings, re-work the steps, and spread the message. However inevitable confession may be in OA, I was drawn to this topic because of the distinct patterns in which confession occurred during meetings, a point I will examine later using both my fieldwork and interview data.
A majority of interview participants and OA participants in my study were female, in a world where females are primarily affected by eating disorders and where the confession of these disorders is extremely taboo. I questioned the OA program’s ability to empower female members when a mode through which the group operated was through confession. It seemed to me that a key aspect of confession was that the speaker made herself vulnerable to the listener(s), and while this certainly did happen in meetings, I wondered if these women ever received any sense of accomplishment, pride or empowerment from the admission, and if so, where did this feeling come from? In addition, I wondered about the lack of other factors of diversity in OA meetings, including the lack of youth in the program. I turn next to the question of women and youth in 12-step culture.

Gender and Age in the OA Program

I was not sure what to expect when I attended my first OA meeting. I suspected that a majority of the members would be women, but I could not predict what age the majority of participants would be, whether or not they would be primarily steadfastly religious or atheist, or if they really would identify more with overeating rather than starving and purging food. The pattern across all groups I originally proposed in my research was that OA, as an organization, would be made up of mostly female members. According to the 2010 Membership Survey, 87% of members surveyed were female (www.oa.org). While people certainly came and went during my seven months of fieldwork, in the two groups I observed I saw four men and twenty females, and only one male consistently attended the meetings in which I was present. My interest in OA was prompted when I started to study how fatness has been treated within American culture and American law, particularly with an eye towards female fatness. Therefore, my interest in feminist perspectives in the OA program is no surprise.
As discussed in the literature review, Lester’s (1999) feminist critique of OA asserts that by ignoring the relation between women’s bodies and eating disorders, OA effectively upholds a status quo of double standards surrounding gender and fails address the problems that women experience at the intersection of their womanhood and disordered eating. In addition, Lester argues that the OA program forces OA participants, who are disproportionately women, to admit powerlessness over food, therefore stripping their ability to resist disordered eating in empowering or positive ways; instead, the program encourages women to submit to a Higher Power. Understanding feminist criticisms of the OA program begins with understanding the relations among womanhood, religion/spirituality, addiction, and food. Due to the pressure on women to maintain certain types of bodies, fat women in particular may choose to consume food in private, making food illicit for females “engaging in a shameful perversion” (Millman 2012: 174). This description paints food as deviant and even similar to an illicit drug. For example, Kandall (1996) notes that upper- and middle-class females historically have been allowed certain substances to medicate, from opiates and cocaine in the 19th century to herbal alternative treatments in modern times. Historically women have been overmedicated by doctors, have had their use of addictive substances tied to their sexuality, and have been often blamed for their own drug use while also being responsible for their children’s use of medications and addictive substances (Kandall 2012). All in all, women have been asked to walk various fine lines around substance use and abuse with few judgment-free sources of recovery (Kandall 2012). Women today could be understood to face this same need for finesse and lack of freedom around consumption when it comes to food. Food is increasingly imbued with values of good/bad, right/wrong, healthy/unhealthy, and women are primary targets onto which these values are projected once they prepare or consume the food.
I am interested in how women navigate two different conceptions of food: 1. that food is a drug at the same that time they need food to survive and 2. that women are generally the ones preparing food for their families yet they try to avoid consuming it themselves (Dr. Rachel Jones, pseudonym, personal communication). What sort of empowerment, if any, does the OA program give these women? Do women question whether or not the program has their best interests in mind?

More work has been done to answer questions like these about participants in AA. While AA was originally designed as a male-only organization, that slowly changed from the 1940s until the 1970s, when feminist consciousness led to some female-only groups, with most other AA groups opening up to females (Sanders 2009). This 1970s boom was one of the many products of the women’s health movement, which helped to shape public consciousness about women’s health issues, and included reforms on the treatment of drugs, midwifery, and alternative and complementary therapies (Ruzek 2012). This movement also aimed to give more lay access to medical information (Ruzek 2012). At this time, many feminists asserted that it was simply not possible for AA to be an apolitical organization, and that if AA was choosing not to be actively feminist than they were upholding a patriarchal status quo (Sanders 2009). In addition, some feminists believed that the 12-steps were anti-feminist in that they reinforced gender roles by asking members to submit to a supposedly male God. Some of these advocates still urge women to attempt a feminist movement within the 12-steps by creating their own groups or starting a discussion about the gendered nature of God in the program (Sanders 2009). While beyond the scope of this discussion, Sanders’ eventual conclusion from her research on women in AA groups is that women empower themselves within the AA program (Sanders 2009).
The relations among God, women and eating over time are intriguing. Women who starved themselves in Medieval Europe were sometimes regarded as saints. Brumberg (2000) writes that women who went without food from 1200-1500 were seen as committing a “female miracle” (42). Catherine de Siena, who died in 1380, was a saint who was said to have survived on herbs and would often purge what little she ate. Other 13th century holy figures were said to have vomited at the smell of food, or to have avoided seeing food. Similar attitudes were not mentioned about male saints. Such tales allowed female fasting to become synonymous with holiness and of taking only the body and blood of Christ as sustenance. At the same time, medieval European culture associated women’s bodies with food. Brumberg (2000) writes, “mystical women exuded oil from their fingertips, lactated even though they were virgins, and cured disease with the touch of their saliva” (47). I do not mean to suggest that OA participants engaged in fasting or purging rituals in order to attain spirituality, but want to point to the historical patterns at play and suggest that the OA program is another way for women to use food and their bodies as symbolic language. I approached my interviewees with questions about their opinions on the language of the OA program, but I avoided asking individuals whether or not they believed the OA program was feminist because I wanted to see if feminist viewpoints would come out in the interviews.

The connection of women with spiritual or religious values makes sense given the fact that in more recent polls women have been found to be more religiously observant than their male counterparts, particular women of the baby boomer generation (Fowler et al. 2010). As women become more active religious and political participants, they have continued to form groups that speak more directly to human needs such as eco-feminism, a spiritual philosophy that highlights community and the hierarchical control of nature seen in patriarchal societies (Fowler
et al. 2010). The rise in popularity of alternative and complementary medicines, which includes prayer and meditation, also points to why OA might garner particular attention from women. Women see this as a way to avoid medicalization that has previously been a source of repression (Badaracco 2007). Of course, the popularity of alternative and complementary medicine has been aided by the simultaneous rise of and commercialization of the self-help industry, with women being the majority consumers (Simonds 1992).

Wendy Simonds’ (1992) study of the self-help reading habits of thirty women suggests that women use self-help books to gain a sense of identity and to strike a balance between their notions of self and other. In a culture where women are expected to care for others, self-help books allow them to indulge themselves and work on their sense of self. Simonds’ (1992) interviews suggest that women read self-help books because they feel that books hold a key to self-improvement or something sacred. According to Simonds’ (1992) research, these women believed that the authors were knowledgeable and trustworthy. One-sixth of Simonds’ participants read religious self-help books, with the same amount reading New Age books. Overall, Simonds’ research suggests that women consume self-help books sometimes looking for religious help, but most of all looking for direction in their lives. Yet, the consumption of self-help material on the individual level speaks to a lack of collective and community organizing around women’s issues. Again, OA may be seen as an organization that promoted women’s empowerment because much of its membership is female and they often discuss what might be considered largely women’s issues. On the other hand, 12-steps organizations, as Rapping (1996) argues, ignore the developments of second wave feminism, which in part advocates that women should examine *de facto* inequalities in their lives and challenge these disadvantages and double standards. Rapping (1996) asks if by encouraging members to examine their own lives and
blame themselves for their life problems, do 12-step programs risk erasing the social context of suffering? I entered my fieldwork with this question as a final point of inquiry.

Most participants in OA groups I observed and all interview participants in this project were well into their adulthood. The youngest interview participant was fifty-two years of age. Where were all the young people? While this was obvious to me at the beginning of my fieldwork, I soon became used to the groups, to the familiar faces, and felt comfortable in their presence even though most were much older than me. Where were all the young people with eating disorders? Anorexia, bulimia, and overeating are common among younger populations, and I knew that many of my closest friends and peers struggled with under eating, over-exercising, and poor body image.

In part, the age gap was a reflection of my sample. The 2010 Membership Survey Report demonstrates that 2% of OA members are 18 or under, 14% are ages 19-25, 27% are ages 26-35, and 27% are ages 36-45. Additionally, 18% are 46-55, 11% are 56-65, and 1% are 65 and over. The two groups in my study fell primarily into the second-to-last and last age ranges. The age distribution of these populations were not proportional to groups in the rest of the country, although it must be taken into account that perhaps the 2010 Membership Survey was distributed in such a way that it was not as accessible to older populations. The differences between age profiles in the two groups was interesting on a local-culture level, as there was an abundance of college students in the geographic area of my study, yet they were attending OA meetings disproportionately when compared to these national statistics. A second perspective is that younger populations are choosing to take their recovery elsewhere. Perhaps they see therapists, nutritionists, and doctors or go to rehabilitation programs and clinics. Perhaps they don’t view
their experiences with food to be eating disorders, a perspective that I believe is well-worth exploring as a cultural phenomenon, but beyond the scope of this paper.

**Summary**

Medicalization, ritual and confession, and women’s experiences were important areas of interest for me before I began my interviews with participants. What became evident over time was the fact that many of participants in my study were aware of or concerned with these components of the OA program. In part, my ethnographic work is designed to highlight and explicate their viewpoints and concerns, and situate them within the context of the OA program and the histories presented here.
Chapter IV
Field sites and the Research Design

This chapter details my two Overeaters Anonymous meetings sites were chosen in which to observe meetings, and from these groups 10 participants agreed to be interviewed. In this chapter, the format of meetings and the field site spaces where participants engaged in OA recovery are described to frame the patterns and nuances of meetings. Points of interest for the ethnographic researcher are set out to clarify my role as a participant-observer in a 12-step setting, focusing on some of the ethical and moral boundaries I encountered while conducting this field research. I address my roles as a researcher engaged as an observer with key aspects of the OA program and the ways in which OA members understood my role. Interview questions I asked and rationales for choosing these questions are addressed as are my concerns encountered through conducting ethnographic research in a 12-step setting. These struggles of working as a participant-observer and conducting interviews with group members reveal important aspects of the OA program and OA culture.

In my time doing fieldwork, I found that while OA groups have different formats, OA meetings have many similarities. A typical OA meeting consists of opening with the Serenity Prayer, then members take turns reading aloud passages from an AA or OA text (recall that OA uses some of the literature from AA, including Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism (1939), often referred to as “The Big Book”). Usually the reading of passages will be followed by time for each member to share about their experiences with compulsive overeating, after which participants close the

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3 While my two field site meetings had some similarities and differences, radical differences between ‘sects’ of the OA program will be discussed in Chapter 7.
meeting with a prayer; at some point during the meeting, members pass around a phone book to write down their contact information, are solicited for a suggested donation of $2 or more to help pay for room rental and literature, and share about upcoming events or openings in program volunteer positions. A final important commonality with all OA groups is that OA is a democracy. A group conscience is necessary for all decisions in OA, and even newcomers have the right to vote for measures in business meetings. However, each meeting has its own style and format, and therefore it is important that I detail the two field sites used in this research.

Field Sites

At one site, the OA group meets once a week in the mid-mornings in a community building in a small New England town named here by the pseudonym Bridgeton (and I refer to this meeting as the ‘Bridgeton meeting’). In front of the meeting room is a community bulletin board with data compiled by the area library regarding the years houses in the town were built along with maps of the town. The entry to the meeting room is through a set of heavy wooden double doors. The meeting room has mustard and sunshine-colored walls. The air in the room is always brisk and cool, a blessing during the humid summer months but in the winter, many members wear jackets throughout the meeting.

The left wall of the meeting room has two metal and glass exit doors that are sometimes propped open during meetings to let in fresh air and sunshine. These doors face the parking lot, which is huge and usually fairly empty, even when the room feels full during meetings. Against the left wall are seven stacks of green chairs, each four or five chairs high, and an American flag and state flag. A piano, platform TV and projector occupy the wall in the front of the room. Large tables line the right side of the room along with doors to a number of wide closets. The group keeps all the OA-approved literature and everything else necessary to run the meeting in
these closets including a collection basket, a watch to time speakers, and a notebook where members write their phone numbers. Near the end of the right wall is a small kitchen area with a mini-fridge, microwave and an empty coffee pot. Participants sit on chairs around four large rectangular metal tables put together in the center of the room. No food is visible in the room, not even Splenda™ packets by the coffee pot. The room feels spacious, and participants usually spread out their chairs and sometimes go for walks outside during the writing/meditation part of the meeting.

The Bridgeton meeting follows the same format each week. Members take turns reading a chapter in the *Overeater’s Anonymous Twelve Steps and Twelve Traditions* (1990) book, often referred to as the ‘*Twelve and Twelve*.’ In this text, each chapter addresses one of the steps. One step is read each week, and the group reads the Steps in order unless there is a newcomer present, in which case the group has agreed that Step One should be read instead of the planned step. Over the course of 12 meetings, all the chapters for the twelve steps will be read. At each meeting, members are asked to write for ten minutes on a question from *The Twelve-Step Workbook for Overeaters Anonymous* (1993) that is relevant to the Step that was just read. This reading and writing period usually takes ten minutes, after which members share what they wrote or share some experiences, usually having to do with compulsive overeating or other struggles. The 13th meeting, or ‘week thirteen,’ is a speaker meeting, when either a person from the group or an OA member who usually attends another OA meeting somewhere speaks about their experience and growth in the OA program. Usually someone from the group volunteers to find a meeting speaker.

The second field site was a modest-sized church, in a town here given the pseudonym Franklin (referred to as the ‘Franklin meeting’). In front of the church is a small town common.
The meeting room is full of green and red chairs and a long couch of muted green, gold and maroon. Above the couch is a watercolor painting of a church in a field of trees. The right wall houses a large fireplace and a grandfather clock. Along the back wall is a basket of knit shawls and a china cabinet with a few plates and other knick-knack type items. The right wall only has a small table which the OA group uses to place their boxes of materials. The front wall has the couch against it and a few side tables with plain lamps with white shades. The couch and chairs are placed around a dark brown coffee table, which holds the relevant literature for the meeting and is often also used as a place for people to put their monetary contributions to the OA program. Again, the room is devoid of food, but it is not uncommon for participants in this meeting to bring water bottles.

This meeting has a slightly different format from the Bridgeton meetings. Each week, a group member reads from a particular source depending on the week of the month (the group has a four week rotation for literature selections, while the Bridgeton meeting has a 13 week rotation). Week one is a step from the *Twelve and Twelve* (1990). Other weeks include reading from *The Big Book*, reading the tradition of the month from the *Twelve and Twelve*, reading excerpts from the *Lifeline Sampler* (1995), a book which includes short narratives originally published in the Overeater’s Anonymous *Lifeline* magazine, or reading from the text *Abstinence, 2nd Edition: Members of Overeaters Anonymous Share Their Experience, Strength and Hope* (1994). The narratives cover topics relevant to OA including weight, relationships, and the steps and traditions. This group occasionally has a speaker meeting as well, and the meeting is held in the same way, with speakers talking about their experience in OA thus far with enough time left in the meeting for other members to respond to this person’s story in relation to their own experiences. Both groups hold a business meeting once a month to take stock of literature and
the treasury, and also to announce any necessary Overeater’s Anonymous Intergroup messages, which are reported by the Intergroup representative, a group member who attends Intergroup meetings. When the groups have a business meeting, the regular OA meeting closes early and most members choose to stay in order to vote on various proposals. Business meetings have their own designated format, and orders of business can be brought up by any members.

Interview participants and their OA experiences are given in the next chapter to acquaint the reader with examples of what OA members mean by ‘compulsive overeating’ and ‘recovery’ in the program. First, I address my role as an ethnographic researcher working within a recovery setting.

Research Plan and Demographics

I applied for and received IRB approval from my institution in late May, and from June 1st to December 9th I attended two OA meetings each week, taking field notes after each meeting on themes of the meeting and questions raised from my observations, I observed fifty OA meetings. For those meetings I attended, the Bridgeton meeting had an average of 6.4 women and 1 man in attendance, and the Franklin meeting had an average of 7.4 women and 0.5 men. I encountered many more female than male newcomers, with females being more likely to attend both in the Bridgeton and Franklin meetings and being more likely to return for a second time to either group.

My role in the OA groups is important to understand in order to establish how I negotiated conducting participant-observations, particularly given the private nature of 12-step meetings. I established myself as a participant-observer four months before I began interviews with participants in late September of 2013. Thus, interviewees were familiar with me and my role in the groups by the time I interviewed them. That role is described fully in the next section.
Role of the Ethnographer in a 12-Step Culture

When I attended my first Overeater’s Anonymous meeting I was unsure of what to expect and knew very little about the OA program. In fact, I made the most common newcomer mistake; I walked into the room, approached the one woman who was setting up and asked if she was the one who “ran” this OA meeting. She gently informed me that OA was a democracy and that no one runs OA meetings; instead members propose and vote on all measures. I was admittedly relieved. As a first-time ethnographer emerging from a series of college courses that stressed researcher ethics and responsibility, I was concerned about how my potential research could fit into the 12-step culture of anonymity, personal recovery and, to some extent, secrecy. I also had the growing suspicion that there was culturally something very important happening in these meetings. The opportunity to make a case for my research to the entire group, as opposed to having to go through one person who made the decision for all members, relieved many of my concerns about the ethics of permission. However, I would soon witness how my research brought into question the democratic structure of these OA groups.

I originally proposed my work to four OA groups, attending one meeting at each and then learning when the next business meeting was. I then attended the business meetings to bring up my research as an order of business. For the two groups I would eventually work with, there were few concerns and questions about my potential role, and each gave a unanimous vote to allow me to attend meetings and conduct research. My proposals created an interesting dilemma in the groups, as members openly questioned each other about what democracy means in the context of OA. Was a majority vote enough to permit me to conduct observations? If one member dissented, was that grounds to reject my request on the basis of that member’s need for recovery? What if members who had attended the last few meetings were not present the day of
the vote? These questions were posed during the business meetings, and were often sources of concern for members attending. It became clear that even OA members did not fully understand what democracy meant within their groups. In this way, my research not only questioned the politics of OA within the groups but also highlighted the fluid nature of groups, where newcomers and experienced members would come and go without notice. But all members would have to live with decisions made at previous meetings. The fact that the vote was unanimous in the two groups who accepted my research certainly made my thesis possible. For those members who were not present during those meetings, I requested their permission when they did attend a meeting, and explained my research and role within the group before obtaining verbal consent. I went through the same conversation with newcomers. All of these individuals consented to participate in this research.

It was essential to many members of the two groups I was observing that I abide as strictly as I could to the OA closing statement, “Please remember our commitment to honor each other’s anonymity. ‘What you hear here, whom you see here, when you leave here, let it stay here.’” (oa.org). For this reason, I chose to significantly alter or exclude exact details from my field notes unless the same or similar comments were made by multiple members, opting instead to focus on the broad themes and concerns of the OA program in an effort to both protect the experiences shared in meetings but not necessarily with me during taped interviews, and also to go beyond the experiences of single individuals shared in meetings to see patterns amongst the entire group.

Interviewees were a rich source of life events and anecdotes about their time with compulsive overeating and in recovery, so being able to focus on similarities amongst participants and between groups strengthened my ability to look at detailed accounts and the
bigger picture. Thus, I have used interview data for the more in-depth analysis of the causes and effects of compulsive overeating as participants understand and experience them.

As an observer in OA meetings, I was met with a number of ethical dilemmas. I debated how I should act and observe in meetings. I was willing to share my own experiences with eating and weight loss, but I simply did not have many of the kind of life experiences that most participants reported they had. For example, I will later discuss the prevalence of past traumatic experiences among participants, and how these individuals felt these histories related to their development of compulsive overeating. I also lacked an upbringing that included or purposefully excluded a spiritual figure in any way, shape or form. However, most of the participants in this research spoke of having some relation, either positive or negative, with God or spirituality. It was not just the experiences of marriage, divorce, children, and other life events that participants often spoke about in relation to their compulsive overeating that I didn’t have, but also some life-defining experiences. While there were periods in my life when I struggled with food and eating the appropriate amount for my body, I was missing some key intersections that I saw in my data. I questioned whether or not compulsive overeating should be considered a disease. I questioned if spirituality was the answer to cure that disease, especially as I have been a life-long atheist with no claims to either spiritual or religious experiences. I wondered just how much of myself I could offer to participants, especially when my own identity made me reluctant to accept many of the essential components of the OA program. Although I was amazed at the recovery conveyed in meetings and during interviews, I did not fear ‘going native,’ as is the typical struggle of the anthropologist, but instead wondered how I could give back to OA while still being genuine. Although it would take me months to become fully comfortable in the role of the ethnographer (it took me a month to write a single field note, because I was so concerned with
protecting everyone’s identity), I came to understand that I did not have to agree or disagree with any aspect of the OA program in order to be present and observe meaningfully. I have a firm retrospective belief that it does not matter if compulsive overeating is or is not a disease, but instead that my participants experienced it as such and, as a result, had unique explanations for where it came from and what they could do to recover. I had great respect for the recovery I saw, and I was able to contribute my own experiences and life struggles in meetings. Sometimes I was thanked for sharing what I said, and other times I thanked participants.

I settled on being present in meetings by responding to questions and readings presented in OA meetings in ways that let participants get to know me better. While I wanted to make it clear I was doing research, I also wanted to be careful not to disrupt the flow of meetings or constantly remind participants that I was there to observe. I spoke of my life history, my family, my school life and classes, and occasionally problems I was having. While my responses rarely had much to do with food or eating, I sometimes talked about my experiences with weight loss and the dieting industry. I tried to let participants get to know me without changing the flow of the conversation or the topic at hand. While I desired to contribute in productive ways, I also feared affecting the kinds of responses members made after I spoke, so often I stuck to the subject at hand to the best of my ability.

My behavior in meetings might have been viewed as different from regular members in other ways, as well. For example, an essential part of the OA program is the phone book that is passed around each meeting. At first, I included my phone number in the book, but I was unsure of how I should approach the situation. I wondered if giving out my phone number was too informal, or if a newcomer would take it and call me for advice about the program when I could really give none. Only a few individuals ever called me from OA meetings; they were all
experienced members of the program who wanted to check-in about my research and see how it was going. Sometimes, they did not even bring up my research, but instead were just interested in how I was doing for that day. I began to realize that phone conversations from OA members were causal, often short, and more about how a person was doing in the moment than about addressing life or eating issues. Phone calls were also a way that individuals in the group expressed interest in and compassion for one another. Although initially I was startled that I was being contacted, I came to understand that phone calls were a sign of acceptance and recognition within the OA community. While I would later start to give out my email address instead of my phone number, as this was a much better way for me to respond in a timely manner, I was unconcerned when members asked for my number.

Another issue of my role as participant-observer was the expectation that sponsorship is key for being in the program. The OA literature reads, “sponsors are OA members who are living the Twelve Steps and Twelve Traditions to the best of their ability” (oa.org). Sponsors share their experiences and recovery with their sponsors, typically outside of OA meetings. Part of giving service in OA is being a sponsor. I found that participants at times forgot that I was in a research role--at which point I politely reminded them. I was flustered about how to respond and quickly re-explained my role as a researcher. Over time I came to understand these offers as signs that OA members accepted my company or maybe even just liked me as a person. I realized that by offering to be my sponsors, OA members were coming from a place of vulnerability. They were offering to be quite open with me about their recovery and working the steps. Having someone ask to sponsor you rather than asking someone to sponsor you, was in some respects a compliment.
It took me a while to adjust to how some of the normal boundaries of society are stretched in OA meetings. Over the course of my fieldwork there were four or five instances when members fifty years of age or older solicited me for advice on social situations. For me, this was an odd experience. My inclination is to look to older generations for advice and not vice-versa, particularly for issues about relationships in home life or the workplace. Perhaps they were asking me as anthropologist or as an equal participant in the meeting or as a neutral third party, but I wasn’t certain. These moments, which I consider to be one of the many products of OA’s lack of leadership culture, demonstrate how cultural hierarchies are broken down for brief moments in the name of recovery.

I struggled initially with how best to show my appreciation to the OA groups’ participation in my research. I could not offer them myself as a member of OA, nor could I be a sponsor or confidante. At times I was saddened that I had met some of these individuals in my role as ethnographer, as I was sure that in another context and another time we would have become friends. Part of this feeling should be rightly attributed to the 12-step culture, as the type of vulnerability that occurs within 12-step meetings simply does not happen in many other places. One participant, Joyce, put it perfectly when she said,

If I have the kinds of conversations or the kinds of sharing, if you had that intimacy, that level of intimacy that we have in meetings with anybody outside of a meeting, you would feel like you had to call them the next day. You would feel compelled to follow-up…

(Joyce)

What occurs in 12-steps meetings is a kind of intimacy that does not regularly happen outside of meetings, but these are normal and every day events in those spaces. In the process of conducting research, I became a quasi-actor within the community. I was able to blend in while
negotiating the boundaries of my research. I chose to give service by helping to set up meetings, volunteering to read, and at times reading the script for meetings when no one else wanted to lead. In these ways, I found modes of participation that intruded the least upon the flow and content of meetings without announcing my differentiation from everyone else present.

**Interview Questions**

The interview questions (Appendix D, and below) were borrowed primarily from or inspired by Arthur Kleinman’s (1980) questions for cross-cultural medical encounters. Kleinman’s questions are open-ended and allowed me to use follow-up questions to clarify participants’ often broad responses. I began interviews by telling participants, “I’m going to ask you some questions about eating, food and overeating, okay?” After getting verbal consent, I asked the following questions, with Kleinman’s questions shown in bold type. Some have been slightly modified for clarification:

*What do you call the problem you experience (with food)?*

*What has been your life history in regards to food?*

*Can you pinpoint when your problem with food may have started or gotten worse?*

*What do you think may have caused your problem with food?*

*Why do you think it started when it did?*

*What do you think the sickness (disease) does? How did it work?*

*What kind of treatments have you tried for the disease/eating problem?*

*What are the chief problems the disease/eating problem has caused for you?*

*What do you fear most about this disease/eating problem?*
Did you try any other solutions to your eating problem before attending an OA meeting?

After going through those questions, I asked participants’ permission to ask about their experience in the OA program. These questions reflected a desire to understand better the interviewees’ experiences with recovery rather than disease. Once I received verbal consent, I asked the following questions:

What made you decide to come to OA?

What was your first OA meeting like?

How long have you participated in Overeater’s Anonymous?

How would you describe your relationship with Overeater’s Anonymous?

How has your relationship with food changed since you started the program?

How did you feel about the OA program when you first joined? How do you feel about it now?

What are the most important results you hope to see in OA?

Are there any parts of the OA program that have proved particularly difficult for you?

How have you felt about the use of religious language in the OA program?

Did you have a Higher Power before entering the program?

How do you define Higher Power now?

If relevant: What has having a Higher Power done for you?

How has being in the OA program changed parts of you beyond your eating habits?

What has been the most important aspect of recovery to you? Do you think OA provides this, and how so?
These questions allowed me to understand participants’ experiences both with compulsive overeating and with recovery; I especially wanted to understand ways in which participants used the disease narrative provided in OA to interpret their time in OA as recovery. I wanted to give credence to those participants who were fully dedicated to the OA message or were questioning it; and the participants did both. For this reason, I tried to ask questions that were as open-ended as possible.

In retrospect I recognize two limitations in my methodology. First, the order of my questions could potentially be viewed as encouraging participants to want to seem as though they have gained recovery in the OA program by beginning with their past selves and moving forward. Although this is an instinctive strategy, I question if this method would have encouraged participants to emphasize growth over time. In addition, I believe that some of my questions may have been too narrow; broader questions that place fewer quantifiers may have prompted a broader range of responses. For example, it might have been beneficial to say “tell me about your experiences in OA” instead of inquiring about their first meetings, relationship with OA and food, and feelings about the program. In this way, participants could have chosen what was important to them about the OA program. Despite these limitations, I believe that my questions elicited valuable data about my participants’ experiences with compulsive overeating and recovery.
Chapter V
Compulsive Overeating and the OA Program

I am interested in understanding how OA participants apply the disease narrative to their lives and therefore re-conceptualized their experiences with food as either diseased or healthy behavior. How did participants’ narratives hint at a time when they did not understand their eating behavior as ‘diseased,’ and how did they now understand their eating behaviors in recovery? Furthermore, I wanted to understand how participants viewed the OA program as helping them with aspects of their lives and being. This section documents general sentiments of participants about how they came to consider OA and find recovery in the program.

Interviewees

From the two groups I interviewed ten individuals, with a few of these individuals regularly attending both groups’ meetings. Nine of the ten interviewees were female. The average age of interviewees was sixty-three, and I believe that this age was representative of the average age of the group members in my two field site meetings, although I did not collect the ages of all those individuals. Nine out of ten interview participants described themselves as white collar, with all of interview participants claiming to have some level of higher education, such as a B.A., B.S., M.A., or trade certifications. In addition, interview participants had an average of 13.9 years in the OA program, ranging from 8 months to 37 years. On average, interview participants attended two OA meetings a week, with most attending between 1-3 OA meetings. One interview participant attends an OA meeting every day, while some other participants that used to attend 4 or more a week when they first joined noted that now they find one meeting a week to be
sufficient. Seven interview participants mentioned attending other 12-step meetings, a detail that I did not solicit from participants but was often openly told during the interview process. These individuals typically attended Alcoholics Anonymous, Al-Anon, a 12-step for family and friends of alcoholics, or Co-dependents’ Anonymous (CoDA) meetings.

Participants engaged in service for OA in a number of ways, including being group treasurer, being the literature person, leading meetings, sponsoring individuals, making OA materials to give to OA members and friends, making phone calls to OA members or newcomers, being a 13th week meeting speaker, conducting public outreach by giving OA literature to doctors’ and therapists’ offices, and participating at the intergroup and sometimes the regional level of OA by being a group representative for their hometown groups.

Before attending OA, most participants reported that they tried a variety of other methods to address their overeating, including diet pills, commercial diet clubs like Weight Watchers and TOPS, fasting, over-exercising, meditation and yoga, and other 12-step groups like Food Addicts Anonymous. All participants claimed to have stopped using these methods, with the exception of meditation, when they entered the OA program. Finally, interview participants typically attended meetings in the areas in which they lived but were diligent in attending new meetings when they travelled, even if only for a week or less. While forty percent of participants had only attended meetings in Massachusetts, the remaining sixty percent had attended meetings in other New England or Mid-Atlantic states. Of these, fifty percent had attended meetings in the South, Mid-West or on the Western coast of the U.S., and one-third had attended 12-step meetings in international locations. One member even was helping to found a meeting in Southeast Asia, where AA meetings are already held but where OA meetings have not been previously well-established.
It was evident during my research that many participants in the two field sites had been in program for a number of years and dedicated a considerable amount of service to the program and were knowledgeable about the beliefs that the OA program promoted. However, little seemed to vary in relationship to time and commitment in the program, except that those participants who had participated in OA the longest (10+ years) seemed the most versed in the program and its literature. The following sections explore how participants conceptualized these beliefs in their lives, specifically the beliefs that compulsive overeating is a disease and that the OA program was the only appropriate way to manage the disease.

The Formation of the Disease

*Compulsive overeating is an entity. It takes over. It comes in and it looks like, it looks real pretty. There’s something about [compulsive overeating] that extinguishes it, that kills me if I just keep doing it... It was a way to hurt myself.*

*(Diane)*

When asked what they experience with food, all participants said that they *have* (rather than *are*) compulsive overeating, indicating that even in abstinence they are still diseased. I want to stress that in general, and in line with the OA program, participants believed their disease caused their diseased behavior and that their diseased behavior was cause for the disease. In other words, my attempts to define the disease were complicated because participants understood the disease to have a cyclical nature. This complication was added to the variety of eating disordered behaviors and issues of identify that became apparent in interviews with participants. For example, two participants said that they had also struggled with anorexia or bulimia at some point in their lives (*Eliza, Diane*). In addition, some participants also stressed that they did not
want to be identified as the disease, but instead aimed to identify with the disease. Adding to ‘compulsive overeater,’ two participants also labeled themselves as sugar-addicted or as food addicts (Meredith, Diane, Gloria). Most participants suggested that they were particularly addicted to foods with sugar and refined flours, although other foods were mentioned as problematic, including nut butters and dried fruit. The exact nature and causality of the disease for each participant was unique, as was how that participant chose to identify within the program, making OA a complex site for ethnographic inquiry.

Most participants recognized retrospectively an awareness of compulsive overeating or obsession with food in their childhoods. One participant attested that she “always liked to eat... always found comfort in food” (Kelly), while another recalled having the feeling that she needed to guard her food from siblings who were in the habit of eating off of others’ plates (Joyce). Those individuals who discussed childhood issues with overeating often also connected these experiences with being bullied or teased by others from a young age (Kelly), particularly for being skinny (Joyce, Gloria). “I was mocked a great deal as a child for being so skinny... there was always this sort of anxiety attached to that. [I thought,] ‘Oh, [my eating] will catch up with me--I better eat while I can,’” (Joyce). Kelly discussed how daydreaming about food served as an escape from the stresses of going to a Catholic school where she experienced bullying from both the nuns and her peers, claiming that in this daydream “the food was protecting me.”

Other participants understood their compulsive overeating as having to do with the ties between food and tradition in their families. While some individuals grew up with food rituals (discussed in Chapter 7), others simply associated food with the best and worst of times. Meredith summed up this sentiment well: “I would eat when I was bored, eat when I was upset in some way or another, eat to celebrate... Food was just a central part of life... I think I became
addicted to sugar when I was a child” (Meredith). Those individuals who associated food with family togetherness, or comfort from lack thereof, often attested to having experiences with addiction to foods during their childhood (Gloria, Diane, Joyce).

However, other participants said they developed compulsive overeating during their teens and twenties. The life stresses of college and being away from home were also common pivotal moments in the formation of compulsive overeating for some participants. Eliza explained that for her, compulsive overeating started early, with a particular mode of remembering “childhood events by food.” However, she notes, it wasn’t until her college years when she was out of the house that she was “seriously on [an] eating and binging journey” (Eliza). While some of the habits around food were there for Eliza from childhood, these behaviors were exacerbated later in life. Similarly, Robin noted that while sugar was always an issue for her, she remembers “in college not eating anything but sugar... or I’d go from sugar to salt cravings and just eat sugar and salt all day long, or as much as I could.” Tracy spoke of the formation of “an abnormal interest in food” when she was fourteen that led to “incremental weight gains” and “a noted marked loss of interest in life, which had then been replaced by a greater interest in eating.” A smaller number of participants ate compulsively starting in adulthood. Jaime’s compulsive overeating did not start until he was in his mid-thirties. For Jaime, food was a “pacifier, [a way] to avoid life, to avoid myself,” but also a response to personal traumatic experiences, a common theme I found among several participants.

The Effects of Compulsive Overeating

I’ll go, oh, oh, that’s right, I’m addicted to trail mix, I’m powerless over trail mix, I’m not going to buy it again. I’ll take it and throw it outside so the squirrels can eat it. And two weeks later, I forget. There’s a lot of amnesia that goes on with this. I forget.
For most participants, overeating was not a problem at first but grew to be a way of life. It was only in retrospect that they began to consider their overeating to be an issue and, often after joining OA, as a disease. Some participants responded to the question “What effects has compulsive overeating had on your life?” by using the three-legged stool metaphor of OA to address the physical, emotional/mental, and spiritual problems the disease caused them. While two participants felt that they got away relatively unscathed from weight issues despite overeating, other participants focused mainly on the negative effects of carrying ‘extra’ weight and being heavier because of their compulsive overeating. Some participants cited years of pain from just walking or about gaining weight to the point of discomfort. For Eliza, a major source of physical pain was the dental work she had to endure including “numerous cavities, lost... teeth, [and] crowns [and] bridges,” all of which she contributes to being sugar-addicted, in addition to having digestive issues that were exacerbated by compulsive over- and under-eating. Other participants mentioned struggling with heartburn, having to try elimination diets because of digestive sensitivities, having to deal with excess skin after dramatic weight loss, high blood pressure, and various health conditions relating to obesity. Few participants reached a point of severe under- or over-nutrition that was recognized by doctors to be an immediate health concern; instead most came to the conclusion that their eating was a problem on their own. A particularly captivating anecdote that displays this is Diane’s narrative of her struggle with bulimia:

*I’ve had periods in my life where I’ve been anorexic, mostly in high school. And I find it interesting when I think back on that time in my life in high school. I was in high school when Twiggy was the model, she was the thing to be, to look like, and so I wanted to be a Twiggy. I*
didn’t have any idea how to eat properly, how to have the right amounts of nutrition, so I just didn’t eat. And this went on for quite a while, and what happened was my thyroid shut down and I started to lose my hair. My body was reacting of course, I was starving my body. I remember going to the doctor and no one could figure out what was happening to me. They did all these tests and nothing showed up, and no one ever asked me about my nutrition. I think there was something inside me that said you know, ‘you’ve got to start eating because you’re really sick.’ So I did, and it seemed to take care of itself.

(Diane)

The physical effects of compulsive eating behaviors ranged from minimal to debilitating for participants, but above all it became clear that most interview participants saw their eating as primarily affecting other aspects of their lives. Half the participants mentioned a mental ‘fog’ that they achieved with sugar that made their thinking unclear and prevented them from having to feel everything they were experiencing. One participant even connected this mental fog to not having the ability to “make healthy choices in all areas of my life... and having spiritual connection” (Eliza). Jaime understood his mental fog as being “anesthetized all the time,” adding that, “I was angry all the time, although that was often masked in humor and joking.”

Kelly mentioned that a staple of her experience with compulsive overeating has been an “amnesia,” which kept her eating compulsively and unhappy with her food decisions. Without abstinence, some participants felt that they lived life in a drugged or forgetful state, unable to accept their powerlessness over food (as is required in Step One). It was this lack of mental, emotional and spiritual clarity that participants emphasized over the physical aspect as the main problems of compulsive overeating.

However, above all participants seemed to view compulsive overeating as the most damaging to their sense of self and their relationships to others, and often discussed this damage at great length during interviews. Participants shared that their compulsive overeating made them
feel shame and embarrassment, self-hate, a need to isolate themselves from others, and low self-esteem. Gloria experienced a loss of a sense of respect when she gained enough weight to be uncomfortable in her own skin. Robin believed that she used food to avoid living her life, allowing herself “to be ruled by fear and anxiety and resentment”. In addition, participants expressed that their eating had had profound effects on their relationships to loved ones and co-workers. Alice noted that the disease had caused her “rage, anger at [her] children, blame, blaming others for [her] unhappiness, blaming [her] husband, [and] isolation.”

Nine out of ten of the participants claimed that their compulsive overeating negatively affected their relationships to others, and most often they supported this statement with the explanation that they avoided dealing with their feelings with others by eating. Others felt a fear of rejection if they became too intimate with other people, while a handful of participants shared that they felt they didn’t have relationships with other people because they didn’t even have a healthy relationship to themselves. As Jaime rhetorically asked, “I didn’t have a relationship with myself. I couldn’t bring myself to a relationship, how far can you get that way?” For participants, the inter- and intrapersonal effects of the disease were the most profound, and often it was these relationships that prodded them to seek help.

One final point is that many participants mentioned feelings of fear and shame linked to their compulsive overeating and, sometimes, body size. While a few participants had been in recovery long enough to maintain a stable, healthy weight, others spoke of their weight as unstable, unmoving, or mentioned that they had good enough metabolisms that their compulsive overeating did not show on their bodies. Body image and body size was a source of anxiety for about half of interview participants, while others had achieved a type of recovery that kept them
at peace with their body size. Above all, however, body size and image was almost always a key
factor in bringing participants to their first OA meeting.

Finding OA

[My spouse and I] actually got the point of trying to clear alcohol you can clear out of your house a lot easier than food- but at one point, every night, since nighttime was when I’d eat, we’d take all the bread and all the cereal and all the peanut butter and anything else and put it in the trunk of the car, and put my car keys and my husband’s car keys and put them inside his pillow case, because I knew that since he wasn’t such a sound sleeper I couldn’t somehow weasel them out. That’s what I had to do.

(Gloria).

Many members, like the participant quoted above, went to extreme measures before seeking out OA. It was not uncommon for members to share that they frequently found themselves eating foods they didn’t like, or throwing away perfectly good food to get rid of it, only to dig it out of the trash later. Of course, eventually all participants had a moment where they realized that their eating was getting unreasonably out of control. When I asked participants to pinpoint when their eating might have gotten worse, some had definitive moments while others still saw these moments as a progression (i.e., ‘during my college years’). For some members, their realization came when they found themselves sneaking, hiding or stealing food, stories they often told by comparing these habits with those of alcoholics concealing alcohol. Other interviewees had spiritual epiphanies during which they realized they were killing themselves with food, while still others were repeatedly invited to OA by acquaintances in other 12-step programs until they eventually attended, at which point they realized they, too, had this disease.
Another ‘way’ into OA is well-represented by Meredith’s path to the program. Meredith began attending OA meetings in part because someone close to her had a substance abuse problem and got sober in another 12-step program; this person suggested to Meredith that Meredith “did with food what they did with their substance,” a point to which Meredith agreed (Meredith). Participants learned about OA through friends, family, and peers in other 12-step programs, newspaper advertisements, and spouses. Two participants decided to try OA specifically after they had given up on losing weight in Weight Watchers. Others had only tried their own diets and weight loss plans. Fewer participants had tried nothing at all. Tracy found out about the program over 35 years ago in a magazine:

*I read in the article someone describing that they used to go to a 24-hour convenience store late at night, in the middle of the night, with a trench coat, sunglasses and a hat, you know, the secretiveness, and that caught my attention. I said, ‘Oh, I have those kinds of feelings about how I eat and how I want to get food too.’ And I thought it’s worth a try, I’ll do that. So I looked up in the white pages of the telephone book somewhere in 1976, and I found Overeater’s Anonymous, sure enough, it was right there in the telephone book. I call this number... and this woman on the [other line of the] phone...she said, “Oh yeah, we have a woman who used to wear, she used to wear this thing that was this little t-shirt on her, now it’s big enough to be a dress because she’s lost so much weight.” I thought, ‘Oh, that’s impressive, so people do lose.’ So I went to a meeting. So that’s how I found out about it, through a magazine article, the answering service, and the white pages of the telephone book. (Tracy)*

The prospect of weight loss also drew in Kelly, who initially visited OA because she thought it was “another diet,” but “stayed because it’s helped not just with the food,” but with “relationships with other people,” too (Kelly). Other individuals came to OA because they understood the program before joining, and knew that it was the only solution for them. Alice had a husband in Alcoholics Anonymous and would accompany him to meetings, so she was
well-versed in what a 12-step program looked like. However, she realized one day that weight loss couldn’t be the issue, as she had reached her ideal weight in Weight Watchers. She recounts,

On day I was standing in my kitchen arguing with the cupboard over a binge, standing in a cute little size seven dress, and I said to my husband ‘There has to be an x factor. There has to be something else wrong with me besides a weight problem.’ That was the first time I ever suspected it. I never questioned all those diets, and all the times I gained weight and lost and gained and lost. I eventually did get to OA. That was in 1977, and I’ve been going ever since.

(Alice)

Alice believed that her ‘x’ factor was that she had a disease, something that was not her fault and which could also be managed in recovery. Alice’s viewpoint stresses that framing compulsive overeating as a disease in part removes blame from the individual. In addition, newcomers to OA learn that compulsive overeating is a disease at the same time they’re given the solution of the OA program. Instead of finding fault in themselves for extra pounds or unsatisfied hunger, new participants are absolved because they suffer from a disease. Participants are only implicated once they engage in compulsive overeating after they have learned of their disease.

Like Alice, Jaime also had a spouse in a 12-step program, this time OA. However, it would take years before Jaime adopted the OA way of life that his partner had. While Jaime knew from their “first day” together that his wife was in the program, Jaime noted that his “denial was absolute” that he, too, needed the program. Regardless, Jaime attended OA meetings with his wife for years before realizing that his wife was hoping Jaime would realize that Jaime, too, needed the program. Jaime described:

So I go to these meetings, again- no recognition whatsoever, I didn’t understand anything anybody was saying. And I thought ‘Well, this is very nice, all these people get together and talk about their feelings,
okay. But nothing for me there.’ And this went on for two years. With us being married, [my wife] going to meetings, taking me to meetings occasionally, and me having no clue that this was about me. And we were fighting a lot, more and more. Which I now know was really just me fighting because I hated myself because I was eating, unaware that I was hating myself but angry all the same. So I was taking that all out of on her and picking fights, and the fights were getting really ugly. There was one afternoon...we were having a fight. She did something that to me was just beyond the pale...so I was going to lower the boom and let her know what was what about that! [I said] ‘Come here, we’ve got to talk!’ And she sat down and said, ‘You’re right, we do have to talk. We have to talk about your weight because it’s killing you, and that’s killing me.’

And because I was prepared to let her know what was what, I was so full of myself, that my guard was down just for a second, for one like millisecond my guard was down, and that’s when she slipped that comment in the crack, and it went all the way through the five feet of steel reinforced barbed concrete I had around my consciousness, broke through my denial and I heard it, heard it as the absolute truth. I knew it. It was like she held up a mirror in front of me and I saw this disease, naked, right in my face. And it was devastating. I literally fell on the floor crying, and laid there on the floor crying for what seems to me to be hours, but probably a few minutes. And when I finally got a grip on myself I stood up and said ‘Oh my god, I’m a compulsive overeater, where’s the next meeting?’

Having a spouse in the OA program is certainly what prompted Jaime to eventually join, whereas Alice simply had already seen what the 12-step program was able to do for some people by attending meetings with her husband. Joyce’s story demonstrates a slightly more intimate connection with the 12-steps before coming into program. Joyce had already been an established member of AA and Al-Anon for almost a decade when she joined OA, a process which took her years even though she acknowledged that food was a problem for her. For Joyce, food was the final addiction, and entering OA would have to be a point of no return. She explained:

The things that I knew were the drugs, like the foods that I knew had become drugs for me, the idea of giving them up was so painful and so scary to me that I just put off going to OA, and I looked at OA as the only solution... I was enough of a 12-step cadet to know that diets and
nutritionists and you know, trying self-control weren’t any solution at all... I knew that if I went to OA that was going to be the point at which I would have to actually own my disease and deal with it, so I really put it off, I really did not want to go.

It took Joyce until her nine-year anniversary in AA to admit that she felt more discombobulated and upset than she had “ever felt in sobriety” (Joyce). She had reached the point, she explained, that she knew she wasn’t doing something right in her recovery, and she knew food was the problem. She quickly found her first OA meeting after that event.

The prospect of weight-loss and a familiarity and working knowledge of the 12-steps were the major points that drew participants towards the OA program. Those participants that came for weight loss often came from other programs, like Weight Watchers, where they had not been sustainably successful. However, these participants always acknowledged that OA addressed much more than weight loss, and that working on other areas of their lives was what perhaps kept them in OA, even when weight loss was not necessarily sustained. Those that were drawn in by a familiarity with the 12-steps often did not mention weight loss much or at all in their interviews, instead focusing on their nutrition and how they have changed emotionally, mentally or spiritually within the program. This next section will address the specifics of how participants believed the 12-step program has affected aspects of their lives and selves.

Effects of the Program

*The interpersonal and the intrapersonal affects [of compulsive overeating] have been pretty profound, but very treatable with the 12-steps.*

*(Tracy)*
For those individuals who were not already familiar with the 12-step program, attending their first OA meeting was a moment of vulnerability and discomfort; many of these individuals would later find that they had found something akin to home. Tracy attested that upon attending her first meeting she thought, “this is definitely a cult!” adding, “now I get it... they’re my people. OA’ers are my people. There’s not a more comfortable group of people for me.” Kelly expressed similar feelings when she noted that she was uncomfortable with how friendly and “huggy” people were during her first meeting. After attending another meeting where members weren’t as intimate, Kelly found that “it was just kind of a fun place to go” for recovery. She added, however, that sometimes she still felt “resentment” that “I have to go to meetings, resent[ment] that I’m a compulsive overeater... but basically I feel lucky that I’m in OA because I feel like it has so many other things to offer me.”

For Robin, it wasn’t so much the problem of facing other individuals at her first meeting, but the idea of cutting sugar out of her diet, a thought she found “extremely frightening.” Like Joyce’s testament in the last section, attending OA caused Robin some concern because it meant she would be committing to putting down foods that she found addictive. For Jaime and Alice, they came to program absolutely ready to surrender and begin working the 12-steps. Jaime, having attended meetings with his wife for some time, “knew that [the 12-steps] worked and... wanted what it was giving people,” adding, “I thought it was great.” For Alice, she found that she loved the OA program “more through the years,” claiming to have no reservations or difficulties with the program. Participants viewed OA as a “way of life” (Robin), “a bedrock” (Meredith) and as a program they felt they had a lot of “respect” for (Kelly).

In all, participants described four areas in which they had seen marked progress in OA: the spiritual, the interpersonal, the intrapersonal, and weight loss or diet. I have included some
brief excerpts here that testify well to this summary of findings, although it was very typical for each interviewee to mention each one of these aspects of recovery during the interview, as they are all frequently addressed within the OA program.

**A Spiritual Program**

For Meredith, who describes herself as “not a religious type person,” “this program is a way to live a spiritual life,” an aspect that she understood to be central to her recovery. When asked about the most important aspect of recovery, Robin at first noted the “weight loss,” adding that that “doesn’t feel like the most important thing,” but instead having a Higher Power was most important to her experience within the program. Similarly, Gloria suggested that she was still waiting for how OA would most greatly affect her, saying “they said it’s a spiritual program, and I really, I think that’s where it’s going to affect me.” Even if the full effects still weren’t clear, Gloria expected OA’s spiritual focus to have a most powerful influence on her life.

Each of the participants had their own and sometimes very unique ideas of what their Higher Power is, and many times these Higher Powers served to provide exactly what individuals understood themselves to need in their lives, often on the intrapersonal level. Just as the OA program left the definition of disease vague enough for individuals to self-diagnose as compulsive overeaters, participants could also self-prescribe within the program by defining a Higher Power or creating a spiritual practice that worked for them. In this way, the program becomes individualized in a way that reflects culturally popular self-improvement schemes, but which also depends upon group therapy in OA meetings. Again, we see a mixture of old and new ideas of what disease is and what medicine is converging within this program for recovery.
The Intrapersonal

Interviewees spoke of wishing to change certain aspects of their personalities in the process of working the twelve steps. For instance, Robin noted that she would like “to lose that clingy feeling in my brain, you know, that craving-type clingy-feeling,” in addition to “being comfortable within my own skin.” Diane, who now claims to have what she terms a “normal” relationship with food, believed that OA filled her with something inside of herself which she could rely on and take care of:

When I came to OA I don’t think I had anything inside of myself and I just kept on putting food in to try to have something and I was never going to. So, OA...gave me guts. It gave me some innards. So I have something inside me that I don’t want to feed...with the junk, or I don’t want to overfeed it or underfeed it. I like my guts! I do! I like what’s inside me, because it takes good care of me [laughs].

(Diane)

Other individuals understood the program as giving them an awareness around food that they previously lacked (Gloria), helping them to address anxiety and fear and allowing them to build the capacity to be more honest (Robin), and building the tools to put intellect over emotions and make rational decisions (Tracy). Others viewed the program as helping them to learn how to respect their bodies and take care of themselves (Diane), or as making them an “outgoing, positive person [who is] happy, joyous, free, creative” (Alice). These inner changes often had clear connections to relationships with other people, so that participants’ speaking about what changes the OA program had helped them to make to their personalities would quickly begin reflecting on how such changes ended up changing their entire lives through relationships to others.
The Interpersonal

Diane spoke towards the interpersonal skills that OA had given her, noting that she “found ways to deal with people” in OA. Similarly, when asked what his most important aspect of recovery had been, Jaime offered that “having real relationships with other people and having my full capacity as a person” available to him was essential. Two participants mentioned that workplace relationships had changed for the better (Kelly, Diane), including one participant noting that the recovery she was gaining in OA led her to apply and get a job she previously never would have pursued (Kelly). Other participants mentioned things they saw as coming from OA program participation. For instance, participants spoke about the values of gaining friends in the OA program (Kelly, Meredith), learning how to have more personal conversations with others in meetings than in the outside world (Meredith), and learning that “people can come and go in life, and you can open your heart as wide as you want to them, and that’s not going to hurt you because you did it” (Joyce). However, this intrapersonal growth was undoubtedly related to how participants also felt about their bodies and their health, which is the last area of growth participants named for themselves.

Weight and Diet

About half of my participants mentioned that they had reached a weight that they were comfortable with and that they were not trying to lose or gain weight anymore. Others noted that they still had pounds that they wanted to lose. For all participants, weight was a particular source of anxiety; the OA phrase “every compulsive overeater has a 300-pound person inside of them” came up more than once in my interviews. Although participants’ weights and body images
ranged greatly, they had all experienced shame and guilt around body size or eating habits that led them to work on these issues in OA. Jaime summed up this general sentiment for participants well when he said of joining OA, “being accepted not in spite of my size but because of it was profound, and I still get that when I go to a meeting.” While a person’s body size does not matter for participation in OA, body image, weight, and diet are central foci in the program, along with the development of a Higher Power.

For some, like Alice, this has meant staying at a stable weight and following a strict diet, which omits “problem foods,” including sugars and refined starches. Tracy spoke of being “free from obsession with food, free from any compulsion” for almost twenty years now, after a short relapse when she was pregnant. She stated that she no longer uses “food for any purpose other than sustaining good health,” adding that “I always remember that any good things which I experience in life are a direct result of the gifts that have been given to me in Overeaters Anonymous, and my willingness to help other people who want help in the group.” For Diane, the program has resulted in a desire to “put better things into my body,” while Robin spoke of not feeling “sick all the time” or “obsess[ing] about food nearly as much” when she followed a planned diet. Other participants’ spoke about having an awareness around food and the kinds of effects that compulsive overeating has on their weight and sense of embodiment (Eliza, Gloria).

Finally, a few participants mentioned losing their previous love for food. Tracy noted that after being in OA for decades, she chooses foods that are good for her over those abstinent foods that she loves, suggesting that eating has become “something I do for myself because it’s healthy.” Eliza spoke of being taught to look at certain foods, particularly sugary, floury foods, as “plastic,” so that she now is able to look at them without having the same kind of desire she once had to consume them. On the other hand, some participants bounced back and forth
between wanting and dismissing. Kelly admitted, “my relationship with food is a love/hate relationship now. Food never made me unhappy like it does now. Now that I know about what a binge is, I know abstinence, either you’re abstinent or you’re not, and when I’m not abstinent I hate the food.” For Kelly, learning about abstinence and non-abstinence in OA had made food seem to be not what it once was. The 12-steps have changed Kelly’s concept of what health was and which foods were healthy. In these ways, participants had experienced spiritual, intrapersonal and interpersonal changes that delved beyond their understandings of weight, diet and health.

Most individuals interviewed expressed a number fears about their compulsive overeating; some said they had difficulty with parts of the program and each offered hopes about their continued recovery. Almost all the individuals interviewed agreed that they had some kinds of fears and hopes and that they had difficulties in parts of the program.

Fears

Participants expressed fears about their compulsive overeating, sometimes even after decades in recovery. One participant succinctly summarized the entire range of responses when she suggested that compulsive overeating brought with it “self-abuse... self-hatred, guilt and shame,” and the threat of being “psychologically, spiritually dead” while suffering the physical consequences by “losing strength” and causing “a lot of aging-related issues” (Eliza). All participants mentioned at least one of these fears: losing respect for themselves when they succumbed to the urge to eat compulsively; gaining weight; suffering from illness; being labeled as ‘fat’; falling back into old habits and ways of seeing the world; and taking up sporadic eating behaviors once more. One-third of the participants mentioned concerns about what compulsive overeating would do to their aging process (Eliza, Gloria, Meredith), as they were concerned that
having more weight would exacerbate their chances for certain diseases. Eliza and Diane spoke of compulsive overeating as being a “monster” that could be behind any door. Joyce suggested that “you should have a healthy fear of the object of your addiction,” adding that through her years of recovery from alcoholism having a drink “became less of a thing that I could picture myself doing.”

**Difficulties with the Program**

Of course, the OA program was not a cake-walk for participants. While some of the members of the group spoke of not having issues with any aspect of the program, other members admitted to have some difficulty with one expectation or another. One member struggled to make phone calls to other members on a regular basis, while another participant expressed that she felt a lot of pressure to give service in OA. Other members pointed to certain steps or traditions that they struggled with; often they were able to resolve these feelings by working the step or trying to practice the tradition to the best of their abilities. Two participants mentioned that they had previously struggled to handle other people in meetings, resolving that that meeting was not a good choice for them, or that something was wrong with them instead of the other person and they needed to check themselves on this.

**Hopes**

Participants would like to see themselves gain the ability to have moderation in their diets, further their spiritual growth, lose weight, gain peace of mind, and/or gain a sense of self-respect and responsibility. More veteran participants expressed the hope to keep getting what they have already received from the program. This final hope points to why, in part, veteran
members keep showing up to meetings, even when they have been recovered from compulsive overeating for quite some time.

**Summary**

Demonstrating how participants in OA understand their compulsive overeating to be a problem necessitating participation in the OA program was stressed by those interviewed and focused on four prime areas of growth within the OA program: spiritual, interpersonal, intrapersonal, and weight and diet. In particular, the narratives of those I interviewed stress that compulsive overeating is a disease and that there is great value in spiritual recovery. Their voices offer real examples to understand how they felt about their eating behaviors and how they felt in the OA program. Established here is their belief that overeating is a symptom of disease, and that recovery requires the adoption of certain narratives that facilitate their experience with compulsive overeating and bring them to join OA. This does not mean that their narratives are all the same; on the contrary, each is unique, setting the stage for more detailed analysis of the individual experiences of participants in respect to various aspects of the OA program. The next chapter explores how individuals understood, felt, and made sense of their disease.
Chapter VI

The Dis-ease

The kinds of overeating that made me realize that I had an addiction came when I would be going, as an adult, about five years or so, I remember this, I would go the ice box and I would say ‘I want sin.’

(Gloria)

The origins and symptoms of compulsive overeating are examined here to contextualize how participants understood and experienced their compulsive overeating as a disease. It is worth reiterating that it is not my place to evaluate whether or not participants do indeed have a disease; instead I have collected their disease and recovery narratives and examine what these narratives tell us about compulsive overeating, addiction and healing and relate these understandings to larger cultural constructs. In addition, I hope to shed light on the strengths and weaknesses of OA as a program of recovery in the 21st century.

I asked interview participants to share what kinds of programs and approaches they had used to address their eating and weight, and have outlined their answers here. Each participant also answered questions regarding what the experienced as compulsive overeating, when it began, what the symptoms included, and where they believed their disease came from, demonstrating that participants each had unique experiences with their disease.

Past Approaches

The literature review demonstrated that medical and self-help group weight loss solutions have gone hand in hand over the course of the last 150 years in America. Before coming to OA, some participants said they had tried other methods to address their eating and weight. These
other methods were almost always either endorsed by a medical group or individual or programs that had gained cultural popularity for their focus on weight-loss. The approaches can be thought of as three groups: medical, commercial diet groups, and fad diets. Participants believed these approaches failed them because none addressed the need for spiritual practice. This section will explore these methods and the responses of participants while also offering a foundation for the next analysis, which explores how participants understand their Higher Power and what they ask their Higher Power to do for them.

Medical Solutions

Participants addressed their compulsive overeating with a number of different medically prescribed options: diet pills, psychotherapy, professional hypnosis, and doctor-prescribed diets. Three individuals spoke of taking prescribed diet pills in order to lose weight (Alice, Meredith, Diane). Each reported that the pills made them uncomfortable and jittery and they quickly stopped taking them.

Two participants tried hypnosis (Kelly, Meredith), and both found it unproductive in curbing their eating. Only one participant mentioned seeing a nutritionist at any point during her recovery (Eliza), but in this case the nutritionist was seen after she joined OA. One participant, Meredith, noted that after trying a slew of medical approaches, she found that,

Nothing really worked. In fact, everything that I tried to do resulted in me getting bigger because as soon as I had lost weight, I would gain back more than I had taken off every time. So, the end product [was] that I felt really out of control, and I was really scared because I thought, ‘where do I go? Where do I go with this? Am I going to have to be one of those people where they tear down the door to get them out? They die in their house and you can’t get them out.’ I just had all kinds of awful fantasies about how bad it could actually get, and the fact that I was out of control with it.

(Meredith)
Half of the participants said that they had seen a psychotherapist to specifically address overeating and weight. Three said that they felt therapy had been very successful for them and had helped them gain recovery. However, two participants said that they felt therapy had been more so detrimental to their eating.

While I entered fieldwork with the perception that medical solutions would have been most often tried by participants, I found that more often than not it was the commercial and self-created diets that participants tried time and time again. I had assumed that doctor-prescribed diets, diet pills, and bariatric surgery would have been talked about frequently in OA; this turned out to be not wholly true or false. Diet pills did seem to be a popular past solution, but therapists were definitely the most popular medical solution. However, it seems that participants did not as frequently engage in doctor-prescribed diets or with even the idea of surgery. Most participants were not obese or morbidly obese, something that initially surprised me when I started to attend meetings. Their doctors had probably not recommended surgery, even ten, twenty, or thirty years ago when they were heavier, before they entered the OA program, in part because of the relative newness of surgical solutions to obesity. It would be interesting to see if more OA participants get these types of medical recommendations a decade from now.

In addition, doctor’s visits meant medical expenses, and money was a concern brought up for two participants, who said that they originally chose the OA program in part because it is much less expensive than other solutions. Moreover, medicine seems almost superfluous when you can open almost any woman’s magazine and find the new diet to ‘lose up to ten pounds in one week.’ Diets that were created without prior medical approval were a way for participants to attempt to take control of their weight and their eating without feeling they had to engage with the medical establishment. Thus, fad and commercial diets might seem empowering, if only
temporarily. Of course, ideas rooted in medical approaches like counseling, hypnosis, and nutritional therapy contributed to self-made diets, but, many participants felt that by joining diet programs or following prescribed diets they had failed not only on medical levels, but on sociocultural and personal levels.

Self-made and Commercial Diets

It is not surprising that diets were a popular approach to controlling overeating and weight gain among participants. What I mean by the term ‘diet’ is a drastic change in eating patterns implemented for the purpose of altering some aspect of the individual. In some sense, certain groups or members/sponsors in OA offer diets for individuals, usually encouraging members to abstain from flour and sugar (Joyce). However, this is not true across all of OA, and the groups that I observed largely disagreed with this approach, instead advocating that individuals learn which foods caused them to eat compulsively and eliminate these from their intake. The OA program does not promote a uniform diet for participants, in part to discourage individuals from ‘yo-yo dieting’ or going on ‘crash diets.’ However, by the time they came to OA, many participants had been on at least one diet plan, be it self-imposed or through joining a commercial group.

Two-thirds of the participants I interviewed engaged in self-made diets, usually getting ideas for caloric restriction from magazine articles, friends, and family. Usually these diets led to yo-yo eating. Participants described having short, even just two or three day diets, where they would lose a few pounds and then resort to overeating almost immediately, only to start a new diet the next day. In OA, yo-yo diets are even talked about as an addiction, a viewpoint shown by Kelly’s experience with the Weight Watchers program:
Every year a new Weight Watchers program comes out and I would sign up for it because this was ‘the one.’ And I’d buy all the books, you know, the scales, the equipment, and two weeks later I’d be like, ‘Oh, oh I went over my points again, oh, I went over my food allowance for today,’ not knowing how that happened. I still think, you know, I could go to Weight Watchers, I could do it this time. I still think that. That’s, to me, addictive-disease thinking.

(Kelly)

Some participants did engage in extreme diets to the point of severely under eating and starvation:

I didn’t have any idea how to eat properly, how to have the right amounts of nutrition, so I just didn’t eat. And this went on for quite a while, and what happened was my thyroid shut down and I started to lose my hair. My body was reacting of course, I was starving my body. I remember going to the doctor and no one could figure out what was happening to me.

(Diane)

Robin also admitted to fasting, sharing: “I would fast every Monday, and then tried to do three days in a row a couple times, or juice fasting or really tightly controlled eating and that was pretty crazy.” Five of the participants, including Robin, had joined Weight Watchers at some point before coming to OA. All of them found that while they were able to lose some weight in WW, they soon gained it back. For the most part, participants felt that WW did not address the actual problem they were having with food: the compulsiveness of their eating and the roots of this compulsion. Robin said that she gained the weight back that she lost in WW because she “hadn’t really dealt with any of the compulsivity. I was just eating constantly but I was eating stuff that was low fat.”

Some participants also tried other group diets, including a “One Bowl” program where participants slowly eat a bowl of food for each meal (Eliza), Nutrisystem and TOPS (Kelly). In addition, one-third of the participants engaged in over-exercising in order to lose weight,
sometimes spending three or more hours exercising a day (*Tracy; Diane; Kelly*). Participants primarily chose these approaches because they were easily accessible and popular. They did not require a visit to the doctor, they could be performed privately, and they seemed like quick solutions. Tracy best summed up the general sentiment of the participants who tried various diets:

*Commercial diet clubs, my own diets, eating with other people, exercising, copying what other people ate, fasting, oh my goodness, I’ve tried everything I could think of. Everything worked for a short time and build up my ego and I’ll feel about capable and competent and I’d think ‘Oh, I’ve got this thing licked!’ And then, I would be worse off than ever.*

*(Tracy)*

**Other Solutions**

Only two participants (*Robin, Joyce*) spoke of trying meditation or yoga in order to gain a sense of recovery before coming to program. However, as Robin noted, she tried these things for emotional recovery and did not realize until later that these methods could be used to deal with compulsive eating. Only three participants tried Overeaters Anonymous as their first attempt to address their compulsive eating. These members either knew someone already in the program (*Joyce*), felt that only the 12-steps could help them (*Joyce, Robin*) or did not feel it was ever a problem until recently (*Jaime*), when they went to their first OA meeting. These members had already taken steps to address other issues in their lives such as attending psychotherapy counseling or other 12-step groups, like AA, Al-Anon and CoDA. Joyce and Jaime spoke specifically about knowing that they needed a spiritual practice in order to recover making OA the only option they felt was appropriate for them.
Participants’ attempts at other solutions to their eating and weight problems indicate that they were not resisting the dominant culture around weight loss solutions; in fact, they often resisted joining OA because they desired quick, easy solutions over programs that advocate lifelong commitment. Participants still operated within a culture, in which thin bodies and specific diets are valued, but as will be discussed later, the OA program can be interpreted as both countering and propagating similar values. The fact that only two (Joyce, Jaime) out of ten participants immediately turned to OA also speaks to the way in which OA is not a well known method to address weight loss. My data suggests that the OA program is often a fourth or fifth solution, after culturally popular methods have failed.

The Disease

*I guess I fear going back to doing it. It’s just one day at a time, but you know, somebody said to me the other day that they have a list of symptoms of relapse being eminent, and she gave me the list. And I’m like ‘I have these every day!’ [laughs] It’s just, you know, it can happen. You can’t take it for granted that I’m cured or whatever. I have to work at it every day.*

*(Robin)*

Perhaps what struck me most about assuming that compulsive eating is a disease was how unapparent it was as a disease at times during my fieldwork. Occasionally during interviews I asked why individuals came to OA, why they stopped trying other treatments, or even if there was any aspect of the program that proved particularly challenging at first. The responses were similar and always seemed to catch me off guard: “I was trying to save my life.” I do not mean to sound flippant, as I took participants’ experiences seriously. Yet, by the time I talked to many participants, they had been well on the path to recovery and displayed this sense of recovery
during meetings. They seemed well and looked healthy. When they used such language I began to understand just how serious they understood their compulsive overeating to be and just how important they understood OA to be to their lives.

Overeaters Anonymous believes that compulsive overeaters are never cured from the disease of compulsive overeating. The 12-step program is a way to maintain recovery and good health, but it does not claim to free individuals of their disease for good. Members are expected to continue to use the tools of recovery, which include sponsorship, phone calls, a food plan, and attendance in meetings in order to maintain abstinence indefinitely. During meetings, individuals were always asked to reflect on their “experience with the disease.” Some members reflected on the disease as a disease, usually noting that they would never be fully cured, that the disease required constant and vigilant treatment through the 12-step program, and that the disease is life-long and gets progressively worse without treatment. Sometimes members admitted to finding the disease framework of OA to be a source of relief. Some noted that seeing it as a disease implied that treatment was necessary, allowing them to accept that quick-fix solutions were no acceptable answer. Often someone in the meeting would bring up the idea that everyone in the room had this disease in common and that the reason all members could be so open and honest about what they did with food was because they all recognized these experiences to be the product of diseased behavior.

Although I entered fieldwork with the notion that OA members believed compulsive overeating is a disease, I came to understand that they perceived this diseased state as life-threatening. The fear of death seemed to be always as imminent; if members did not keep careful surveillance of their own behaviors around food and in the OA program (i.e., ‘am I going to enough meetings? Do I make enough OA phone calls?’), they lived in danger of relapsing. In
addition, on occasion individuals made suggestions about what they believed to be the reasons behind their disease, often making references to childhood experiences, the abundance of sugar and flour-filled foods in America, the needs of our ancestors to eat when food was available, and psychological ‘tricks’ the mind plays on the body. The disease was sometimes described as “conniving,” in that members occasionally portrayed it as making them think they were hungry when they were not.

The ways that OA members conceptualize where their disease came from and how it affects their bodies and behaviors are key to understanding their commitment to OA. I wondered if all participants believed they had a disease, what the symptoms of compulsive overeating were that led them to believe it was a disease, and what participants understood to be the origins of the disease.

**Disease and Addiction**

The concepts of disease and addiction as the participants explained them as well as the symptoms they describe shed light on their understanding of compulsive eating. While it is not my place to determine whether or not my participants have a medical condition, it is productive to examine how they understand behaviors they consider either diseased or addictive and what this means for their life narratives. I asked participants in interviews to specify which of their behaviors indicated to them that they had a disease or addiction. All but one of ten participants confirmed that they definitely believed that their compulsive over or under eating was a disease. The tenth participant often referred to it as a disease but also expressed a desire to not accept this belief.
Participants made disease claims by focusing on their behaviors or symptoms around food, including stealing food, binging and purging, and eating until they made themselves sick on a regular basis. Many emphasized the irrationality or repression of emotions that drove these behaviors and a lack of spirituality and an obsession with weight loss as symptoms of the disease. The disease was recognized through emotional, physical and spiritual symptoms by the OA program, but otherwise participants were to decide themselves whether or not they believed they had a disease.

Participants may have been more willing to understand compulsive overeating as a disease in part because the program equates addiction with disease, a concept that originally gained popularity in AA. Participants I interviewed understood addiction to be irrational behavior committed time and time again with no actual benefit, and often to the disadvantage of the individual. The equation of addiction with disease is not a universal concept, but it is one espoused by the OA program and one that was accepted by all ten participants. By addressing a comprehensive understanding of the symptoms and recovery of participants, I hope to accomplish two things: to present findings relevant to shaping future programs aimed at recovery from disordered eating and to demonstrate that participants understood their compulsive overeating as culturally relevant and as signifying a set of historically and culturally situated beliefs around acceptable forms of eating, embodiment and empowerment.

Disease, Addiction, and Symptoms

Almost all the study participants accepted the OA tenet that eating issues are a disease. If the response was positive when I asked participants, ‘Do you believe you have a disease”, I asked “What do you believe the disease does, how does it work?” I drew in part from
suggestions by Kleinman, (1980) for this interview approach. Most of the people I interviewed believed they had a disease; three showed hesitation, two justified the definition by noting that the word could be broken down to “dis-ease,” with which they readily identified. Kelly hesitated about labeling compulsive overeating as a disease, noting that: “in OA... we say it's a disease.” But she “still question[s]” whether or not it is a disease, even though she felt that she could not control it:

* I guess I do have a disease. When I eat sugar, or flour, I know I have to break the pattern again, because if I go home and have sugar tonight, it’s going to be really hard for me to not have sugar tomorrow... I have a lot of doubt, I have cravings. I still fight the idea that I am powerless and that it’s a disease.

(Kelly)

Kelly understood her disease as being out of her control, but she struggled with the idea that she was powerless. In my interview Kelly likened her compulsive overeating to the addiction of alcoholism:

* Alcohol is an addiction, but it’s a disease. And, compulsive overeating, it depends on how you’re affected by it, but when you, when I say ‘I’m not going to eat that again’ and I turn around and eat it, that to me is an addiction which is a disease.

Kelly also likened compulsive overeating to mental illness, saying that her experience was that she could not physically stop herself from eating sometimes, adding that she sometimes thought food was able to “[do] evil things to my mind and it makes me want it... it is like alcohol to me.”

Similarly, Diane described compulsive overeating as an “entity... it takes over.” For Diane, the disease of compulsive overeating was separate from her being and acted as an invader to the body. Diane also found that food was a way to deal with “not wanting to be in the world, not wanting to be present, not wanting to deal, not wanting to have a life.” It seemed like while
she was physically plagued with the disease, it was also an emotional coping mechanism. She, too, likened compulsive overeating to the abuse of alcohol or other drugs and found it to be “a way to hurt myself” to avoid feeling pain or discomfort. Those individuals who compared compulsive overeating to other addictions--and alcoholism was a popular substance for comparison--frequently saw compulsive overeating as a way to avoid feeling their feelings (Joyce, Alice, Diane, Kelly, Robin, Gloria). Robin saw overeating as a “coping mechanism” that “helps you not have to deal with feeling and memories” while also likening the experience of compulsively overeating sugar to “drugs altering [people’s] thinking, or altering their state of mind.”

Kelly, Diane, and Robin all stressed the psychological effects of compulsive overeating by suggesting that it is an addiction that seems to produce what some members in OA meetings referred to as the “fog.” “Fog” was described as being “high” or as being in a drowsy, somnambular state of mind or as a way to drown out emotions and distract oneself. Joyce also related to this viewpoint, saying that she used to be a skeptic about whether or not compulsive overeating was a disease. She recently had taken an online Coursera neuroscience course that convinced her otherwise, noting: “it had been such a struggle all my life to be convinced that alcohol and any form of addiction was a disease, but it is, it’s a brain disease.” She added that it became a disease when “it goes from being a bad habit to ‘you can’t stop without help,’... it’s not a willpower issue anymore” (Joyce).

While Meredith agreed with the psychological effects, she also spoke of the physical effects of the disease: “when I stopped doing the things, there was the element of leaning off the particular foods and breaking the habit, like the habit of eating all day” and “there were cravings that were due to something physical, physiological, and there were cravings that had
more to do with habit, and learning that you know, that it was pleasant to eat when I feel bad.”

The act of eating was a part of Meredith’s understanding of her addiction, so that she gained something from the habit of physically eating, rather than just altering her state of mind or feelings.

Some participants linked their compulsive overeating to past abusive and traumatic experiences. Gloria linked her habit of cycling between overeating and under eating as stemming from an “all or nothing” attitude that she believes “is very common among people who have been abused.” Eliza thought that her disease “kept me stuck and shut down and emotionally numb, and basically, immature in that I developed emotionally and then got stuck as a little girl.” She attributed these feelings to being “triggered by my childhood,” which included emotional abuse from her mother. For Eliza, having compulsive overeating framed as a disease helped take away some of the “guilt and shame and blame” that she felt regarding her eating patterns. Jaime understood his compulsive overeating as being started by a devastating event during his adulthood. For Jaime, compulsive overeating had both psychological and physiological roots, but for the most part he believed that it simply was a disease because it existed and manifested in this way:

_I always think of it this way. There are three components. The psychological- I’m afraid, I’m going to eat so I calm the fear. Then there’s the physiological aspect of if I feel the fear and then I go get the muffin and stuff it in my mouth then I’m going to have to have another and another one until there’s no more left in the store or I’m passed out on the floor. But then there’s the third piece of it, which is the insanity. I’m a compulsive overeater because I’m a compulsive overeater and I eat compulsively because I have this disease. It’s just like I have the flu so I get a fever. I’m a compulsive overeater so I eat. It’s a symptom of the disease in and of itself._
Jaime sees his compulsive overeating as a symptom of a disease that is more about the circumstance a compulsive overeater faces, be it trauma or inner demons. Jaime also suggested that the disease was both an invader and a coping mechanism. Driven by fear, Jaime found that he reacted by overeating, yet he also expressed the “insanity” of the disease, sometimes claiming that the disease “affects my brain.”

Other participants saw disease as a product of simply craving foods uncontrollably (Alice), being self-aware, embarrassed and always feeling the need to lose weight despite a desire to eat (Gloria), and of isolationist and self-destructive tendencies (Tracy). Participants who accepted the concept of compulsive eating as a disease that has symptoms had some ideas about the origins of their disease. To clarify their understandings of how the disease developed, I pursued questions about their understanding of its origin.

**The Origins of Compulsive Overeating**

When asked about the origins of their compulsive overeating, participants had a variety of answers. Some chose not to question the origins, focusing instead on solutions particularly by following the OA program (Alice, Tracy). Diane, Jaime, Eliza and Gloria linked the beginnings of the disease to traumatic experiences. Participants also offered a variety of explanations for the origin of their compulsive eating: environment, psychology, evolution, and/or genetics. While no participants who spoke of these different scientific theories were experts in them, their constructed narratives about these reasons for the disease shed light on individuals’ attempts to understand themselves and their experiences with food and eating. What is perhaps most interesting about these narratives is how participants used popular conceptions of science and its meanings in order to understand their own lived experience with compulsive overeating. In part, this data demonstrates how scientific language and theories cause individuals to reframe their
perceptions of self and identity in new and interesting ways, even when there is little scientific data to support a connection between these theories and the development of compulsive overeating.

Psychological

Five individuals I interviewed spoke of a variety of possible psychological origins for their overeating. Robin discussed the role of anxiety and fear in drawing her to overeat consistently. Others discussed feelings of isolation (Tracy), self-hate (Diane), and depression (Kelly) that eventually led them to look to food for comfort until food was equated with comfort. Tracy and Gloria theorized that being forced to wean earlier than expected, Gloria just three days after birth, might have proven traumatic and forced them to look for food excessively later in life. These propositions were always presented by members as vague theories, typically followed by “I don’t know” and a shrug, suggesting that they thought such explanations were outdated or had little scientific credence.

In all, I found that the group did not have strong support for psychological history being a major source of overeating behaviors. Some members tip-toed around how they felt about their mental health, but in the group as a whole, mental health as a topic was rarely brought up. Instead, members seemed to prefer categorizing negative or undesirable feelings into ‘character defects,’ so that isolationism, self-hate and self-deprecation were not understood as products of mental disease, but instead as symptoms of compulsive overeating that the individual had to choose to change. The program encouraged individuals to look at what might otherwise be considered mental health issues as defects of character to be addressed and changed to more positive character traits. For this reason, while psychological reasons were sometimes presented,
most participants rarely used them to justify their disease unless they had experienced significant trauma or abuse (addressed in Chapter Six).

Evolutionary Adaptation

Only Joyce offered an evolutionary adaptation argument for the origins of compulsive overeating, although this viewpoint came up a three or four times during group observation, as well. Joyce and other meeting members wondered if humans evolved to seek out sugars or fats, perhaps in the form of fruits or nuts, and energy-dense foods in order to survive millions of years ago. OA meeting members sometimes noted the abundance of food, especially refined sugars and flours, that just didn’t exist one thousand years ago. Some members speculated that those humans with a propensity for these foods survived, while those who could not access these foods or did not seek them out died, leading to humans today that found these particular nutrients addictive. The participants suggested that when famine struck, those that went for the sugar and fat fared well, and maybe overeaters today still have that ‘survival’ instinct. For Joyce, this explanation of evolution was a clear reason why she struggled with compulsive overeating, especially when it came to sugary products. Joyce believed that her compulsive overeating was the result of a combination of several different mechanisms of the human body and brain, including hormones and survival strategies.

That’s what my mind does, because that’s the hunter-gatherer mind. It doesn’t know that there is plenty in the refrigerator, that’s the hunter-gathered mind that thinks, I’ll never see a fruit tree again, possibly, or at least until next week after I’ve killed something and eaten it. So I need to eat every fruit on this tree, and you know, so it’s that desperation that comes up, you know, the pre-evolutionary desperation that will come up, and now I recognize it.
Joyce identified her overeating as a leftover strategy from hunter-gatherer ancestors, something that from the “pre-evolutionary” that still was a part of her experience of desire with food. When asked about how the disease works, Joyce suggested that it was “purely chemical” that while “all addictions start out as an attempt to medicate certain emotional or psychological pathologies... they can be chemical.” Joyce connected this idea to her own experience trying to medicate what she later learned was ADHD. By the time she received that diagnosis, she had tried a variety of drugs in order to address what she was feeling, including food, which she described “as a very numbing thing.” Joyce concluded her hypothesis—that overeating is a product of humans’ adaptations to consume whatever is available in whatever quantities are available—by adding that she believed that by the time our sedentary lifestyles came to be, “our brains hadn’t evolved to the place where we could turn off the cravings for sugar that had evolved to keep us going through the next hunt.” Joyce’s explanation for compulsive overeating ties together human evolution and ancestor cravings with the chemical abilities of sugar when taken in abundance, presenting biological and chemical reasons for contracting compulsive overeating and addiction more generally.

The evolutionary adaptation explanation is a narrative that circulated throughout meetings, and Joyce viewed this adaptation as a possible link between ancestors and compulsive overeaters today. However, this was just one of the ways in which individuals explained their predisposition to become compulsive overeaters.

It is not my goal in presenting these narratives to critique the validity of any of these theories. These stories are told to reveal one of many ways in which the ten participants conceptualized the origin of their disease. These narratives are essential to reveal how participants understand overeating as a disease in terms of mental and spiritual health and
embodiment. More popular than evolution to explain the roots of overeating were environmental and genetic explanations; these seemed to reflect the nature vs. nurture divide often evoked in explanations of human behavior.

Environment & Genetic

Environmental and genetic reasoning were often proposed by participants as a part of a nature/nurture explanation for overeating. They often traced compulsive overeating to their childhoods. Often, they talked about family members, from aunts to grandparents to siblings, who battled obesity, anorexia or bulimia to suggest that their own eating habits were genetically inherited. At the same time they argued for nurture, analyzing family dynamics to understand if their eating behaviors were learned. While it was difficult for participants to surmise if their behavior was learned or inherited, participants sometimes created a narrative of the origin of their compulsive overeating that incorporated both influences.

Participants understood their environments, especially when growing up, as affecting their development as compulsive overeaters. Meredith considered herself to have a “predisposition,” and explained which family members seemed to have problems with food, including bulimia, obesity, and the propensity to eat food very quickly. Yet, she also questioned this conclusion in that her sister, who grew up in the same environment and around the same family members, did not develop the disease. Meredith understood that part of her family dynamics growing up was an association between affection and food, so that food became a way to show and receive love. She concluded that the development of her disease might have had to do with environmental conditions growing up, in combination with a “hereditary predisposition to go for the sugar,” adding, “and I think I really went for it when life got tough.”
Jaime, whose compulsive overeating got much worse after a traumatic experience, struggled with pinpointing where his compulsive overeating came from, citing obesity and obsessive dieting within his family. Eliza understood her compulsive overeating as “a way of dealing with trauma and abuse,” and thus stemming from environmental circumstances. Eliza also shared that her Jewish identity might have also garnered the disease to some extent, “where food is equated with love, and where it was very encouraged and social to eat, especially tasty things, sweets, desserts…. That’s how I always get my love.” Kelly surmised that while her problem with food “could be genetic,” it may also have had much to do with environmental influences, reasoning that she grew up in a large family and didn’t get as much attention as she would have liked. In addition, she understood that because her father was critical of her growing up, she often turned to food for comfort, another way in which the environment affected her eating.

Diane believed that addictive behaviors in general were learned behaviors in her family, because addiction “was the norm, it was the environment; my dad, his family, [were] all alcoholics and probably addicted to food, too.” She also traced her disease to growing up in a family with low socio-economic status and having a lack of food. Interestingly, Alice saw compulsive overeating as a genetic disease and that eating “the proper foods for my genetic makeup” has been a helpful solution to compulsive overeating. She even described the new nutrition plan that she has incorporated into her life based on her genetic profile. She agreed that compulsive overeating ran in her family, and said that she thought that her mother, sisters, cousins, and aunts had the disease. The genetic and environmental (nature/nurture) arguments presented here were the most prevalent among the ten participants, while psychological and “evolutionary” (adaptive) reasons were used to a lesser extent. Explanations that the participants
perceived as being based in science were the most popular, but participants also presented a few other explanations for their compulsive overeating as noted below.

*Other Explanations*

Some participants’ responses did not fall into purely social or scientific categories for the disease. Robin’s idea was that many members of her family are obese and that her family rarely addresses negative feelings; however, when asked what she believed caused compulsive overeating in her family, Robin suggested that, “it’s an emotional-spiritual problem more than [a] genetic [one].” This reasoning more closely fits the OA program, and certainly deserves recognition here as one possible way that OA members might understand the origins of their disease. Specifically, the OA belief is that compulsive overeaters, when eating compulsively, lack spiritual guidance. They should instead put their faith in something outside of food, and something greater than themselves in order to achieve recovery.

Tracy believed that she was a compulsive overeater “just naturally.” However, she suggested that it was perhaps unproductive, or even harmful, if we look for reasons why some individuals are compulsive overeaters.

*I don’t try to figure it out…. The thing about trying to understand what caused it, that’s the belief that for many people, if we can find a cause, then we can find a cure. And the fact is, I really believe it’s true what they wrote in the Alcoholics Anonymous book: there is no cure. Once the line has been crossed, where I step into the world of being a compulsive overeater, I’ll never cross back into it. It’s only through the day we reprieve that I can avail myself through the 12- step, that I can experience normal living, but I’ll never be cured, it will never go away. And as long as I can believe that, and hold to that belief, I won’t ever have to go back to it.*
For Tracy, the answer is the 12-steps, and for dedicated OA members, looking beyond this solution actually risks relying on other solutions available to overeaters, including medical treatments and weight loss programs. According to OA, other programs fail to recognize the fact that compulsive overeating is a disease and without the disease framework, individuals are treated as if there is a cure. The OA program suggests, and Tracy believes, there is no cure and many of these other solutions play into compulsive desires about food and eating. By forgetting the message that compulsive overeating is a disease, OA claims that the compulsive overeater will return to those same old habits, having never really solved their troubles. Overall, Tracy eventually concluded, “I really believe [my compulsive overeating] was in my nature. I don’t go so far as to say I was born a compulsive overeater, but maybe I was” (emphasis mine).

Summary

Participants in this study clearly feel that the symptoms of compulsive overeating necessitated a broader way to manage them then programs based on diet alone or simple medical solutions such as diet pills. They all see the OA program as a tool of recovery that offers more than the medical/diet route. Members use a variety of discourses to explain the origins of their compulsive overeating, relying on their popular constructions of scientific theories as well as the frameworks discussed within the OA program. Psychological and evolutionary arguments were less frequently used, which may be accounted for an increase in popular ideas around the roles of genetics and environmental explanations.

My preliminary findings strongly indicate that OA members interact with, and incorporate, their personal constructions of scientific ideas in order to make sense of their own experiences with overeating. Participants’ explanations for their disease were very personal, and
when they discussed compulsive overeaters as a group, participants’ explanations were always vague about how the disease acts and how it feels. In part, these broad descriptions allow participants room to define themselves within the terms of the program and therefore they can self-diagnose and, to some extent, self-prescribe. However, their solutions to understanding the disease were precise about some things and vague about others. Individuals shared their own specific recovery solutions but they also all expressed that it was essential to turn to a Higher Power while in the program. After having established the experience of the disease and its possible origins during interviews, I asked participants to reflect on the roles of having a Higher Power in recovery.
Chapter VII:
The (spi)Ritual

All ten interviewees believed that the only way to recover from the disease was to work the 12-steps. Of course, a main component of working these steps is to have a Higher Power. While I entered fieldwork with the perception that there may be slight variation among participants’ understanding of a God or devotion to a particular religious practice, I was surprised by the plethora of definitions, practices and rituals that participants claimed to use in order to recover from compulsive overeating. In this chapter I highlight how participants defined their Higher Power and created Higher Powers based on what they believed they needed most in recovery.

The Higher Power

*I don’t know if [Overeaters Anonymous] is going to be there for long, or for forever, I don’t see how it could be, but I sure am glad it’s been there for me during my lifetime. Things like this, these huge spiritual movements, have cropped up from time to time in history, and this is just a great one that’s good for the people right now. There will be more.*

*(Tracy)*

I wondered how each participant defined their Higher Power, since during the interviews almost half of participants admitted that when they first entered the program they were uncomfortable with the word “God.” While some were previously strict atheists (*Alice, Jaime*), other members had been raised in a family that believed that God was inherently mean or punishing, and most were still uncomfortable with this notion (*Kelly, Robin*). But as this is a
major part of the OA program I began to wonder how they chose to define their Higher Power, and what purpose that definition served them.

Through my interviews I found that while most people used the word “God” to refer to their Higher Power, some members presented a dualism between the God they prayed to in OA and the “punishing” God with whom they grew up (Robin, Kelly). Other members presented original frustrations with entering a program that used the word ‘God,’ specifically because of the patriarchal (Meredith, Gloria) and religious (Jaime, Gloria) connotations implied by having God as a Higher Power. In order to combat this, some individuals defined their Higher Power in unique ways that they connected to their specific needs in recovery (Joyce, Jaime, Gloria, Eliza). My second finding was that individuals typically found that their Higher Power did whatever they needed it to do in order to achieve recovery from compulsive overeating and other life issues. Finally, my third conclusion towards the use of a Higher Power in OA suggests that many looked to a Higher Power in order to achieve what medicine and other ‘weight-problem’ solutions failed to do.

In some ways, for OA members there seemed to be a reversal in the progression from spirituality-based solutions to medicine-based solutions of Western history. Whereas healing in general has historically gone from religious and spiritual methods to medical and biomedical ones, participants looked towards a ‘God’ to recover, often rejecting medical and commercial solutions. As I will discuss, however, the language used by some participants demonstrates an imposition of modern expectations of doctors onto the Higher Power, suggesting that participants imbued God with the technology and ability of science. In this way, Higher Power and Doctor are not only upheld as the authority figures which can heal compulsive overeating, but the modern expectations of technology and medical professions are projected onto spiritual figures
which are themselves hybrids of old and new perceptions of what “God” can be. The participants believed their Higher Powers could be and do culturally specific things, including biomedical acts. While this conclusion certainly could have used more field research to support it, I want to suggest it here as a topic of acute interest and an area for further research.

**Defining a Higher Power**

“In Goddess, I trust.” - Eliza

In addition to the ten interviews with people participating in OA, and my interview with Dr. Jones, I also interviewed Margaret Bullit-Jonas, Ph.D., author of *Holy Hunger* (2000), Episcopal priest, and Missioner for Creation Care in the Diocese of Western Massachusetts. While much of Bullit-Jonas’ present-day work is concerned with the intersections of environmentalism and the church, her book *Holy Hunger* dealt with her experiences growing up in a nuclear family at Harvard and negotiating the circumstances of her compulsive overeating and her father’s alcoholism. In the book she also wrote about her time in the OA program. I was interested in contacting Bullit-Jonas because of her considerable historical experience with OA, and because I valued her opinion on my preliminary findings about the program. When I asked Bullit-Jonas about the use of spiritual language, including ‘God’ and ‘Higher Power’ within the program, she responded with:

> *The Higher Power you can frame however you like and people in meetings I went to named all kinds of things as their Higher Power and there was complete permission to do that. As long as the Higher Power functioned to keep you abstinent for today, it didn’t matter.*
I found the same to be true of OA interviewees’ experiences with their Higher Power. For the most part, participants confided with me that they were originally uncomfortable with the use of religious and spiritual language in the OA program but that they came to reshape or accept this aspect of the program until they were comfortable. I should note here that although OA calls itself a “spiritual” program, participants both referred to this language as spiritual and religious, although some participants insisted during our interview that it was not religious. Other participants felt that that language was religious, and voiced either initial discomfort or ease as a newcomer when they found God was referenced frequently within the program literature. However, there were many variations for how individuals defined their Higher Power, all of which were accepted during the meetings.

Some participants came from religiously-oriented families and felt comfortable with the concept of God in the program, while others also came from these backgrounds and initially took some time getting used to reconceiving of their God in a way that was more conducive to recovery. As Kelly claimed:

> I grew up Catholic, I believe in God, but I have to say that being in OA has changed the way I view God, the way I look at God, the way I picture God. When I was a Catholic, I don’t practice Catholicism right now but, God was a scary God. Not a forgiving God... the OA God has turned into a loving God for me. A beautiful God... I’ve just learned that God is. I have access to God all the time, God protects me, God wants me to be happy. I believe in God now.

(Kelly)

Similarly, Robin initially struggled with having God in her life, but OA allowed her to redefine how she interacted with her Higher Power who she now found to be “very, very comforting.” She shared that she felt like she had “to be careful” because “there’s a difference between my OA Higher Power and that God that I learned about in my childhood,” a God she later went on to
describe as punishing. Robin defined her Higher Power as knowing what she needed. While she felt her Higher Power didn’t prevent her from making mistakes, she felt that it was with her at all times and that it knew “what’s best for me, even if it’s not fun.”

Three participants tended to refer to their Higher Power as ‘God,’ usually agreeing that they meant this in the traditional, Judeo-Christian sense (Alice, Diane, Tracy). These members also talked about the spiritual nature of the program, explicitly noting that the program was not religious for them. Other members discussed how the program was a “spiritual path” for them (Meredith). Some of these members even had a unique definition for their Higher Power (Eliza, Gloria). Meredith felt that the program could be easily “re-phrased without the religious language” as she sometimes felt uncomfortable with its use within the program. While she sometimes calls her Higher Power “God,” she let me know, “that's as far as I go.”

For Joyce, who was experienced in AA and Al-Anon, it was apparent that the OA God was “really nicely modified, nicely edited down a bit, in the OA books, in the OA literature... I think there’s just much more of a psychosocial approach to recovery.” Recall that OA still uses AA literature and language, including The Big Book, a text which discusses God frequently. Having researched AA and been an observer-participant in OA, this had been apparent to me early on in my research, and I would argue that it is the product of OA’s birth in the 1960s compared to the 1930s founding meetings of AA. Simply put, by the time OA was created, individuals were looking for more psychosocial approaches than ones relying purely on doctors and God as AA largely did during its first decades. Joyce, who identifies as an atheist but mentioned that she was “always looking for a Higher Power,” found that through understanding the principles of powerlessness and surrender, she was able to find a way to bring spirituality into her recovery:
I’m surrendering to the laws of nature, and I know that every element inside and out of me is at play at any given moment and I know that there are, that I’m just one part of that, I’m not controlling that, I’m not in charge of that, I just play my part.

For Joyce, having a Higher Power allows her to “recognize [sic] that one tool is going to work when another one won’t, and it’s a matter of reaching for the right tool, so what some might call a Higher Power I call an effective tool.” Joyce’s tools included mantras, praying, and going to 12-step meetings; whatever serves the purpose of keeping her abstinent.

Eliza recognized retrospectively that her Higher Power was Nature, but more recently had begun to believe that her Higher Power had several different names which she found to be important, including “Goddess, Gladys, Loving Spirit” and a final one from her Jewish tradition, “Shekinah, which is the Feminine in Dwelling.” Eliza recognized that she “definitely [has] a need for it to be either feminine or all-encompassing” which she considered to be “against [her] upbringing.” She also spoke of her Higher Power in connection to her history of trauma and abuse, noting that “it’s hard to let go and trust something that’s unknown, whether it’s large or outside ourselves… [but] there’s something that is there for me and it’s not necessarily logical or concrete.”

Eliza’s Higher Power served her need to look towards a feminine presence for guidance while also combatting past abuse, both aspects seen in Gloria’s Higher Power as well.

For Gloria, the use of the word ‘God’ was extremely difficult during her first OA meetings. She shared that she was “absolutely allergic” to its use, in part because she associated the word with the patriarchal ‘Father in Heaven,’ a troublesome association for her due to a history of abuse from her father. Gloria was able to create a unique Higher Power that addressed her needs in recovery:
My Higher Power actually has a split personality. There is three of her. There’s Spirit, who I picture being up on a mountain, who can see all the weather patterns, can see the big picture, has a sense of things, and then there’s River, who is more practical. River is more like telling me what she’s going to...but she reminds me that there’s rapids and there’s calm and there’s curbs. “Yes, you can paddle the canoe, but you can’t control where the river is going to go.” And then I needed Turshine, and Turshine is a cross between Turtle which is somebody who has her home on her back, that you can be safe in her home because I was raped when I wasn’t home, and Sunshine, which I just absolutely adore, being in the sun. She’s a big, earthy, awesome person whose lap I could crawl into. She would just comfort me. She would not remind me that I could not control the River, and she would not remind me of the big picture. I can just cry, because sometimes I just need the comfort before I can even hear the other two. So, I will frequently, I have a set of morning rituals that I do, and then I will frequently write, and sometimes Turshine will say “I’ve gotta talk first” and River will say “I’ve gotta interrupt you.” Sometimes Spirit will calm River down.

Gloria’s Higher Power demonstrates just how unique and personalized OA participants can be with their Higher Power. In addition, Gloria’s serves the dual purpose of helping to acknowledge and address her past experiences with abuse, and avoids perpetuating a father or male figure as Higher Power that might adversely affect her recovery.

Jaime, too, had a particular discomfort with the word God, telling me that every time he heard the word ‘God,’ “I would flinch, physically flinch.” He shared:

I was very worried that I was going to be expected to adopt somebody else’s ideas about God, about religion, about spirituality. I didn’t, [but] that discomfort I was in lasted maybe six months and I eventually learned to translate that term into a more abstract concept that I was comfortable with.

Although Jaime lacked a Higher Power before entering the program, he had a real interest in mythology and world religions throughout his life. When asked how he defined his Higher Power, he simply said he did not define it, adding that:

I find that first of all it’s unnecessary to define it. Second of all, for me, inadvisable to define it. It’s unnecessary because the thing you hear
people in AA and OA saying is, you don’t have to know what God is, you just have to know you’re not it. And I find that in a functional sense, working the OA program, that that is the case. That is important is that I surrender to a Higher Power. Doesn’t matter at all what that Higher Power is, and for me, if I get caught up in what that Higher Power is that then that suddenly becomes the important piece...But then the other piece of it is that I don’t define my Higher Power because that for me is the nature of my Higher Power, is that it is indefinable ... If I start trying to define it, it becomes much smaller, much simpler, much less true. It’s only when I leave it undefined that it’s got its full reality. So for me, not defining it is actually really important.

What is evident in this collection of participant’s definitions of their Higher Powers is not only the variation in creation and beliefs in what their Higher Power is, but also the ways in which Higher Powers did not simply serve as an omnipresent being. Higher Powers were personal and personalized by each member for themselves and their unique needs. This next section demonstrates what individuals felt their Higher Power did for them in the process of recovery.

**Ability of Higher Power**

*I definitely feel like there’s a Higher Power that’s making these people come into these rooms and be with each other. I really feel there’s divine and guidance in it. OA is a very spiritual thing for me.*

*(Kelly)*

What I suggest in this section is that participants experienced both a spiritual and almost medical expectation of their Higher Powers. In an era where medicine and science are understood as being the dominant methods to reshape the individual’s health and bodies, participants relied on a spiritual-religious counter-culture, to some an outdated method, to heal what they defined as a disease. Here I suggest that participants believed their Higher Power both healed inner character traits and also bodily traits in ways that sometimes evoked the medical
and which verged on the biomedical and techno-scientific. Participants combined centuries-old expectations of God with more modern interpretations of what can be done to heal the body. This section displays new understandings of what a Higher Power can do and in some ways mirror the work of scientists and doctors. The OA Higher Power then becomes, to some extent, a combination of the cultural authorities of God and doctor.

Character Defects

In OA, members often discussed having ‘character defects’ that they prayed for God to remove. It was no surprise that most participants talked about how their Higher Power had removed traits of the personality that they saw as inhibiting their recovery. Kelly found that her Higher Power had aided her in just this way when she told me: “It’s helped me stop worrying, it’s helped my anxiety, it’s helped me to let go [of] a lot. It’s helped me let go of that feeling that I have to do everything myself.” In addition, she confided that “it’s just made me realize that I have a part in a lot of the situations that I thought were difficult… It’s like having a therapist, a really good therapist.” Meredith felt that her Higher Power had helped her to “live without fear. It’s helped me to accept myself, it’s helped me accept the world, without fear.” Similarly, Alice attested that God helped her to “remove my fear” and that he “solves all my problems.” For Tracy, her Higher Power helped her to find more peace with the world. She noted that her Higher Power “makes it all make sense. It’s all okay with a Higher Power.”

Jaime expressed that his Higher Power helped him to meet adverse situations more calmly, saying that “before OA life seemed chaotic and hostile. Now, life seems unpredictable, but benign…. When anything happens in my life [that] is shocking, unpleasant, bad in my mind...
I now understand that in an intuitive way in the context of that Higher Power, that each thing happens is what is supposed to happen.” In a similar manner, Diane believed that her Higher Power had given her an addictive family to “learn how to take care of myself and learn how to love myself,” adding later that, “I always think it’s a Higher Power thing. I was born into that family, I was given those parents.” Participants clearly believed that their Higher Power was able to both take away character defects and give them more positive traits with which they could go through the world as more stable and healthy individuals. However, participants also spoke about what I refer to here as ‘technologies of the spirit,’ meaning that in some cases participants were inclined to imbue scientific or medical qualities onto their Higher Power, almost resembling what would be expected of the cultural authority of doctor or scientist.

Technologies of the Spirit

When discussing the ‘disease’ during meetings, some individuals mentioned how they felt the disease affected their brains or bodies, sometimes adding that they prayed for their Higher Power to take away these physical side effects. Often, they were referring to their experiences with compulsive thoughts or obsessions, but other times they talked about weight loss or weight gain in this manner, hoping that God would help them to take off the burdensome pounds. More than once during my fieldwork OA meeting members brought up their desire to have their Higher Power ‘rewire’ their brain, a comment that verged on the technoscientific. While gastric bypass surgery was never brought up in any of my interviews or during my fieldwork, participants occasionally characterized their Higher Power has having the ability to remove physical pain, change their brain chemistry, or affect some aspect of their physical being,
requests that were not as common as those pertaining to character defects but that still
demonstrate a belief that the Higher Power could possibly do these things.

Although my findings in this argument are admittedly preliminary, I want to suggest it as
an area of acute interest and further inquiry. I should recognize that not all participants expressed
this type of characterization of their Higher Power, that most of the time members expressed that
they felt empowered when they were able to ask God to changes some aspect of their being.
However, these comments sparked a particular interest for me concerning the boundaries
between science and spirituality for participants. Specifically, I wondered just how frequently
members understand their Higher Power to have the abilities of the surgeon? How often did they
imbue their Higher Power with the cultural authority so frequently bequeathed onto science and
scientists in Western culture? Do these doctor-God projections change how participants
understand their identity, genetic and social being, and if so, what does this mean for participants
as they move through the world?

Of course, these questions became reminiscent of Foucault’s (1973) work addressing the
authority of medicine. Here, Foucault coined the term “medical gaze” in order to describe the
way in which doctors were able to separate the body of the patient from the patient’s identity,
thus creating a dehumanizing aspect within medical practice. In this work Foucault also
theorized that as the human body entered the realm of medicine it was more easily surveyed and
controlled.

Relating these terms to the fieldwork outlined above, there are two points I want to make
here. First, this preliminary data suggests that OA members sometimes use this medical gaze,
which creates a mind-body dualism, to analyze their own disease, and turn to their Higher Power
in order to cure the disease. Of course, the Higher Power itself cannot diagnose the disease, but
OA members did at times believe their Higher Power was capable of healing. Therefore, the OA program gives a cultural sense of medical empowerment to OA members as they are allowed to define and diagnose their disease as they see fit; however, simultaneously, members can be understood as both being disempowered in turning their will over to a Higher Power, and as being empowered by having a Higher Power to support them. After all, if we are to follow the analogy being drawn here between doctor and Higher Power, excellent medical care is often indicative of more power and ability in the longer term, while at the same time receiving medical care can be understood as a temporary loss of control and a lack of knowledge. By imbuing their Higher Power with the qualities of the culturally significant and powerful medical practitioner, OA members project both powerlessness and a sense of control onto their chosen Higher Power.

My second point is that the language chosen by OA members in these meetings, in pleas to their Higher Power to “rewire the brain” or heal the body, demonstrate moments where members evoked the mind-body dualism within a program that often stressed identity and identification (i.e., “My name is Joan, and I’m a compulsive overeater”). In this way, members mixed the values of the OA program and of the Western culture in which they existed to create new meanings of what a Higher Power could do. However, my questions are also ones concerning identity and the effects of this conceptualization of identity on socialization. How did this view of a Higher Power affect how participants understood themselves and how they move through the world and interact with others as a result of this understanding? This question led me to examine the work of Paul Rabinow (1992; 2009) and his term biosociality; because of the preliminary nature of my answers, I discuss my findings on this topic in the Conclusion.

Having laid the framework for the use of the disease metaphor and a Higher Power in the OA program, I now turn to my final area of interest for this chapter, the importance of ritual
within the program. The OA program would not be complete without either of these three areas, as the disease necessitates spiritual recovery, and spiritual recovery necessitates the use of ritual in order to create a patterned spiritual practice. In particular, confession is used to help solidify members in this practice by attesting to their experience of disease and recovery.

**Ritual and Confession**

As discussed throughout my fieldwork I became increasingly interested in formats, language and patterns of OA meetings. I began to understand that much of what occurred in OA was ritual. There were the same opening and closing prayers at meetings, the same slogans said at particular points at meetings (i.e., ‘it works if you work it’ after the Serenity Prayer), and each meeting had a particular format that was read aloud so that each of the meetings was much like the last. There were moments of silence, hand holding, and meditation, at the same point of each meeting. Interviews with participants also provided something interesting about ritual, namely that members had their own rituals that they practiced outside of OA meetings that contributed to their OA recovery.

During our interviews members stressed the absolute importance of these practices to their continued faith in the OA program. A final point I would like to make on the note of ritual is the ritual of confession in OA meetings. Confession was a vital part of the OA program, considering that the fifth step of the program reads: “Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.” However, there were other ways that confession circulated within meetings, too, which I discuss further. The aim of this portion of my work is to display the pivotal role that ritual and confession plays within the program, both in creating new, supposedly more productive and healthy behaviors for compulsive overeaters, but
also for making members feel included with in the OA community. The rituals of OA become a way for members to feel versed, knowledgeable and empowered in their 12-step recovery.

**Meetings and Ritual**

It is easy to tell who is a newcomer in a meeting because they hesitate to say their name, followed by “and I’m a compulsive overeater.” They may be unsure what the Serenity or Rozanne’s Prayer is, or might simply say “Hi, and I pass,” when it is their turn to speak. However, the nuances of the OA program are easy to learn, and I was able to witness one individual become more versed in the program throughout my fieldwork, so that by the end she appeared to be well on her way to recovery and knowledgeable about both the twelve steps and the sayings, prayers, and actions members were intended to take part in. My first point in this section is to assert that rituals within the program were particularly powerful for members’ recovery and sense of healing. Although none of the rituals of OA were mandatory, they were a way for members to all engage in a single act or thought together, to relate to one another, and to all feel a part of something greater than themselves. By partaking in rituals of OA, members were able to suggest whether or not these rituals were helpful for them. More often than not, they found that they were. As one member put it, “I’ve done the program without prayer and meditation. I’ve done it with. It’s better with.”

In addition, many members were actually replacing old rituals with food with new rituals aimed towards having a spiritual practice and recovering from compulsive overeating. While members described to me in detail the things they used to do with food, from hiding it in the car overnight to throwing it down the garbage disposal to purging it, they had chosen to replace these food behaviors with new ones, learned in the OA program. Here is where we can begin to understand food rituals as pertaining to disordered eating just as much as eating in recovery. The
difference is made by what the ritual does for the individual. Participants spoke of using patterned behaviors, typically carried out while in private, in order to achieve thinner bodies before coming to OA. These actions were meant to appease both the individual and a wider cultural fixation on slimming. This section explores the seeming contradiction in the continuation of the use of rituals in recovery. At the same time, the OA program would not exist as it does without the use of spiritual practices and rituals. In some ways, the program draws upon an individual’s natural inclination to form behaviors around food and changes these behaviors through introducing new practices and beliefs.

When talking of past eating experiences, participants detailed how they treated food, often emphasizing the repeated nature of their behaviors or ‘habits’ with food. Members talked about hiding food, binging and purging at certain times of day. Some members discussed going through patterns of binging, purging, throwing away food and then digging it out of the trash to binge on again. Others talked about stealing food from certain stores on a daily or weekly basis. It seemed to me that for some participants, the symbolic nature of these behaviors were what made them important, and thus they strived to accurately confess their strengths, weaknesses, fears and frugality around food. The fact that the OA program made use of rituals was not a fact lost on participants; Kelly even acknowledged that other programs addressing eating disorders made use of them, saying of one clinic, “we had to eat our meals together, we had to eat on plates, you know, there were rituals.” However, I believe what makes ritualization an effective part of the OA program is the program’s foundational focus on spiritual growth and practice, connecting the program with religiosity and increasingly popularized spiritual modalities in the West.
When asked about the importance of ritual in the OA program, Margaret Bullit-Jonas, the author referenced above, responded that she was easily able to see ritual within the program:

*The meetings are amazingly structured. They start--at least in my experience--they start on time, they end on time, they have a very particular, very predictable, at least for that meeting, format, which for someone who is just coming in from a very chaotic place, it’s very calming, at least for me, to have a very set structure that you know what’s going to happen in the meeting and how it’s going to go…I haven’t thought a lot about the rituals in OA, but I just, maybe that’s part of the power of the group as a whole is doing something together. I was just thinking about the ritual of standing, and we will all now hold hands and say the Serenity Prayer, or the Lord’s Prayer, or whatever, whether you name it that way or not, you’re possibly tapping into some larger sense of energy.*

(Margaret Bullit-Jonas)

I have to agree with Bullit-Jonas that the rituals of meetings seemed to be particularly effective. These rituals were events that I could experience and take part in even though I myself was not a member of these two groups. However, it became apparent during my interviews that rituals performed outside of OA were of equal if not more importance to members. During one of the Bridgeton meetings, participants were given a question to meditate on before sharing their thoughts or writing. The question was, “How important is it to me to have a regular daily time for prayer and meditation?” As memberss shared their responses, I realized that outside prayer and meditation was actually considered to be one of the key foundations off of which members were taught to build their recovery. Members discussed how learning to meditate gave them a new life outlook, a clearer perspective on situations, and renewed strength in recovery. In addition, some members reflected on how without their daily prayer or meditation, they felt they had lost touch with God or their Higher Power. These practices were rituals that solidified
members’ recovery just as much as attendance at meetings, repeated reading of the 12-steps, and other in-meeting aspects of the program.

Prayer, meditation, journaling, or “quiet time” was something that each of the interviewees attested to using in the program. As one informant put it, “I can’t afford not to have a quiet time” (Robin). Meredith attested to having a “spiritual practice” that included writing every morning before eating, often recording where she was and how she was feeling about various aspects of her life:

And so after I’ve written all of that out, a prayer comes out of it. The prayer is something like, let me open to the possibilities, um, of this day, and of myself. Let me be open to whatever guidance there is. Let me receive it, let me accept it, let me accept the world on its terms. Let me be useful this day, and if there is some specific issue, like help me to be forgiving of this, this and this that somebody else has done, give me some wisdom around this problem that I’m having, and so it sets my intention for the day, and it sets my orientation and attitude for the day, and it just, uh, what? It just flavors my day to just do this first thing. And then, I prepare my breakfast which is a big deal to me, I love my breakfast, first meal of the day, so I eat my breakfast and then I go about my day.

(Meredith)

Gloria discussed the role of ritual regarding how her birthdays, and certain foods more generally, are treated within her family. Because her mother was a social worker who was always worried about the family and her clients, Gloria felt that:

The only day I could count on being mine, as being special, was my birthday, which of course is filled with cake and ice cream and that kind of thing. So, when somebody gives that to me, that’s a sign they’ve sort of noticed me, you can say it started with my mother, but it then continued and my family also, part of it I think is because they were immigrants, is that they were strong on certain traditions. ….European marzipan is a real tradition in my family. It’s made at certain times, and poppyseed cake and spaghetti. My father had lived in Germany before he fled Italy from Mussolini, so had learned- he wouldn’t marry my mother until she had learned how to eat spaghetti
rolled up on a fork without having cut it or anything and that became a big deal. So there were a lot of traditions around food.

(Gloria)

Similarly, Gloria also discussed how she associated certain friends with certain foods adding that she struggled with moderation in eating these foods when she was with these individuals. For her, the consumption of specific items became imbued with tradition, and became in some sense ritualistic, making them even harder from which to abstain.

Yet Gloria also spoke about rituals that she used in recovery from compulsive overeating, as well:

I have these different cards and quotes that I’ve collected over the years, and I have this ritual where first I draw one thing at random, and then I have two books full of quotes that I’ve written down over the years, and let’s say today is the 13th. I will randomly open a page and I will go to a page that is closest, to a page that ends in three, so the messages I get either from the quotes [or my cards].... feels completely random to me and the number of times I can get a consistent message or any absolutely right on the money message or a quote I haven’t gotten for four years, is to me my Higher Power speaking to me.

Gloria added that “my version of Higher Power and my rituals, and all of that has helped me to grow in a lot of ways and help[ed] me to get out of situations [that are] emotional, or just difficult situations.”

Like Gloria, Joyce discussed having ritualistic behaviors both inside and outside of recovery. She shared that she and her husband engaged in nightly overeating or eating of sugary foods to the point where this habit was damaging their relationship with their children:

What came up around that was that first of all, we were eating buddies, so that when we would go out to eat we would always overeat, before we had kids. But after we had kids, it seemed to really
affect not only our relationship, but our relationship to our kids, and in this way that I just described where, you know, there are a variety of ways, but one of them was we had our time. It was kind of like my parents had their time to drink, and they didn’t want us around, and they had the kitchen. Oh, that was another thing, as I got older and I realized, that the kitchen was kind of this sort of citadel for them, because that’s where they drank at night, my parents. And my husband and I, after we had children and it was that we wanted the TV to ourselves and we wanted our chocolate chip cookies, these Pillsbury cookies we would make, or something else, whatever it was it was sort of our time to do that because we didn’t drink and we didn’t do drugs, this was our drug…. We’ve always, all our children’s lives, we read to them and we put them to bed, and it was time with them that was very precious to us, but there came a point where it was, there were a couple of years there where it was clear that we just wanted them to go to bed! You know? We still sat with them and we still sang to them, but it had to happen at a certain time so that we could get ourselves in front of the TV or make the cookies. It became very ritualistic in terms of the after they go to bed routine. But that ritual, you know, was not something- it was something we enjoyed in the moment, it was something we desperately had to do- but there was never this sense of ‘Gee, glad I did that.’ And rapidly that turned into ‘Gee, really wish I hadn’t done that.

(Joyce)

Yet, while in recovery, Joyce had been dedicated to meditation and other ritualistic aspects of the program, including certain ‘sects’ of OA programs, which restricted very specific foods while allowing others. In some sense, it seemed as though Joyce had replaced old rituals with new ones, now recognizing that sitting in front of the TV with her family while they were eating was a “vulnerable” place for her.

While rituals served as a keystone for recovery and for replacing the old rituals of disordered eating with new, healthier rituals, the changing of rituals sometimes proved to be a source of fear and concern for members. For example, one member discussed their fear in changing their food plan in order to better fit their lifestyle during a meeting. Other members talked about the fear and devastation they sometimes felt if they accidentally ate something they later found out had flour or sugar in it, two foods that are
especially fetishized in some sects of OA because these members believe these foods are naturally addictive to compulsive overeaters. Others discussed how upset they were on days they couldn’t meditate, pray or journal. OA program rituals were deeply embedded into the lives of participants, and their practice seemed pivotal to some members.

All of the rituals in OA seemed to be saturated with deep symbolism. Reciting the Serenity Prayer together while holding hands was a tradition that seemed to unify the group and brought participants physically closer together at the meetings’ close. Prayer and meditation were meant to be a way for individuals to commune with their Higher Power. Weighed and measured meals were equated with abstinence, while making OA phone calls and giving service were ways to demonstrate continued recovery. On another level, the rituals of OA meetings also ensured that individuals could go from meeting to meeting and always be met with familiar actions, readings and sayings. As Tracy said in our interview,

_I don’t travel too much, but whenever I go somewhere I find out where the OA meetings are, and I just go there. It always feels the same though, mostly. It’s not about intelligence, wealth or education level or any of that stuff. It’s about the same OA language, those same 12-steps, those same 12 traditions, and the courtesy of the heart that exists in the meetings, the welcoming spirit there._

(Tracy)

However, certain rituals seemed to evoke confessions from members. Over the course of my fieldwork I began to notice the necessity of confession in OA, and realized that certain OA rituals served to bring out confessions from members, further uniting them through the identity of compulsive overeater.

_Confession_

Confession is undoubtedly a central part of the OA program. It is included in member introductions (i.e., “I’m a compulsive overeater”) and the steps (i.e., “admitted to God, to
ourselves, and to another human being the exact nature of our wrongs”). It was also not uncommon for one member to admit to slipping up within the program, only for the next two or three members who speak to also confess their recent pitfalls. However, while confession was present in each meeting, in other meetings it became particularly central. In these meetings, most if not all of participants engaged in confession, often focusing on how they had eaten before joining in OA, or their relapses and struggles since starting the program. My argument here is that confession circulated in very specific ways within OA meetings that reinforced both members’ involvement within the program and newcomers’ own association with the program and its participants during their first meeting. Reflecting back on my first few meetings, I realized that no matter what the format of the meeting was, or what step we were reading, members recalled their own journey with disordered eating. This entry in the program would not strike me as odd until much later because members typically do not recount their entire life histories with eating during each meeting. Yet, this was a distinct part of my first impression of OA. As my fieldwork continued, I noticed patterns to meetings where eating histories were re-told, and often, these meetings were newcomer meetings. I understood that my presence had given shape to my first meetings that might not have otherwise been there.

Newcomer meetings are when anyone new to that specific group is present. In one of the groups in which I conducted research the group even had a plan in place to change the reading for that day to Step One should a newcomer be present. (And of course, Step One, “admitted that we were powerless over food, that our lives had become unmanageable” encouraged members to meditate and share about how they came to realize they were powerless over food and how they came to OA.) However, in the other group with whom I worked, the meeting format did not change for newcomers but instead members often chose to reflect on their journey thus far
through the program without prompting. The presence of newcomers simply changed the meeting to that of confession, and members no doubt confessed with the best intention to make the newcomer feel at home and comfortable in their admission to being a compulsive overeater. After all, that label itself is a confession to the type of relationship the person feels they have with food and with addiction.

As mentioned above, reading Step One seemed to consistently engage members’ in thinking and talking about how they had come to believe they had a problem with food and their journey in OA. Step One was cause for reflection, and members often shared their recovery and the struggles that they felt still plagued them. In a similar manner, Step Twelve meetings were also rife with confession. Step Twelve reads, “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” (www.oa.org). In responding to the reading on this step, members often admitted how their struggles with continued recovery and with appropriate ways to spread the message of recovery. Members would also reflect on how they had worked the previous steps and what they still needed to work on. These meetings demonstrated pitfalls and successes in recovery for those who had made it to Step Twelve, while those who had not worked the program this far expressed their desire and, more often than not, anxiety in reaching that part of the program.

A third and final type of meeting in which confession was prominent was the speaker meeting. Speaker meetings are meetings when an OA member, generally someone from outside the group, tells about their history of eating and recovery within the program. Speaker meetings generally took place three or four times a year in any given group. During my field research, I witnessed three speaker meetings. However, they all followed the same general format. The
speaker would share about the type of person they were before joining OA, often emphasizing undesirable personality traits or habits. Then the speaker would talk about their moment of realization that they had an eating problem. Sometimes they would discuss failed attempts to lose weight, and sometimes they would discuss how they kept on compulsively eating. Then, they told of how they learned about OA and found their first meeting. Inevitably, the speech would end with how they were changed by the OA program, maybe including how they had worked each step or what tools they found particularly useful in shaping them into the person they are today. Speaker meetings always ended with everyone present having time to speak and reflect on the speaker’s story. When other members spoke, they often admitted to having some of the same struggles as the speaker, often looking for similarities in their experiences and feelings. Some members even chose to point out that everyone in the room knew the experience of the speaker because they all had the same ‘disease.’

In some sense, confession in OA is a disease narrative, in that it attests to the onset, continuation and progressivity of the disease, along with the idea that the disease is incurable. Although the act of confession did not take away all blame from the diseased person, it did partially absolve them in that members were seen by their peers as taking the necessary steps to recovery. Furthermore, members progressing in working the steps were seen as having a continually closer connection to their Higher Power in relation to their recovery, making them appear as further absolved through unique introductions like “I’m a recovering compulsive overeater” (although no one ever said they were ‘recovered.’) In some sense, this change in introduction was admittance to working the steps, often in their entirety at least once, but still always having the identity of compulsive overeater. Not only did the group confessional unite members in their recovery but it was also used as an introductory ritual for newcomers and an act
of reflection for old-timers. In these ways, confession served as a ritual that solidified members in their continued growth and invited newcomers who identified with the disease to feel ‘at home.’

Summary

The spiritual nature of the OA program and the ways in which spirituality in the group are presented and practiced contribute to individual recovery and Fellowship. In particular, my research strongly suggests that allowing individuals to define their Higher Power is a source of empowerment amongst group members, particularly those who used the opportunity to create a Higher Power that worked to heal past trauma. Members also equated the powers of cultural authorities by sometimes combining the abilities of Doctor and God in unique and telling ways. Simultaneously, members’ understandings of self and sociality were redefined by the program, which gives a disease-label but also encourages a spiritual connection between participant and a Higher Power. Members shaped their Higher Power as they so chose, but spoke of their Higher Power in ways that indicated little control over what the Higher Power actually did while hinting at the ability and technology of this spirit. Members were able to bond over shared experiences with compulsive overeating while fostering individual and group spirituality. In this way, members engaged in a community that promoted individuality, spirituality and community based on disease status.

My research also suggests that the use of ritual, particularly the ways in which confession circulated among group members, created a sense of coherence and unity. The use of a Higher Power, ritual and confession in OA were ways that OA members addressed their compulsive overeating that were for them very different from their prior approaches, but which reflect many
of the same dynamics of medical and cultural solutions to disordered eating behaviors. However, for many members OA was a solution in part because they had the freedom to create their own definitions and unique practices as long as they could honestly attest to gaining recovery from their created program.
Chapter VIII

Trauma, Abuse, and Addiction among Compulsive Overeaters

_The only way we give to ourselves is to eat. You know? Because that’s something we can do, we don’t have to count on anyone else. The boyfriend can be good, the boyfriend can be bad, the boyfriend can be thoughtful, the boyfriend can be indifferent, but we don’t have to depend on him to buy a candy bar._

(Gloria)

Discussions of the origin of the disease and spiritual practice for recovery inevitably brought up two themes among participants: addiction and past trauma or abuse. Some participants believed that they had addictive or obsessive personalities, while others felt that they had used compulsive overeating as a way to cope with past abuse. Some participants even identified with both of these statements. When I originally entered my fieldwork I expected to deal with addiction on the level of compulsive overeating, and to a smaller extent, alcoholism. I felt that it was probable that participants who were comfortable with the 12-steps and utilized them would likely know about 12-step programs in their area from either AA members or through their own experiences in AA. However, over the course of my fieldwork participants discussed a wide variety of addictions that they or people they knew struggled with.

There was a common thread amongst participants and their experience with disease and recovery, and it is clear through the voices of my participants that health care professionals who work with compulsive overeaters should be sensitive to the possible role of traumatic and abusive experiences among their clients. The first half of this chapter will discuss the most unique cases presented to me of traumatic experiences to the more frequently expressed examples that members presented. I begin with Jaime, who dealt with a traumatic experience as an adult and who related this directly to the onset of his disease. Then, I focus on a small handful of participants who felt that their histories of childhood trauma or abuse played a role in the
formation of their disease. The second half of the chapter presents the variety of addictions discussed in OA. While half of participants spoke openly about past trauma and abuse as starting or escalating a tendency to overeat compulsively, all participants spoke about addiction besides compulsive overeating and its relation to their behaviors.

**Trauma and Abuse**

Jaime discussed his overeating as a product of never knowing when he was full and not knowing what was the appropriate portion size for his body. While he spoke of always eating larger portions, when asked when his eating behaviors got markedly worse or compulsive Jaime suggested that he knew exactly when this happened, stating “[In] 1986 my best friend killed himself.” Jaime noted of the situation, that “if your goal was to set up maximum psychic damage than you couldn’t have done better than I did with that.” In short, Jaime’s friend lived with him for six months during which time Jaime would “be on the phone with him or sitting down with him at the table for three or four hours talking him out of killing himself every single night, seven days a week.” Jaime said:

And this is actually relevant to my overeating experience because eventually it got to a point where he called me up one night, and he said ‘Look, I’m not calling to talk tonight, I’m calling to say goodbye, I’m at the place where I’m going to kill myself.’ He had picked out a spot months ahead of time and had this whole complicated logic about how he was going to do this. ...And I could tell he really was.

Jaime got to the scene and convinced his friend to go to the hospital, and the friend was checked into a mental health facility for two weeks during which time his friend participated in AA and achieved sobriety. After being released Jaime’s friend stayed with him, and weeks later Jaime trusted his friend with staying home alone because they seemed to be recovering very well. Jaime left for the weekend, and came back to an empty apartment. Immediately, Jaime called the
police in the town where Jaime’s friend had previously attempted suicide and insisted that they go look for the friend’s car, but the police were resistant. Ten days later, Jaime received a call that the car and Jaime’s friend’s body had been found. Jaime cleaned out his friend’s car, an experience that Jaime found especially disturbing because his friend’s body had been in the car for ten days during the summer months. Jaime described the experience as “beyond, beyond horrible. I had nightmares about that for years and years and years,” adding “that’s when the [compulsive] eating started.” While Jaime connected this change in eating patterns with growing up in a family that “didn’t do emotions... all the messy emotions [we] just did not do,” the compulsive overeating truly started in Jaime’s adulthood. He went on to say:

And all of a sudden here comes this emotional freight training hitting me at one hundred miles per hour and I just was completely, completely ripped by it, and didn’t have any way of knowing how to deal with it at all, and so started eating. That was... I didn’t eat to deal with it, I ate to avoid dealing with it because I couldn’t face it. It wasn’t just the horror of what had happened to [my friend]. It was all the very complicated emotions that come to a person who has been involved with somebody who commits suicide ...Having your best friend die under any circumstances would be a massive emotional load, but to feel responsible for that happen[ing], it was really hard and for it to happen in that way was just... so yeah, I know exactly when my eating started. I know exactly why it started [laughs].

(Jaime)

Jaime’s eating “escalated pretty quickly and pretty dramatically” over the course of the next few months, at which point he tried to get help for himself. When trying to call a mental health services number, Jaime found it difficult to get any words out, taking minutes to just say “I need help.” Then he saw a therapist who declared him ‘cured’ after one appointment, during which Jaime simply told the therapist what had happened to him. Reflecting on this point in his life, Jaime confided that, “I was homicidal and probably suicidal myself although I didn’t know it at
Jaime’s traumatic experience occurred during his adulthood and he believed this experience to be the onset of his compulsive overeating. However, Jaime also understood the disease to be exacerbated by behaviors learned during childhood, specifically a learned tendency to repress negative emotions and feelings. The rest of participants who described their compulsive overeating in relation to traumatic or abusive situations mainly focused on childhood events. Most interview participants spoke about negative childhood experiences that they felt affected their eating patterns in drastic ways; however, for the sake of respecting participants’ own understandings and interpretations of their experiences, I have only included the stories of individuals who explicitly used the terms like ‘emotional abuse’ and ‘physical abuse/violence’ here. While I acknowledge that some narratives told by participants could have been included here, I avoid disclosing them in this chapter because I feel that it does a disservice to how those participants may expressly feel about their identities and their histories.

When asked about her life history in regards to food, Gloria began by telling me about how she had been weaned from her mother’s breast on the third day of her life, explaining that “right from the get go” she learned that “you better take it while you’ve got it.” However, Gloria had another traumatic experience four years later that she believes further instilled this ideology in her. At the time, Gloria’s mother needed to go to Washington, D.C. indefinitely to care for Gloria’s dying grandmother. Gloria’s father was working two jobs in New York City where the young family lived, and so Gloria’s parents chose to have an immigrant friend’s sister take in Gloria and her younger brother. Gloria explained:
It turned out my grandmother took six weeks to die, and in those days, especially with my parents’ income, you phoned once a week, because phoning was expensive and you certainly didn’t take a train back and forth, and of course my grandmother was about to die, you know, once [my mom] got down there and was told it was six weeks she had to rethink the thing. It could have been any day, so we stayed in that place six weeks, and my father came to visit us on the weekends. My brother was born this bubbly, curly-haired Gerber baby, delightful, my mother’s ‘perfect child.’ When [my father] came back [my brother] would go absolutely rigid and scream if anybody touched him. So it was clear that something went wrong in that place. That was such obviously wrong behavior that my father actually splurged and called my mother to describe the change in my brother...Well, it turned out that what happened to me there, is that at some point when I was playing, I was grabbed and taken down to the basement and severely raped with knives, and the reason I know this is I had to have surgery in order to have intercourse and they said the scar tissue went up higher than any male [genitalia could have gone] and I was left to die. I wasn’t fed.

Gloria went on to speak about how she was able to appear emotionally fine when her father came to visit because “I just left my body” during the traumatic instances. In addition, her caretakers later took her to a doctor and convinced them that she had fallen onto a chair, at which time Gloria was given medical attention but was not removed from that home because the doctor accepted the story. Gloria also added that “during that whole period, and I don’t know how long it was, I wasn’t fed,” connecting that traumatic experience with her inclination to overeat later in life. Gloria shared that after her mother had returned from D.C., “my mother had just had her mother die, my father was a total wreck, my brother was a completely changed individual. [My mother] couldn’t have handled me not being fine.”

For years, Gloria either didn’t know about or did not address these events and put on the appearance of being fine. However, she would eventually go through years of what she referred to as “abuse work,” or working through her past abusive experiences with therapists and independently. She spoke of being challenged by a therapist to return to the scene of her rape,
and of immediately leaving the therapists’ office after the appointment and “I double-parked... I ran into the store and just grabbed all the- I waited in line, and started grabbing all the candy bars, they were falling on the floor I couldn’t even hold them. I was in such a panic that I needed to eat.” She continued:

So, I associate that time in that basement when I also got the message that you don’t know when you’re next food, if you [have a] next food, is coming, and so if you send me to a buffet or a potluck, I will just eat and eat and eat because right now it’s there, and the four year old in me doesn’t know when it will be again, and as I got older, I realized that other people weren’t doing that, then I started being sneaky about it. I’d pick up three or four cookies and hold them behind my mug as I walk back over to my seat. So then I got into the alcoholic behavior of hiding it, [I] became to realize how peculiar it was.

Finally, Gloria also faced having a father whose treatment of her was sexually inappropriate, a point she brought up when discussing both her experiences with abuse and in regards to her struggle with the idea of praying to a male or patriarchal God in recovery. She shared:

I had a very complicated situation because my father used me to masturbate until I was old enough to talk. He would not hurt a flea, he would not have physically harmed me. Mostly that’s another deal because it was using things extensively because it was me, extensively because I loved him, that I didn’t like it didn’t matter. I found that out at one point when I was early on when I was in my abuse work. I asked my mother if my father had ever tickled her... I said to my mother, ‘Do you think there was any chance that my father would have tickled me as if it were for my pleasure, but in fact, I hated it?’ Her face went absolutely white, because he did that to her. So, as soon as I could talk, and I could talk early, that was over.

It is evident that Gloria felt that at least one of the abusive situations she survived threatened her ability to eat, but both led to a history of abuse that would affect her eating patterns and later play a large role in her compulsive overeating.
Eliza also connected the abuse she faced as a child with her development of compulsive overeating. When asked what she believed caused her compulsive overeating, she responded:

Well, I think I grew up in a very abusive, verbally and physically, emotionally abusive home. My mother basically was very abusive and my father was not really present or sort of, interfered, with my mother’s abuse. My mother was very emotionally incestuous, so I think it was the only way I had, other than being a very obedient and good little girl, was to eat, to stuff feelings. I didn’t know that that was what I was doing but I see now the sort of sugar, that I can’t control the amount of sugar I intake.

What Eliza says here resonated with the opening passage of this chapter, quoted from my interview with Gloria, which begins with “the only way we give to ourselves is to eat.” I want to suggest here that Eliza and Gloria both understood their compulsive eating as a response to their abuse, and that this eating was a way for them to nurture or protect themselves from the threats in their environment.

The same might be true for Diane, who connected her experiences growing up in a home with a physically abusive and alcoholic father to times early on in her life history when she would engage in compulsive overeating. When I asked Diane where she believed her compulsive overeating comes from, she responded by telling me this story, which takes place when she was six:

Everybody in the town, it was a small town, they knew my dad and a lot of his behavior became very abusive towards my mom, and the police would come and they’d bring him back the next day, and say you know, [whispers] ‘He’s drunk. It’s okay, it was just because he’s drunk.’ I don’t know where I got it. I always think it’s a god seed inside of me. I remember saying to a police man one day, ‘You know, he’s going to kill her if you don’t do something.’ And the police man just looked at me and he said, ‘He’s drunk.’ It never was satisfying to me that that would be answer...They would fight usually on the weekends and he’d usually try to kill her.
And honestly...I thought he did a couple of times. Her laying on the floor and six kids standing around to see if she was going to breathe again, you know. But she never like, made him leave, do you know what I mean? Because he would be sober the next morning and apologize, and then he didn’t drink all week and he was fine. It was crazy. When he finally did leave- I remember, I’ll never in my entire life forget this. He had come home and they had started fighting, so my oldest sister could drive, so she put all the kids in the car except for me because I was taking a bath and I got left behind. I remember them fighting in the living room, I could hear them fighting, I could hear my sister driving away. I was like, ‘Oh my god, they left without me.’ This was my thing. And I remember looking at them and throwing my clothes on, and I’m like ‘Ok, he’s going to kill her,’ because he was going after her with something. I don’t know what it was.

So I run down the street, it was a dirt road, to my uncle’s house who lived nearby, and I told him what was happening, and I said, ‘You have to call the police because he’s going to kill her this time.’ And my uncle said to me, ‘I’m not getting involved, here’s the phone.’ And I’m like six years old or something, so I said, ‘Okay, okay, okay.’ Where I get this from I don’t know, but I call the police, and they came and they took him. I don’t remember what happened that evening, and I don’t remember any of that. All I remember is the next day I was in the kitchen with my mother and of course he comes back because they keep him over night and then he comes back. And he said to my mother, ‘Who called the police?’ And my mother said ‘Diane did.’ And this is the last time I saw my dad. He looked at me and he said ‘Did you call the police?’ and I said ‘Yes, I did.’ And he left. He left. They got divorced. And I never saw him again.

During our interview, Diane also discussed times in her childhood when she had overate compulsively, often focusing on specific foods like tomatoes or apples. However, later in life she found that she engaged in under eating, especially throughout her years in high school. Diane could not explain why she had over and under eaten throughout periods of her life, and often answered questions pertaining to this point by telling about her abuse, which she understood as potentially causing the emotions that led her to eat. In addition, Diane’s story serves to demonstrate the role of addiction within the family in her development of compulsive eating behaviors. During our interview, Diane shared that she felt that there “are so many addictions in
"my family," adding that “I see so many addictions. People get addicted to computers, they get addicted to computer games, they get addicted to books, anything to not have to be present.”

Addiction was a popular subject among OA participants, who generally attested to having experienced addictions other than compulsive overeating first-hand or among family members. In addition, members would sometimes discuss the plethora of addictions that they felt existed. Some of these examples were not the typical addictions that come to mind when the program equates addiction with disease (i.e., “addicted to books”). What participants mean here, in part, is that addiction is a behavior that is diseased. However, what I also want to shed light on here is the limits (or lack thereof) of what can plausibly be classified as addiction, and the various other types of addictions participants engaged in beyond compulsive overeating. Finally, while slightly less than half of participants tied abuse and trauma to their compulsive overeating, all participants admitted to at least one other addiction they had experience with personally or within the family. Furthermore, they often portrayed their compulsive overeating as a continuation, exacerbation or as an accessory to this addiction or vice versa.

Addiction

*I’m sure there are details, ways in which particular addictions are different from each other, but it seems to me the whole structure of addiction is very similar, so I feel that I can relate to- my issue is not alcohol or drugs- but I feel I can relate to a drug dealer, even, or an alcoholic, [a] drug user. Just out of empathy for what it feels like to be out of control with food.*

*(Margaret Bullit-Jonas)*

*When I was listening to the stories [told in an AA meeting], I identified with a speaker who said that he filled up mouthwash bottles with booze so nobody would know he was drinking. And I realized that I walked around the house with a coffee mug filled with softened ice cream, so the kids would think I was drinking coffee. And I said to my husband, ‘That man is talking about me. I do with food what he said he did with booze.’*
Addictions were broadly discussed by OA members throughout my fieldwork observations, and more acutely during interviews. My findings suggest that compulsive overeaters often engage in other behaviors they label as ‘addictive,’ sometimes as accessory to or separate, but in addition to their compulsive overeating. In addition, many participants spoke of growing up in households where addictive behaviors were commonplace, and suggested that addiction itself was a behavior they inherited from their family and/or growing up in an environment where addiction was present. This point is reminiscent of the earlier discussion on childhood abuse and learned addiction as a coping mechanism; similarly, I assert here that the development of addictive behaviors, often different from those exhibited by the child’s guardians, was a coping mechanism against an environment that had addiction already present in forms inaccessible to the child (particularly alcohol).

Another point I’d like to make is how OA involvement made participants consider the limits of addiction. Which behaviors or substances are addictive, and why does it matter? Where does one draw the line between an addiction and a bad habit? I conclude this section by wondering what the prevalence of other addictions and abuse/trauma experiences amongst participants tells us more broadly about compulsive overeaters, suggesting that these should be subjects of interest for health care and anthropological professionals working with individuals with histories of disordered eating.

**Other Addictions of OA Members**

During OA meetings and interviews, members discussed an array of other behaviors that they felt were addictive behaviors. Some of these ‘addictions’ included: alcoholism, compulsively drinking soda, yo-yo dieting, stealing food, computer games, and drug use. Some
participants also identified with being ‘compulsive over-doers,’ meaning that they often found themselves always saying ‘yes’ to others’ demands and rarely having free time to themselves as a result. Unsurprisingly, some of these other addictions, like yo-yo dieting, stealing food and alcoholism, led to compulsive overeating. For instance, members sometimes discussed how drinking alcohol or yo-yo dieting facilitated a binge later on (Kelly, Alice). However, participants linked other addictions, like an addiction to computer games or shopping, as exhibiting the same behaviors as compulsive overeating. For example, Gloria connected her addiction to computer games to her compulsive overeating in that she used both behaviors to avoid being in the present.

In all, my interview participants and the OA members present for my fieldwork generally attested to having experience with at least one other addiction, if not multiple addictions. Another general sentiment among participants was the difficult quality of compulsive overeating compared to these other addictions. It was frequently pointed out to me that compulsive eating is particularly difficult because participants could not clean their houses of food. Sometimes participants asked me or other group members to consider, what if alcoholics had to have a glass of wine every day? What if drug addicts had to shoot up just a tiny bit of their drug every day while in recovery? It was this reasoning that led some participants to say that they wish that if they had to have an addiction, why couldn’t it have been a substance they could avoid?

During meetings members also connected their family member’s addictions to alcohol into conversations about abstinence. These members seemed to have understood the addictions of food and alcohol as very different, with food being the more challenging problem. Yet, when they discussed their family member’s alcohol use and abuse, it seemed that participants often felt that their compulsive overeating grew out of the alcoholic environment, particularly when the
alcoholic family member was a parent. This leads to my next section, dealing with addiction as a learned behavior.

**Learned Addiction?**

As discussed earlier in this chapter, some participants turned to compulsive overeating after instances of trauma and abuse. Other participants felt that they began to compulsively overeat to deal with difficult emotions. For example, Meredith spoke about how she viewed all of her “problems with compulsive behaviors, addictive behaviors” as starting when she was a teenager “trying to escape difficult feelings of adolescence.” Other participants spoke about growing up in homes where addiction was a part of life, with parents who had addictive tendencies. These three reasons are far from mutually exclusive, but they still represent the three foremost explanations that participants told me they turned to compulsive overeating.

Almost half of participants spoke about alcoholism within their families growing up, slightly less than the number of participants who spoke about struggling with alcoholism themselves. When asking participants if they felt that addictive behaviors ran in their family, the answers varied. Diane felt that addictions “definitely” run in her family, noting that she “grew up in a family where alcoholism was perfectly acceptable, I grew up in a town where it was perfectly acceptable.” Diane felt that addiction was a behavior that she learned from having an alcoholic father and a mother who Diane felt was addicted to smoking, weight loss and overdoing. Diane saw her development of compulsive over and under eating as a way to cope in a family whose economic resources were often lacking because her father spent a large amount of his earnings on alcohol. In addition, Diane contributed her under eating to her mother’s persistent demands that Diane and her sisters be thin. For Diane, compulsive eating was a way of negotiating the economic and social constraints of and surviving within her family.
In *Holy Hunger*, Margaret Bullit-Jonas also attested to having the same life-defining relationship with her parents’ alcoholism while growing up. During our interview, Bullit-Jonas described the continuation of addictive behavior across her family as a combination of:

> Some genetic predisposition, maybe, [and] it certainly involves conditioning, because I grew up in a house, the classic adult-child household, where you “don’t talk, don’t trust, don’t feel.”

*(Margaret Bullit-Jonas, quoting Claudia Black, 1987)*

For Diane and Margaret, their parents’ addictive behaviors defined the terrain of the family and their own development as individuals having to negotiate this terrain. They both connected their compulsive overeating with this life history, and compulsive overeating became a way to cope with the situation. However, not all participants who claimed to have addicted family members contributed the same nature to the development of their compulsive overeating.

Tracy spoke about her dad’s alcoholism as:

> More than being a factor in my development as a compulsive eater, he’s more like an ally. [He was] somebody else in the family who had the same problem and was there to help absorb my pain as a compulsive overeater.

*(Tracy)*

Tracy’s comment suggests that a shared tendency towards addiction was something that bonded her with her father, secondary to any possibility that her father’s addiction might have predisposed Tracy towards having an addiction.

Eliza spoke about learning components of addictive behavior from her mother as a young child. She told me:

> I know my mother would hide things for her bridge, whatever clubs that she had, and my brother and I both know where to look. We were really good at finding where she would hide stuff. That was another
thing. I got good at being sneaky and hiding things. It was something that I learned to do very early on in order to be safe and comfort myself.

(Eliza)

In addition, Eliza saw aspects of addiction in her mother’s treatment of cigarettes and sugar, and also thought that she (Eliza) used sugar to cope with a mother who was emotionally abusive. Overall, participants who grew up in households with addicted parents attested to using compulsive overeating as a coping mechanism which started in childhood and often continued long into adulthood, but this was one perception among other possible understandings of the relationship between addicted parent and child.

A few members brought up concerns that they believed current close family members might have addictions, particularly overeating. Jaime, for example, expressed that he suspected his brother might be a compulsive overeater. In addition, some members presented worries that their children might learn addictive behaviors from them. During our interview Kelly expressed concern that her son had traits of a binge eater; Alice had the same concern for one of her children, noting that she felt that her son would “suffer if he does not realize it soon.”

When I entered fieldwork, I expected overeating, alcoholism and drug use to be the addictions discussed in these meetings, mostly because I contributed these addictions to the addiction of consuming in the most literal, hand-to-mouth sense. Over the course of my fieldwork I gained two perspectives that challenged this conception. First, the addiction was not just one of consuming, but also one of stuffing emotions, self-hate, self-deformation, or infantilization to participants. Furthermore, I’m sure that there are countless other ways in which compulsive overeating functions as addiction for compulsive overeaters beyond those discussed by informants. My second finding was that there was a plethora of addictions I did not expect to be discussed on a regular basis, and more than that, it was often not just one member discussing
them. During one meeting, a member admitted to stealing food long, long ago; within minutes, half of the group admitted to doing the same thing before coming to OA. Members saw addictions within their own lives that they probably would not have considered as such before entering the OA program. It was these realizations that made me question the limits of addiction among members. In other words, at what point was a habit a problem, and at what point was a problem an addiction?

The Limits of Addiction

In general, participants stated in meetings and in interviews that something was an addiction when there was no actual benefit gained by the individual for partaking in the activity. This is a part of the ‘insanity’ of the disease to which some members referred. That is, they would compulsively overeat and gain no benefit from doing so, but would still compulsively overeat the next day. This type of ‘insanity,’ in part, is what made members view the disease as a disease. However, at times members questioned the limits of their definitions of addiction as well. Eliza did so during our interview when she wondered whether or not her brother’s extreme physical activity could be counted as an addiction, saying “I don’t think it was self-destructive, but it’s definitely a major force in his life, so I’m not sure what the line is.” Similarly, some members questioned during our interviews what counted as compulsive activity when it came to ‘diagnosing’ others with addictive behaviors. Tracy, who had been in recovery for over three decades, spoke to this when she shared that:

*The problem with me was, I was getting the help for me, but I thought everyone else needed it too. I did not understand that it’s a continuum of compulsive eating. That many people eat too much sometimes or eat for the wrong reasons or eat socially or overeat and then feel sick, but they don’t qualify as true compulsive overeaters and it’s not my place to go around diagnosing people, either.*
When it came to diagnosing other individuals, members usually either claimed that they were entirely unsure about whether or not others they knew had addictive behaviors, or they spoke of seeing the addictive behaviors everywhere in the individuals they knew. In this way, the limits of addiction became self-defined and individualized. Overall, though, members were much more critical of their own behaviors as signs of addiction.

Members frequently named other behaviors they had that they felt were addictions, often synonymizing their behaviors with these addictions to those they exhibited when eating compulsively (i.e., hiding the object of their desire, hoarding these objects, or swearing off from an object/substance only to ‘binge’ on it later). For example, Diane explained that food was a way for her to hurt herself, noting that “I did it with cigarettes, too... and it was a way I could hurt myself. It was a way of escaping from the world.” Therefore, it was the nature of the behaviors that indicated addiction and disease, yet the limits were often ill-defined and left up to interpretation. Members were allowed to see addiction where they interpreted it, but often tried to withhold outright diagnosing or labelling of others as addicted. Those that did claim to see addictions in family members often noted that they knew they could not confront these people about their addiction/disease, as this would be an unproductive strategy. Instead, members chose to try to encourage their loved ones to partake in positive behaviors and make their own realizations.

**Summary**

The participants in this study all share some experiences of abusive and/or traumatic experiences or addiction. In addition it is likely that overeating is just one of a series of
addictions faced by compulsive overeaters throughout their lives, both personally and within their families. Members who had experienced abusive or traumatic situations spoke of these situations having a direct effect on their development as a compulsive overeater. In addition, members who grew up in households where addiction was prevalent primarily suggested that these environments led to compulsive overeating as a coping strategy.

Also suggested here is that the limits of addiction are potentially boundless when self-defined. Clearly, compulsive overeating is a complex addiction, and participants’ narratives suggest that its development has much to do with learned behavior, coping styles, and a need for (spiritual) guidance. Many participants turned to OA because they felt that the program addressed aspects of their addiction better than previous solutions to their compulsive overeating. Of course, the conclusion here is to ask how other medical or therapeutic solutions could be better prepared to work through these aspects of addiction with overeaters who have complex histories of trauma and addiction.
Chapter IX

“Carrying the Message”: The Politics within Overeaters Anonymous

*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.*

-Step Twelve (oa.org)

The majority of this work has focused on the experience of individual participants who identify with compulsive overeating. These individuals all participate in the OA program and identify their own formation of a disease narrative, having a Higher Power, and the frequent role of addiction and abuse. While I have occasionally pulled data from my fieldwork experiences in meetings, I have not incorporated interactions between participants in meetings. In part I have done this to protect specifically what is said in meetings and those details that I have shared were repeated by many members over the course of my fieldwork. However, a less private aspect of OA meetings is the monthly business meeting.

On business meeting days, it is typical for meetings to close fifteen minutes early to start the business meeting which, of course, has its own format which includes opening with the Serenity Prayer. Rozanne, OA’s founder, related in her book on the history of OA that business meetings were a place of tension and disagreement amongst members in the early years of the organization (1996). Thankfully, the OA business meetings I was present for were not argumentative. Yet, these meetings still displayed the concerns of individual members put forth for group conscience. These concerns shed light on what it means to live out step twelve and ‘carry the message’ of recovery. The same can be said of individual concerns that members shared with me during our interviews. These viewpoints, too, demonstrate members’ struggles
with not only carrying the message, but inner battles with what kind of message they are carrying.

Within this chapter I examine group concerns largely expressed in business meetings, including changes in the OA language during my fieldwork and the challenges of spreading the message of OA to the local community, specifically to younger populations. I then turn to concerns expressed during interviews with individual members, including the different ‘sects’ of OA, the debatable patriarchal nature of the program, and how to spread the message of OA within one’s life and on the global scale. Together, these concerns represent areas of tension and contradictions within the OA program, and indicate ways in which OA could thrive or fail in the future. In addition, I have no doubt that these concerns intersect in unique ways that may explain the ability of OA to perpetuate itself in future decades. For instance, I left my fieldwork wondering if Overeaters Anonymous would be frequently interpreted by specifically third-wave feminists to be disempowering, a viewpoint that would likely discourage the youth more broadly from joining. This may explain the current shortage of youth, compared to older populations, in the program. Regardless, for now the program remains disproportionately female (2010 Membership Survey Report). Meanwhile, during business meetings members expressed concern for gaining attraction from youth, and individual female members debated during interviews whether or not they, as women, found the program empowering in relation to that identity. In sum, this chapter is meant to shed light on concerns that will likely affect the vitality of my two sites of fieldwork and OA as a whole.

**Business Meetings**

Business Meetings in OA were, ethnographically, an important sight to witness the politics of the organization. Business meetings were sites of governance, and to some extent
demonstrated debate or conflict among individual members. In another sense, the order of the business meeting and the ways in which individuals spoke reflected the democratic values of OA. As was often said in reference to these meetings, “everyone has a voice and a vote.”

The format of the meetings, like regular OA meetings, is scripted. A member will volunteer to be the meeting leader. Generally, the secretary reads the notes from the last meeting. Then the meeting leader calls upon the literature person, the treasurer and the intergroup representative to report to the group. The literature person is in charge of making sure the group has enough books, pamphlets, and newcomer packets. The treasurer is responsible for collecting donations after each week’s meeting, paying rent, and making suggestions for how the rest of the money should be spent (usually offering that it should go to the World Service or Intergroup offices of OA). The Intergroup representative reports on what has been happening during intergroup meetings, which cover a specific geographic area. Often, the intergroup representative will report back on language changes in OA, volunteer position announcements, or upcoming OA events.

After this is done, members will often discuss new orders of business. During my time in the two field sites, I noticed that three topics continually came up as important new orders of business: changes in OA language, gaining attraction from the local community, and addressing the lack of youth in these groups. These concerns, although group-specific, may hint at the larger concerns of OA groups across the nation.

The Intersecting Needs of Carrying the Message

During my fieldwork there were two notable changes in the language used in Overeaters Anonymous. The first was that there was a change in preferred identification of overeaters, from
“compulsive overeater” to “compulsive eater.” This change came in the form of an announcement sent to all OA groups from the World Service Organization (WSO), after the measure was voted upon at the WSO Convention. This change generated some concern among my participants. For instance, one member wondered if the organization would now have to change its name to Compulsive Eaters Anonymous? Other members during the meeting voiced that they felt that the term ‘eater’ sounded weird, as eating wasn’t quite the problem, but the amount or way in which one was eating. The member who reported on the change during one business meeting explained that it was only for introductions, and not meant for the entire OA program, emphasizing that the decision was made because not everyone in OA overeats. That is, some members under eat. The group then adopted the measure without concern, and for some time afterwards a handful members were working towards changing their language in meetings to reflect the WSO decision. Of course, the events of this change indicate that on the global and local level, Overeaters Anonymous is more cognizant of how their language might include some while excluding others. I have little doubt that this change is in reaction to the increased numbers of men and women who struggle with anorexic or bulimic behaviors. While during my fieldwork there were comparatively few individuals who identified as under eaters, those that did identity as such were often newcomers who attended one of the two meetings I was present in and never returned. This experience indicates that the change in language is meant to both attract under eaters and give them a sense of belonging within OA groups. The second change in language, made to the OA preamble, is written below, with underlined text indicating what was added:

*Our primary purpose is to abstain from compulsive overeating and to carry the message of recovery through the Twelve Steps of OA to those who still suffer.*
Again, ‘compulsive eating’ is the preferred term, putting emphasis on the compulsivity of the act without using quantifiers on food intake. Interestingly, this change also implies that the 12-step message of recovery is only one singular message, ignoring the many variations of the program, which are discussed below. However, what these changes most demonstrate about the state of OA is that the organization is concerned with including individuals who engage in under eating. This language suggests a new emphasis on the commonality of compulsivity and behaviors around food that anorectics, bulimics and overeaters possess. As evidenced by the literature review presented in this work, anorexia and bulimia have become increasingly prevalent over the last forty years, and no doubt OA’s change in language demonstrates a desire to situate itself as a potential resource for under eaters. This desire also speaks to the needs of OA.

Recall that severe under eating typically develops during adolescence and is increasingly prevalent with each generation (Hudson et al. 2007; Hoek & van Hoeken 2003), including geographic areas that were recently Westernized (Gunewardene & Huon, 2001; Pike and Borovy 2004). Only 2% of OA participants who responded to the 2010 Membership Survey were younger than 18 years of age and only 14% were between 19-25 years old. On the other hand, the two groups I worked with did not well-reflect the survey data in that most of the members in these two groups were aged forty-six and over, and the 56 years of age or older group accounted for only 30% of survey respondents (2010 Membership Survey, www.oa.org). However, the lack of young people was still apparent and discussed in business meetings, as well as how to reach out to the local community to attract newcomers to meetings. The change in language of OA around the term ‘compulsive eating’ demonstrates not only the organization’s developing message about what counts as compulsive food behavior, but also a need to carry a modified
message to generate interest in meetings. Furthermore, as evidenced by member suggestions in the 2013 Fellowship Survey, one respondent wanted “greater inclusion of all types of food disorders; i.e., anorexia, bulimia, restriction, exercise obsession, etc.” (Anonymous respondent, www.oa.org), and the suggestion to include anorexia and bulimia within the program was mentioned twice more in the survey. This development in the program goes hand in hand with the next two areas of concern expressed during business meetings: generating newcomer interest and attracting younger members.

During one business meeting, the group was trying to decide where to allocate their literature funds when one member suggested that having more of 12-steps and 12 Traditions books would be most useful because they could have them for sale for newcomers to purchase. Newcomers were an important topic stressed during business meetings, particularly when it came to ensuring that the meeting could comfortably accommodate them. Members in OA meetings occasionally discussed their best approaches to talking to newcomers, how to appropriately attract their friends and coworkers--those that the members felt compulsively over and under ate--to meetings, and how to follow-up with newcomers by telephone after the meeting. Members often spoke about Tradition 11, which in part reads: “Our public relations policy is based on attraction rather than promotion.” Tradition 11 also emphasizes the maintenance of anonymity. The goal for members was to generate interest from individuals who suspect they might have an obsessive relationship with food, rather than to break anonymity publicly within the media or market the program. While emphasis is put on the growth and development of OA as a whole, members are instructed to do this by generating individual newcomer interest and furthering their own recovery (see Opinion/Conclusion, p. 4-5 in 2013
Fellowship Survey, www.oa.org). In this way, members outwardly demonstrate the recovery the program provides.

About half-way through my fieldwork, one of my field sites became more serious about attracting newcomers, and organized to distribute literature within the community in order to do so. They began a campaign to put OA brochures in therapist and physician offices using the OA brochures “To the Newcomer” and “To the Professional.” Members also made suggestions to make “business” cards for their OA group that they could distribute. In these discussions, members made clear that they wanted ways to get the message out that were discreet. Business cards or a flyer placed in a doctor’s office could be easily accessed or read by a patient without much notice from anyone else. What was most interesting to me about the campaign was how the majority of members present for those business meetings mentioned being willing to drop off these materials at therapist and medical offices, instead of churches, schools or community buildings. In some sense, there was an assumption that targeting the medical field would be preferable, even when the OA message largely emphasizes spiritual growth and the value of the fellowship. In other words, it seems that participants felt that compulsive eaters who were not members of OA were probably turning to doctors and therapists for help with their eating, not spirituality and community. This is likely, given the literature review and interview data presented above. The literature campaign aimed to give three-fold recovery when therapy and medical visits weren’t enough. In addition, the campaign represented the push from the higher levels of OA to spread the message, a phrase that was used liberally in the program and that is echoed by the authors of the 2013 Fellowship Survey, whose concluding opinion reads:

The responsibility for the survival of OA rests firmly on the shoulders of all members, not only with the trusted servants who are doing so much to support the fellowship. How do we get that message across? We must encourage members to take action, responsibility and
ownership, not only of their personal recovery, but also of the welfare of Overeaters Anonymous as a whole.

- (Fellowship Survey 2013, p. 5)

Another concern of my groups, and one also reflected in the 2013 Fellowship Survey, is the lack of youth in the OA program. As mentioned above, only 2% of the respondents to the 2010 Membership Survey were 18 years of age or younger and only 14% were between the ages of 19-25. In the meetings I attended, I only met one individual who was younger than 25 years of age. I wondered where the youth were and so did my meeting members. When brought up as the topic of conversation, the lack of newcomers was usually followed by a comment about the lack of young newcomers in one of my field sites; the other field site did not seem as concerned about the lack of youth in the group, although it was mentioned once or twice over the course of my fieldwork there. In the 2013 Fellowship Survey, one respondent noted that:

We don’t do enough to attract young people. The assumption that a lot of people have with Overeaters Anonymous is that it is for overeaters only. Anorexics and bulimics likely do not know how the program could help them. I’d like to see OA as a whole provide more information at the public level.

This respondent linked young people’s compulsive food behaviors with anorexia and bulimia. That is, if OA fails to cater to the needs of anorectics and bulimics in recovery, it fails to cater to a population of young people that could join the program, and therefore the program may not survive. The Fellowship Survey also addresses these concerns by saying:

One member asked: “Is OA dying? I’ve heard that movements die after 3 generations (60 years). The first generation is on fire. The second generation lives off of the first generation’s enthusiasm and the third generation becomes indifferent.” If this is what we’re facing, then we need to work to improve the enthusiasm and excitement that comes from being a member of this program.

The task of making OA thrive is put into the hands of individuals and groups to build their own recovery and make OA known through living the 12-steps and spreading the message in effective
ways. It seems that the OA group implementing the literature campaign may be on the right path to doing just this. In a systematic search of prevention and treatment intervention studies since 1980 in youth ages 12-25 years, Bailey et al. (2014) found that out of 197 trials and 22 systematic reviews, psycho-education, a form of treatment that educates a patient about their illness and what they can do to recover, was the primary trial used in prevention research. However, cognitive behavior therapy and antidepressants were the most common interventions for bulimia. What Bailey et al.’s data suggests is that younger populations with eating disorders, particularly bulimia, are more likely to turn to professional therapy and medical solutions. Culturally speaking, community-based, non-medical prevention programs and treatments are rare, and in terms of treatment OA represents a potentially less evasive way to recovery.

Therefore, there is much reason to advertise OA within medical and therapists’ offices. Whether or not young people with eating disorders are aware that OA exists is a question worth asking, and one that should be further explored. However, a larger question might be, if OA is known to be a resource among younger populations with eating disorders, why would it not be utilized? This leads to a discussion on the other potential barriers of the program as identified by members during interviews.

Concerns of OA Members

The concerns that were presented more frequently in fieldwork during one-on-one interviews with members included the lack of youth in the program, what language should be used in the program, and how to spread the message of recovery on local and global levels. In addition, it was the passion with which these concerns were often discussed in interviews that
has urged me to analyze them here. I suggest here that these are concerns that current members fear could prevent future newcomers from joining OA.

‘Sects’ of OA

One of the first questions generated by my fieldwork was what counted as an Overeaters Anonymous meeting. I only visited four potential field site groups, each of which seemed to have its own meeting format, literature and popular sayings. Each of these groups had its own primary goals, too, whether it was getting newcomers through the door, reaching out to newcomers who visited once and hadn’t returned, or generating interest among compulsive under eaters. In a sense, each OA meeting has its own culture. However, it was the reactions from other individuals that prompted my asking what counted as OA. Often members would ask me what other meetings I had visited, and sometimes this would elicit their opinions of these meetings. More than one group member told me in regards to another group, “They call themselves OA, but they’re not.” It occurred to me after my fieldwork was finished that this type of statement speaks to a kind of politics of OA. Not only were there many variations of the OA program--which some participants referred to as ‘sects of OA,’--but there were specific ideas of what OA is and what OA is not that were not homogenous among participants. Predictably, this variation was cause for some amount of dissent towards different variations in practices of the program.

Above and beyond, the greatest source of difference (and at times tension) among groups was whether or not OA members should follow a certain food plan and, if so, what that food plan should be. This latter part was not a large part of my field research because neither of the groups in which I conducted participant-observation in recommended that members prescribe to a
specific diet, although some members were abstinent from flour and sugar. However, within the
two groups I participated in it was clear that some members had an issue with OA groups
recommending or requiring certain diets for newcomers, particularly when newcomers were the
least likely to know that there were different kinds of rules and requirements in different
meetings. In particular, there was distaste among my field sites for groups that required specific
diets, often adhered to for at least ninety days, in order for newcomers to speak in meetings.
These meetings were often referred to as the ‘90 day’ form of OA, which Jaime spoke about
having a personal preference against during our interview:

_The only difference between those and regular OA meetings is that you
have to have been abstinent⁴ for 90 days in order to share at the
meeting or to hold any kind of office in the group. I strongly disagree
with that approach. I find that just wrong-headed in a very
fundamental way, because to me, if the first meeting I had gone to was
like that, and I couldn’t say why I was there, if I were not allowed to
say anything the first three months of that program, I wouldn’t have
been there for three months, I would have quit. It just seems to me-it
also, in my opinion, just violates the traditions of OA ... Again, for
some people that’s exactly what they need and that works for them,
and so I don’t- I’ll express my personal preferences if somebody asks
me about it, but I don’t, I don’t give those people a hard time because
if it works for them who am I to say they shouldn’t do that._

For some participants, a 90-day meeting or similarly rigid meeting was the first one they went to,
while others lived in areas where these meetings were simply more popular. During our
interview, Joyce discussed what it was like for her when she first entered the program in an area
that had groups that usually followed the “gray sheet” form of the OA program. Joyce described
the gray sheet program as requiring that participants consume “no flour, no sugar, nothing, it was
very rigidly whole foods, and no potatoes, no starches basically of any kind,” adding that “but
you were very scrutinized by your peers in the group... if you slipped.” Joyce passed over this

⁴ Note here that the meaning of ‘abstinent’ might change depending on the groups, but that generally the 90-day
version of the program in the area in which I conducted fieldwork described abstinence as not engaging in
compulsive eating and not consuming sugar, flour or wheat product.
kind of group for one that referred to itself as HOW, standing for “Honest, Open and Willing” which she found to be more “mellow” about food plans. She shared that:

There would be people I saw come and go so quickly because they had gone to other meetings. They were like, “Well, they’re not going to let me speak at the meeting,” or you know, their rules were very, very strict, and I didn’t appreciate a lot of what I was hearing about OA in general, it just seemed a little militant for me.

Nonetheless, Joyce still largely followed the gray sheet food plan during her first months of recovery. She found that the plan didn’t work for her, and ended up admitting to her sponsor that this was not what she had in mind for recovery when she went into the program. Simply put, Joyce felt that she was starving her body of things her body required. Margaret Bullit-Jonas admitted the same sentiment during our interview as well, stating:

For me, after three some months of going to a meeting every day and weighing and measuring my food without exception, and eating off the gray sheet, I started to feel like this is not feeling sane to me, and my therapist said, I think, her opinion was some people for all their lives need this kind of structure in order to be safe, but that other people don’t, and that she said she didn’t think I did, so I made a gradual transition. All the people in the gray sheet community said it was either black or white. If I left them, if I ate a baked potato, if I ate a banana, I was going to go wild and go back on a binge and be lost. So I found someone in the more moderate meal branch of OA who was willing to sponsor me, kind of help me make the transition out of gray sheet into more moderate meal.

The all-or-nothing attitude of 90-day or gray sheet programs was something that also came up during my field research. Some members expressed during meetings that they felt that the 90-day meeting format broke down the meaning of democracy and equality amongst members in the program. I realize that my participants were biased against strict meeting styles, and this is perhaps why a handful of them ended up in groups that advocated that individuals choose diets that work for them and find recovery in the ways they need most (i.e., spiritually, physically, emotionally). An area of further research might be to explore how 90-day meeting members
understand the values of eating and speaking requirements to their recovery. However, my members’ concerns with the rules and rigidity of 90-day and gray sheet meetings also speak to their larger concern with what the values of OA should be, and how they should practice these values within their lives.

OA Traditions and Values

The core values of OA are well-reflected within the 12 Traditions of the program. The Traditions read:

1. *Our common welfare should come first; personal recovery depends upon OA unity.*
2. *For our group purpose there is but one ultimate authority — a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.*
3. *The only requirement for OA membership is a desire to stop eating compulsively.*
4. *Each group should be autonomous except in matters affecting other groups or OA as a whole.*
5. *Each group has but one primary purpose — to carry its message to the compulsive overeater who still suffers.*
6. *An OA group ought never endorse, finance or lend the OA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.*
7. *Every OA group ought to be fully self-supporting, declining outside contributions.*
8. *Overeaters Anonymous should remain forever non-professional, but our service centers may employ special workers.*
9. *OA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.*
10. *Overeaters Anonymous has no opinion on outside issues; hence the OA name ought never be drawn into public controversy.*
11. *Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, films, television and other public media of communication.*
12. *Anonymity is the spiritual foundation of all these Traditions, ever reminding us to place principles before personalities.*

-(www.oa.org)
These traditions speak to how members should treat each other, understand the program, and appropriately spread the message about OA as a resource for compulsive eaters. Yet, there was still some apprehensiveness expressed by members who wondered how to best follow some Traditions, particularly when it came to carrying the message of recovery. Members wondered what it meant to attract rather than promote OA and if it would ever be appropriate to drop their anonymity publicly. During our interview, Eliza admitted that she struggled with choosing attraction over promotion in OA, and often had to stop herself from publicizing her involvement in the organization:

*I identify with people who are recovering addicts and compulsive people, that we have that tendency, [to think] that we have the answer, not only for us, but for everybody else, and I still have that tendency myself, it comes out, and it’s hard for me not to try to publicize or market OA and to just listen and be supportive. And I think even when people, when I share about “Why don’t you have this?”

I’m...learning how to be graceful, sincere and being of service and not knowing the best way. [I’m learning to be] open to the best way at the moment because it’s always different. And I’m trying to learn that maybe it’s something I can’t really handle. Maybe that’s all I have to say, that, you know, I mean I tell people that I’m addicted to sugar, I can’t eat this stuff, I had my quota, but I realize it can just be really simple, and I guess I don’t trust that Goddess will, if people need to hear the message then maybe I can be of service, and maybe that’s not what they need, you know, or maybe they just couldn’t hear it so, just to be gentle. Just say, you know, ‘I have a problem, I can’t eat this stuff.’... I’m very good about anonymity, I’d say for the most part I take that very seriously, but attraction versus promotion is an area that I have many opportunities, I’m given many opportunities to improve.”

Learning how to live the 12-steps and gain attraction from potential newcomers this way, as opposed to marketing the OA program, was a concern elaborated on by members during the business meetings as well. As mentioned above, members would discuss tips for being welcoming, and not intimidating, to newcomers. Eliza shared how another newcomer followed
up with her after her first meeting, an event that urged her to come back to OA. She encouraged others to do the same for newcomers. Jaime shared that while he used to tell newcomers his whole recovery story after meetings, he now takes a step back and simply says ‘good-bye’ to them after the meetings, as he realized his previous approach might have overwhelmed newcomers. In these ways, members suggested ways to attract individuals to meetings through gentle fellowship and a sense of community, as opposed to advertisement. And in some sense, the continuous business meeting conversation about how to best cater to newcomers and garner their attention revolved around a concern for how best to meet the standards of the eleventh Tradition.

A second data pattern worth discussing relates to the first tradition, which ends with “personal recovery depends upon OA unity.” During interviews, two members discussed how OA meetings have progressed with available technology, so that in recent decades telephone and online meetings have become quite popular. Robin and Meredith both discussed how they went to phone meetings, and Meredith commented that she had “mixed feelings” about telephone meetings, noting that “I’ve gotten a lot out of them on occasion, but I like face-to-face meetings much better.” Developments in communication technology have also allowed Meredith to attend OA meetings based in the US from abroad, as well. However, Tracy had a different opinion about telephone meetings, hinting that these new forms of meetings might start taking away from that first tradition and disintegrate the unity of OA. She shared:

_I am a little bit concerned about the big trend towards telephone meetings. For many people, that’s a substitute for face-to-face participation. I don’t want us to get lazy and stop being with each other physically in rooms to sit together. I’m not happy about that._

When I asked Tracy if she felt the same way about internet meetings, she responded that:

_Yes, I do. I don’t want OA to become dehumanized. But, you know, it’s good because we’ve got energy crisis going on, and people are able to_
get help and connect with each other without using fossil fuels, so that’s a good thing. People who are unable to go out because of physical handicaps or whatever medical conditions, they can get OA too from their home, so I’m not worried about it, I just want for people who can get out and go to meetings to go do that, and not to be lazy.

However helpful telephone and internet meetings may be Tracy suggests that they can also be viewed as a way for OA members to lose humanizing and communal aspects of their recovery, thus leading to a breakdown in how the OA Fellowship is currently felt and exhibited. A final tradition members struggled with indirectly was tradition ten, which states that the OA organization has no opinion on outside issues. This tradition, which members questioned the meaning of in terms of the history and values of the 12-steps in regards to women’s recovery, is the subject of the next section.

Women’s Empowerment in the OA Program

When I entered fieldwork I wondered what it meant that OA had no opinion on outside issues, and as my fieldwork progressed I wondered this same question in relation to feminism and women’s experiences. After all, OA’s predecessor, AA, was created by white men and could only be used by white men for some years. OA may have been founded by a woman, Rozanne S., but the program still made frequent reference to a God whose roots lie in patriarchy and the Judeo-Christian tradition. Furthermore, while the organization is disproportionately female, can the OA program be considered empowering for women specifically, or was OA’s lack of comment on feminist issues an upholding of the patriarchal status quo? I wondered if specifically female OA members thought the program advocated action or acceptance of inaction, the latter of which is both a passive response and could potential promote a tendency to blame oneself for all of one’s life issues without looking at societal contributors.
One event that particularly sparked my interest in this subject occurred during a meeting five months into my field research. When I arrived at the field site, the usual meeting room had a group of men in it, and OA members, who were all female that day, were quietly slipping into an adjacent room. During the meeting, participants noted how the usual meeting space was being taken up ‘by men, taking up space.’ Members were clearly peeved that these men had made an assumption that they could use the room at this time, and while speaking some members said they felt this was typical male behavior. Then, one member spoke up and confessed that she was enjoying this drama, and that the tenth tradition speaks to this by saying that we shouldn’t be drawn into controversy. Another member agreed, noting that what the group should be focusing on was the disease and their own spiritual growth. This member added that the disease is progressive and that most members are often in danger of breaking their abstinence at any moment.

I want to suggest here that both sides have valid points. Indeed, the members are there for help with their compulsive eating behaviors. However, I believe the members upset with the situation also had a worthy argument. They were hesitant to disrupt the meeting of men to announce that they needed the space for their OA meeting; to do so would be to break anonymity which may have been a challenging prospect for some members. The most intriguing aspect of this was how attention was re-directed, from a conversation about men impeding in a primarily female recovery space to focusing on looking inwards to do a self-inventory of recovery weaknesses. I do not mean to assert that some members were feminist and others were anti-feminist as I do not believe this was the case, but I do believe this would not be a productive avenue of thinking about these issues. I instead want to explore how the OA program, as understood and utilized by members, contributes to how members understand empowerment
within the program, specifically related to women and their experiences. I should note that my data in this area is preliminary, but that it is an area for further research.

While I did not plan to ask my participants about whether or not they felt the OA program was empowering specifically for women, the more it was hinted at in interviews the more interested I became in soliciting longer explanations from participants on this manner. If the female identity was brought up in relation to the 12-steps, or if experiences about attending female-only groups entered the conversation, I would ask members to say more on this topic. The responses I received suggest that about half of my members recognized the patriarchal foundation of 12-step groups, and sometimes these members elaborated on this assertion by discussing some of the OA language such as the use of the word ‘God.’ However, the majority of these findings suggested that female members found ways to make the program feel empowering to them despite these patriarchal foundations.

The fact that the 12-steps were created by white men for white men was one that came up a handful of times during interviews. Jaime, the only male OA member I was able to interview, spoke about the “cultural presumptions” used in AA’s Big Book that “bug me every time I read it,” detailing that these presumptions include “things like all alcoholics are men [and] that women are wives at home, [that they are] housekeepers, the gender modeling that was current n the 1930s.” Jaime added that he was equally annoyed with the Big Book’s assumption that “we’re all Christians here, we all believe in God, we all read the Bible assiduously... which today, that sort of assumption is just not cool, and for good reason because we’re all not like that.” However, Jaime also argued that OA as a program “is much more liberal-minded than that.” He accredited this difference both to the values of our century, but also to the fact that the OA program is mostly composed of women and “it’s mostly women who in general tend to be
more open-minded than men.” While I can’t necessarily agree or disagree with Jaime’s last assertion, I do think that when compared to the foundations of AA, the OA program from its inception has been more open to a variety of members and has allowed members to have free reign to understand the origin of their disease and define their Higher Power. In these ways, the program has absolutely been more liberal than the traditional AA program, which tied together alcoholism with a need for medical attention, and whose Higher Power was a strictly Christian God (as discussed in the literature review). Joyce also spoke to knowing other individuals who were offended by some of these aspects of the program, noting that:

“I know a lot of people who have not stayed because of it, who’ve said ‘I can’t stand to hear this being read, I can’t stand to say the prayer at the end.’ In AA, we used to say “Thee Our Father,” which is a very patriarchal prayer, and I know people who would just stand there silently and put up with it, but you know [they] couldn’t go there.”

Meredith also admitted to having issues with the program’s foundations. She said:

We were expected to read the Big Book of Alcoholics Anonymous and the Big Book was written about a bunch of white, Christian men, and a lot of white, Christian men attitudes that were in there bothered me. But I felt, at the time, I just really felt that I had to try to get past that and see what the kernel was that was in there, and I did that, I just, I’d think, ‘Okay, yeah, I really don’t like the wording of this, I don’t like this idea right here,’ but I just kind of pushed through it because I knew this twelve step thing had something to do and I wanted to find out what it was.

When I asked Meredith if the fact that the OA program was founded by a group of women made any difference for her, she responded that she had never considered that fact, but instead what impressed her about the OA program was that:

Our book, the main book that we use, The Twelve Steps and Twelve Traditions of Overeater’s Anonymous, was created by a process that involved people arguing and disagreeing and not liking this and not liking that, and by consensus this book was produced that truly has nothing in it that I object to. It really just doesn’t push my buttons.
There may be some things in there that I question, but for the most part I think it’s a really good, well-done book about the problem that we have and about the twelve steps and the way they work. So, I think that’s part of what I most respect about it and like about it, is that it represents kind of a distillation.

Therefore, what Meredith doesn’t like about the OA program seems to mostly come from its connection and use of the AA program and AA literature. For her, OA represents the ability of a group of people who rarely agreed at first to come together and form a coherent and open-minded program that would change the lives of thousands of people. Above and beyond the group having patriarchal foundations, what is important to Meredith is the unity that it represents today, and the fact that OA leaves many aspects of the program up to compulsive eaters to define and individualize. For example, the main text in OA, the ‘Twelve and Twelve,’ uses the word “Higher Power” instead of “God,” therefore allowing members much more freedom to define their Higher Power as they so choose.

In addition to these conversations, Eliza and Kelly also discussed their recovery in relation to other women in and outside of the program. Eliza discussed how her first meeting was a women’s-only meeting. Although Eliza’s choice of a women’s-only group was not deliberate, she noted that “a lot of things I did were mostly with women around food and weight issues” in reference to the other groups and resources that Eliza had used in the past. It is possible that an all-women’s space could be of more comfort for some OA female participants, some of whom, like Eliza, might be used to all-women’s groups. Women’s-only groups were not only a type of OA meeting that I learned about from Eliza, but also represent how some OA groups uphold one of the earliest requirements of OA, that members could only be women. I left my field research wondering what the possible benefits or disadvantages of an all-women’s OA group would be. Would having a community of women in OA change the meaning of the program to participants? Although the early founders of the program eventually decided that this wouldn’t
be the case, I wondered if the findings would be different today considering that we are now experiencing a new level of feminist activity and awareness across the U.S.? Could women-only meetings serve as spaces of feminist empowerment, community and awareness of social factors in disordered eating behavior? Furthermore, would the steps, traditions and tools of the OA program work differently or at all in an actively feminist space? As Kelly noted during our interview, she often feels different discourses from women around body image and food in the workplace, and these discourses challenge what she learns in OA in ways that she feel undermine her recovery. She shared:

“So I’m overweight now, I’m trying not to eat flour and sugar. I feel like there’s a lot of pressure, especially working in the department that I work in, because there’s a lot of emphasis on loving your body, accepting people as who they are, there’s a lot of women that work in my office who question, ‘Why do you deprive yourself?’ You know, ‘You don’t need to. What’s wrong with eating sugar?’ I don’t want to explain, ‘Well, I’m in OA, I’m an addict,’ you know, I just don’t want to. And of course, they think I’m suffering from low self-esteem that, you know, a lot of women put too much pressure on themselves to be thin, so I know some of them are classifying me that way. But, I feel better when I’m not eating flour and sugar, I feel better mentally, I’m much more peaceful.

Kelly’s workplace dilemma touches upon the idea that women who are not eating flour and sugar are depriving themselves in order to reach unrealistic body standards. However, Kelly’s understanding of her food behaviors as being compulsive and detrimental to herself suggests that she indeed benefits from avoiding flour and sugar. In light of Kelly’s remarks, I wonder where the balance is between recognizing addiction/recovery and achieving empowerment as women, particularly within the OA program. While I do not want to assert that the OA program does not already present women with empowerment as it is, but instead that members often struggled with some of the messages of the program and whether or not they provided this empowerment. From the patriarchal overtones of the prayers and language in OA to the gender roles presented by
some of the material still used in the program, aspects of the program challenged some of the fundamental values of my participants that had to do with the political and social status of women in the program.

I do not think that any of my participants would have stayed in the program if they did not feel they were getting some kind of empowerment from being there. In discussing the nature of women’s experiences in the program during our interview, author Margaret Bullit-Jonas noted:

*I’m sort of imagining the anti-feminist argument [against OA] which would be something like how disempowering it must be to admit, or to say that you’re powerless, where as in fact you have a lot more power than you know. But, paradoxically, that’s the whole message of the 12-step program, is a lot of more power [sic] than you know is available to you, it’s just that the source of that power is not the autonomous ego, it’s not the isolated source. The source of power comes from living in relationship, and actually that’s a very feminist perspective. It’s about... experienc[ing] our interdependence.*

Here, Bullit-Jonas took the definition of feminism and moved it towards the communal, and later claimed that she absolutely found the program to be empowering in that it allowed her to come into her spiritual self. This viewpoint well-reflects those members (*Eliza, Gloria*) who purposely created female Higher Powers in order to aid their recovery. I want to suggest that there may be several different ways for individuals to create what can be considered feminist or women’s-empowering experiences in the OA program, a handful of which might be women’s-only meetings, absence of overtly patriarchal language, creating a sense of community, and female Higher Powers. In sum, members drew empowerment mostly from the OA materials of the program that avoided some of the anti-feminist assumptions that the AA literature still includes. Female members in particular created empowerment through connecting with other female OA members to keep their recovery, and creating female Higher Powers. Clearly, female members were drawing empowerment from sources that they felt were respectful of their identities as
women. In part, despite struggles with what exactly the message of the program might be at times, empowerment and recovery was what allowed members to be interested in spreading the message locally and, for at least one member, globally.

‘Carrying the Message’ Globally

The globalization of face-to-face meetings was also occurring within one of my groups. Meredith, who has been in program for ten years, often discussed how she was creating meetings in Southeast Asia. In addition to starting OA Skype meetings in South East Asia, Meredith also went to AA meetings in Southeast Asia, eventually meeting a woman who was interested in establishing a face-to-face OA meeting in that country. They began by holding meetings in this woman’s yoga studio, and Meredith procured OA literature for the meetings. Meredith shared:

I would lead meetings and help with things like that, and then other people just took the ball and it rolled and we ultimately got some... women who were young and enthusiastic, and now we have a translation of the ‘Twelve and Twelve’, which we still have to get published, and we have translated the steps and traditions [and] a meeting format into [the native language]. That was one of my dreams, was to spread the word to Indonesians--not just Indonesians who speak English or ex-pats who are in Indonesia—that obesity is a problem in Indonesia now... there’s lots of fast food, and there is a different lifestyle and obesity is a serious problem, so I really think that OA would just help so many people, and I have a lot of hope that it will actually work, because the other 12-step programs are in operation there.

Meredith’s efforts demonstrate just how quickly OA has managed to spread through one member to another part of the world. While Meredith is only abroad for half of the year, the group meets year-round. Meredith has managed to carry the message half-way across the world while still contributing to spreading the message within her local U.S. meetings. Questions for further research might be where exactly OA has spread to, and where has it not spread to or failed? How
do the principles and values of the OA program interact with the cultures in which meetings are started, and what concerns do these members have about the political and social meanings of the program?

**Conclusion**

This chapter suggested aspects of the OA program that have been brought up as concerns in both business meetings and during interviews with individual members. Business meetings concerns speak to one fear: that the OA organization is dying. The World Service Organization and the work of the two individual field site meetings presented in this project suggest that OA and OA members believe that if OA does not begin to change its language to more obviously include anorectics and bulimics then the organization will fail to attract younger newcomers and may die out. While individuals also expressed concerns about the lack of (young) newcomers to meetings, more concerns were expressed about what kinds of messages the twelve steps and twelve traditions were carrying and how to best outwardly live the ‘twelve and twelve.’ Members struggled particularly with traditions one, ten and eleven (and, in regards to wondering how to best carry the message at all, members struggled with tradition five). While some members believed that new forms of OA meetings challenge or create more OA unity and better recovery, other members worried that they could not appropriately attract members to OA. However, I was most interested in tradition ten in relation to the political and social stance of women within the organization.

About half of participants mentioned that some of the literature in the program, mostly drawn from AA, used outdated gender roles and a patriarchal conception of God, aspects that made these members feel uncomfortable. Female members, however, gained a sense of empowerment from the program by emphasizing the community aspect of OA, defining female
Higher Powers and being validated by other female members in their experiences of compulsive overeating as an addiction. Returning to Lester’s (1999) assertion that the OA program is anti-feminist and disempowering for women, detailed in Chapter II, I present another viewpoint: that OA members find ways in which to make the OA program specifically empowering and contributory to what they themselves need in recovery from destructive behaviors and traumatic past experiences, and that female OA members specifically were able to do this to address histories of sexual, emotional and physical abuse when relevant. In addition, the data I collected suggested that participants did sometimes have issue with the patriarchal assumptions of the AA literature, but that the language of the OA program was less problematic.

Finally, new changes in the program more obviously including anorectics and bulimics and demonstrate a move on the part of the organization to pursue longevity through inclusivity. However, these developments are quite recent. I believe that OA risks losing attention from the next generation if it does not more frequently become known as a program for ‘compulsive eaters,’ and if it does not reconstruct the program in a way that avoids patriarchal assumptions and language. Given the predominance of female members in the ever-expanding OA organization, it is essential that the program is analyzed in respect to the messages that women create for themselves out of the program, both in the U.S. and abroad.
Conclusion

On January 19, 2014, just one month after I had completed my fieldwork, Rozanne S., the founder of Overeaters Anonymous, passed away (oa.org, Rozanne Tribute). This seems to be a critical time for the OA program, not only because of Rozanne’s passing, but also because the organization has been adamant about making significant changes to the language of the OA program to signal a desire, or perhaps a need, to make the program more inclusive. As I end my Division III, I want to reiterate my main findings and explore the experiences of individuals who participate in overeaters anonymous.

My foremost findings are that there are a variety of ways in which members understood their compulsive overeating, including the symptoms they exhibited, explanations for the origin of their disease, and how they defined recovery and abstinence. These modes of being indicate a cultural significance to compulsive overeating; for the participants I interviewed this disease is very real and is relevant to their lives although almost always conceived differently by each individual and even by the same individual at different times. By defining and diagnosing their disease experience, these participants took on an aspect of control for themselves, yet reminiscent of medical authority. They also at times imbued their Higher Power with this same medical gaze and ability, demonstrating a paradox of power. For the most part, participants believed that their Higher Power could help them recover from the disease, and this was strengthened by individual and group practices of ritual and confession.

My preliminary research suggested that the OA program should be viewed as disempowering to women members (Lester 1999). Recall that the OA program gets much of its literature, language and ideology from the AA program, so that while significantly less research has been done about women’s experiences and feminist values in OA, Sanders found in her
(2009) research that women members of AA were able to shape the AA program in ways that empowered them as women.

I observed a similar finding in the experiences of some female OA participants. A second conclusion drawn from this work is that interview participants in my research found ways to make the program empowering by individualizing their recovery to fit their specific needs. My data suggest that the AA literature poses its own set of problems with the use of gendered language and gender roles, an issue that OA participants in this study negotiated by ignoring the presence of this divide in AA literature and putting more stock into the more liberal-minded OA language. Participants were able to use other flexible and vague language in the OA program to fit their specific needs in recovery by creating unique Higher Powers, self-defining the symptoms of their disease, and to some extent self-prescribing recovery solutions. By using some of the older language evoked in the AA program, OA risks deterring younger individuals from joining and perpetuating outdated stereotypes.

I recommend that OA as an organization begin to critically examine the values it promotes in its use of language and ideology. Some members did point out blatantly patriarchal, oppressive or religious discourses within the literature used in OA meetings that could easily be removed in favor of gender-neutral or spiritual, but not religious, language. By not changing this language, 12-step organizations are implicitly promoting gendered and Judeo-Christian perceptions of the world which no longer match up with widely held beliefs about equality, gender and spiritual practice in the U.S.

The OA program as a whole, including the two groups in which I conducted fieldwork, is concerned about attracting younger members. While the program has already enacted measures that speak to eating disorders more prevalent among younger generations, it is also reasonable to
think about popular conceptions of gender and spirituality that may (or may not) intersect with youth membership. While there are no simple solutions to being more open to women and younger members, engaging with how the OA program could be used or shaped by younger members in order to provide them with empowering recovery is a worthwhile endeavor. Including younger members in reshaping the language would likely provide a stronger sense of community for a wider audience of participants.

The OA program will struggle to survive, locally and globally, if it fails to speak to potential participants in ways that validate and empower a broader population of people looking for eating disorder support. The ways in which these messages are framed may have to be slightly altered or evolve to succeed as recovery options for the next generation.

When I started my fieldwork I wondered if OA’s medicalization of overeating caused participants to still put stock in medical solutions while shying away from fad diets. OA medicalizes compulsive overeating to the extent that it uses the language of disease in order to imply a need for healing. However, the disease is not expected to be cured by doctors, medication, or surgery, although counseling therapy is often used by participants. Instead recovery in OA necessitates involving a Higher Power. Thus OA is a blending of medical discourse with the spiritual belief that directs the reworking of the self into solving the modern and culturally specific dilemma of disordered eating behavior. By framing compulsive overeating as a disease, OA not only removes blame, but enhances the spiritual framework of an individual alongside modern understandings of what kinds of behavior and conditions necessitate intervention. The majority of participants may have a hard time swallowing the spiritual dosage of the OA program originally, but they soon learn to appreciate that as a disease their condition is beyond their control and that they require a Higher Power to support their efforts. After coming
to terms with this message it becomes easier to imagine divine intervention as necessary to healing the symptoms of the disease.

OA mimics the flow and nature of Christianity in ways that participants often seemed to deny. The OA program flows West to East; it promotes salvation through abstinence from food, is centered around a congregation, and makes use of confession as a means to recovery (soul-saving). OA not only represents a form of spirituality, but incorporates modern values around food, weight and diet and pulls upon successful aspects of Judeo-Christian religious ritual. However, it is also important to consider why participants seemed averse to associating the program with Christianity, as some were adamant that theirs was a spiritual program. In reflecting on the literature, I credit this distinction to the increasing success and popularity of secular methods of weight loss and dieting. Although participants were likely not fully aware of the long history of weight loss, dieting and spirituality in North America, my data reflect participants’ depth of knowledge about more recent methods for addressing eating behaviors and excess, and a profound recognition of the problematic history of addiction and 12-step groups. Participants understood that stressing the spiritual, over religious, nature of the program would perhaps be a saving factor for the program as the next generation begins to look for solutions to similar eating problems. In an increasingly secular but also culturally diffuse world, spiritual practice is becoming a selling point. However, the language and visibility of the program are still concerns for both the local groups with which I worked and the World Service Organization offices of OA.

The third main question of this study is whether or not OA succeeds in empowering its members. I struggled to understand how the program could empower participants if it asked participants to blame themselves for their problems instead of asking them to identify
contributions of larger social struggles in shaping their tendency to be compulsive overeaters.
The language used in program was at times gendered and assumed male identities of members to an extent that was uncomfortable and severely outdated. Although much of the gendered language arose from direct use of AA program literature, OA has been slow in recognizing ways in which this language can limit empowerment off all members. I still am unsure about what to make of the empowerment/disempowerment dilemma, particularly in relation to women’s experiences in the program. On the one hand some women participants claimed that the program helped them to overcome years of physical and emotional abuse, while on the other hand other women in the program indicated that they felt hopeless because they had an uncontrollable disease. They felt as though they should be able to eat without fear and love their bodies, but some aspects of the OA program doubt they could gain that state of mind and be free of disease.

Analysis of interviews and participant-observation data lead me to conclude that OA can be empowering on two levels. The first is that OA participants had the ability to create empowering messages in OA and therefore participation in the program empowered them to understand their experiences and work toward recovery. Evidence of this is the persistence with which most of the participants advanced the idea that for them, the program was empowering; almost half of female participants expressed that they felt that their experiences as women with disordered eating behaviors were validated by program involvement and the way in which they shaped their individual program.

The second level on which OA can be seen as being empowering is that it provides a place for participants to create a social connection and sense of identity on the basis of shared biological, or even genetic, conditions. Rabinow (1992; 2009) calls the shared identities that such a place supports biosociality. OA stresses that compulsive overeating is a disease and that
participants define this disease as explicitly affecting their biology. In some cases, they see this disease as being inherited, and this shared understanding can help to create biosociality. However, on a deeper level biosociality allowed participants to connect over issues of eating and weight within a wider culture that often stresses individualized and internalized campaigns of slimming. The actualized goal of OA is not to improve the individual so much as it is to improve the communal setting and to link participants with one another through their shared experience of the 12-steps. OA necessitates the communal because it depends on the use of ritual, particularly confession, in order to make ‘real’ the disease-status of compulsive overeaters. The disease and spiritual recovery are cyclical. This is a cycle which propagates itself but which only could exist because of the flexibility of the program.

The OA program itself is purposefully vague in ways that allow OA to continue for decades relatively unchanged. This vagueness may be what saves OA for future generations, since each generation can shape the program to fit itself. OA is neither a counter-hegemonic response to the dominant messages surrounding bodies, weight and eating nor a part of the dominant cultural viewpoint. The program aims to side-step that question entirely, although it does not go unasked by participants in the program. The program is what participants make of it. Aspects of the program are disempowering for some while others find these same passages, same rituals, same sayings to be sources of strength. The interpretation of what one is to do in the OA program is flexible to such an extent that numerous contradictions can be accommodated. It is this flexibility that has allowed the program to perpetuate so far. But its longevity may be threatened by new values in the modern age if that flexibility doesn’t allow the program to actively acknowledge and support social and cultural groups with explicit and empowering language.


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