Implications for Counseling Women Recovering from Binge Eating Disorder

Treatment Modalities

When working with a woman with BED, a feminist psychodynamic therapist would ask, "What is this woman really hungry for?" A self-psychologist would ask the question, "What void (need) is this woman trying to satisfy with food?" And, a behaviorist would ask, "What can this woman do to better manage her disordered eating?" The data from the present study provided insight into the best types of psychotherapy needed for women in recovery from BED.

Feminist therapists contend that counseling provides an opportunity for women to reclaim their *voice*. (Gilligan, 1991; Orbach, 1998). Wastell (1996), a counselor and author, believed that counselors working with women should emphasize the importance of connectedness and assist their clients in finding their lost voice.

Important parallels can be made between Wastell's article and the themes of the present study. The data holds significant evidence to support the claim that women have lost voices and that these voices, once heard, lead to freedom from a particular disorder, in this case BED.

The 10 participants in this study all discussed the importance of coming out of isolation and shame about their disorder by talking to someone about their experience. To begin recovery, they needed to tell their story and be heard. Gilligan (1991) encouraged this by stating that a counselor's job is to "strengthen healthy resistance and courage, to help women recover lost voices and tell lost stories, and to provide safe houses for the underground" (Gilligan, 1991, p. 29).

Following Gilligan's (1991) lead, the therapist and client must develop an authentic relationship, a relationship where the client feels heard and understood and is able to open up with her "stories from the underground." Ideally a woman can practice having a voice (i.e., speaking up, setting boundaries, and dealing with emotions) with her therapist, which will then enable her to speak up with others.

The theoretical model of self-psychology supports the development of an authentic relationship between the client and therapist. Self-pscyhology aims to to strengthen the self. The therapist's role is of utmost importance and it is important that the client experiences a therapeutic environment in which she feels respected, accepted, and understood. In self-psychology, the therapist removes herself from the work of the patient. The therapist neither self-references, nor directs the patient in a particular direction. The work is up to the patient, and the therapist's primary role is to create an environment that is safe and trusting so that the client will feel comfortable to disclose.

Group work with women with BED could be a helpful treatment modality. The women in the present study all expressed some level of shame and isolation associated with their disorders. Groups are a supportive environment, as demonstrated by many of the study participants' involvement in OA and group counseling. Counselors can facilitate groups that integrate many of the components mentioned by the participants as helpful in their recovery processes: addressing physical and physiological hunger, coping with emotions, and incorporating spirituality into recovery.

Counselor education

Of the 10 participants, 2 entered therapy/counseling with the intent of addressing their binge eating. Four participants participated in therapy to deal with other issues and the binging emerged as a secondary issue. The remaining 4 participants began therapy after they had addressed their binge eating and had an understanding of some of the core issues related to their disorder. Thus, women in counseling settings may have issues with food and body that they will not bring to their counselor's attention. A counselor working with women may want to include questions specific to nutrition and to how their client copes with stress, feelings, and relationship issues in their initial assessment/intake.

Family Education

When treating an adolescent with an eating disorder, most often the family is included in the treatment. With adults, however it is up to the client as to how much her family is involved. The

participants in the present study felt a variety of ways about family members and the recovery process. Many felt that because their families did not understand the disorder they were unable to be helpful. Two women confided in family members when they were teenagers, one to her mother, another to her sister. Participants felt their significant other (either spouse or partner) was the best source of support. One woman is grateful for how her husband appreciates and loves her body just as it is. Another woman felt her partner's support when at a social event where food is present. Counselors working with women with BED might want to consider about the significant other as a valuable tool in recovery.

Educating Healthcare Professionals

Several of the women in the present study reported that healthcare professionals lacked awareness of the nature of BED and could not address their health and psychological needs. The complex nature of BED symptomatology may cause confusion with other eating disorders, especially if a woman is not significantly overweight. Clinicians and medical providers, informed of the unique etiology and treatment needs of BED, would contribute to a higher rate of early intervention. Mental-health practitioners treating women who demonstrate BED-related symptoms can support their clients by providing an opportunity to address the psychological and social issues related to the disorder.